ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

SSC5b Reflection – Anaesthetics (6 Week Placement)

Having spent only a few weeks in total on an anaesthetics rotation, I was keen to gain further experience in the field. Upon undertaking the elective, I set the following learning objectives, which I will use to guide my reflection:

Learning objectives:

1. Understand and describe how emergency/major trauma affects anaesthetic approach, and discuss this in the context of elective procedures.

2. Gain an appreciation of excellent anaesthetic care, and discuss the implications of this on recovery and surgical outcomes.

3. Develop and build on current clinical and practical skills, particularly around management of the airway, and to gain first hand experience of dealing with emergencies in a supervised clinical environment.

With regards to emergency situations and major trauma admissions, one case comes to mind. A male patient was conveyed to the emergency department by HEMS with bilateral traumatic amputation of the upper limbs, following a pedestrian-versus-train incident. This was the first major trauma case that I have had the opportunity to observe, and as such had felt daunting waiting for the patient to arrive. In the emergency department, however, I was able to observe a handover between the prehospital team and the trauma MDT. Despite the severe injuries suffered by the patient, it was interesting to note that the handover was performed in a calm and professional manner – but equally in a familiar format to that which I had been taught to document clinical findings over the course of my training as a medical student. This highlighted the importance of adopting a systematic approach to the patient, regardless of the grade of injury or illness. It also demonstrates that clear and concise communication is key, particularly in time-critical situations. This principle carried through to the operating theatre, where I noted that there was a clear dialogue at all times between the anaesthetic and surgical teams. This has real clinical consequences – and often governs the management of the patient. A good example of this is prior to the first surgical incision, which typically results in a physiological response of the patient to raise their blood pressure heart rate. In practice, small delays in the commencement of surgery can result in prolonged period of induction agent-induced hypotension. As such it is then a clinical decision of whether to give vasopressors to counter the vasodilatory effect of anaesthetic agents, and potentially have a resultant hypertensive patient when surgery does commence, or to adopt a watch and wait approach. Good communication between teams reduces this risk, and informs the clinical management of the patient. Clearly this skill extends beyond the operating room and demonstrates the importance of having a broad understanding of the

concerns of other involved specialties, and communicating this information to them in good time to inform their management plan. I hope to implement this skill to my future practice, though I am aware that this will require a certain amount of experience working alongside other specialties, which I hope to begin to gain over the course of my foundation training.

From an anaesthetic perspective, I was initially surprised that the approach to maintaining anaesthesia was relatively unchanged from an elective procedure. Induction and intubation had been performed on scene utilising rapid sequence induction. This was the major difference I noted, where elective patients are typically kept nil by mouth up to 6 hours prior to induction. Despite this it was reassuring, again to see a familiar approach to maintaining anaesthesia through the A to E approach, again highlighting the importance of being systematic in practice and is a skill I hope to emulate in my future practice.

Prior to undertaking this elective, my limited anaesthetic experience had provided the opportunity to build on existing clinical skills and gain insight into practice. However, the longer placement allowed me that gain an appreciation of excellent anaesthetic care. One of the most striking features I noted was that care started before the patient entered the anaesthetic preparation room. Pre-operative assessments are carried out by both medical and surgical teams, anaesthetic machines are tested and checked, equipment is prepared and anaesthetic emergency drugs are drawn. Rigorous attention to detail is clearly an invaluable and essential quality to carry into all clinical specialties, however in anaesthetics I felt that a special case must be made. It was not an uncommon occurrence for patients to be less concerned about the procedure they were about to undergo, but to be anxious about the possibility of anaesthetic awareness. Anaesthetic awareness describes an uncommon intra-operative complication of general anaesthesia, where a patient is conscious and able to perceive painful stimulus from invasive procedures/surgery but unable to move or communicate awareness due to neuromuscular blockade. Understandably, this is a frightening prospect for any patient due to undergo general anaesthesia. The largest national audit of accidental anaesthetic awareness was carried out in 2014 in the NAP5, and many of the recommendations suggested to reduce the risk of anaesthetic awareness and the adverse long-term psychological effects on patients lie in the pre-operative phase. This demonstrates the importance of preparation in all aspects of practice – whether in the anaesthetic room, or, for example, when called to see an unfamiliar patient on call. Familiarising oneself with the patient's history before making clinical decisions in a non-critical situation is fundamental to good clinical practice. Similarly, ensuring all equipment is gathered prior to commencing a clinical procedure is key to a good outcome. Beyond this, from a patient perspective, I felt it was reassuring to be in the presence of a competent medical team, who would address the risks of anaesthetic awareness with anxious patients, but would also then be confident in discussing the checks and monitoring in place to mitigate the risks of this occurring.

In the role of a medical student on the team, I also felt that this provided a safe and positive learning environment for me to practice and develop key anaesthetic skills. As a junior member of the team, there is always a basal level of anxiety when performing skills or procedures with which you are relatively inexperienced with. I felt that I was well supported throughout the placement, and often the pre-operative checks and dialogue between anaesthetic team and the patient did as much to reassure the patient as it did to reassure me in initially performing key airway management skills, to eventually running a routine elective general anaesthesia, under consultant supervision, at the end of my placement. In my mind, I felt that this served as the greatest feedback for my clinical skills learning objective where I hoped to 'develop and build on current clinical and practical skills, particularly

around management of the airway, and to gain first-hand experience of dealing with emergencies in a supervised clinical environment.'. There were few opportunities over the course of my training to have hands-on experience of airway management until now, however, I now feel confident that I would be able to manage this in an emergency situation until senior help arrived. Medicine is, in many ways, as much about teaching as it is about learning. As set out in the 'Tomorrow's Doctors 2016' document by the GMC, the role of a doctor should include supporting learners. I hope in my future practice to draw on my experience with the anaesthetic team to foster a safe learning environment for both patient care and students learning – incorporating good preparation into teaching and clinical duties.

In summary, I found the elective thoroughly enriching, and I feel confident that the skills I have had the opportunity to develop and observe are highly transferable to all aspects of medicine and will stand me in good stead to deliver quality care as I prepare to commence my foundation training.

Key Learning Points:

- **Adopting systematic approach to clinical practice both in terms of assessing a patient, but also in terms of conveying that information clearly and concisely to colleagues**
- **Communication skills are fundamental to the delivery of care and information both to colleagues in involved specialties, but also in terms of delivering quality care to patients and mitigating patient concerns**
- **Fostering a safe learning environment is beneficial for both patients and learners.**