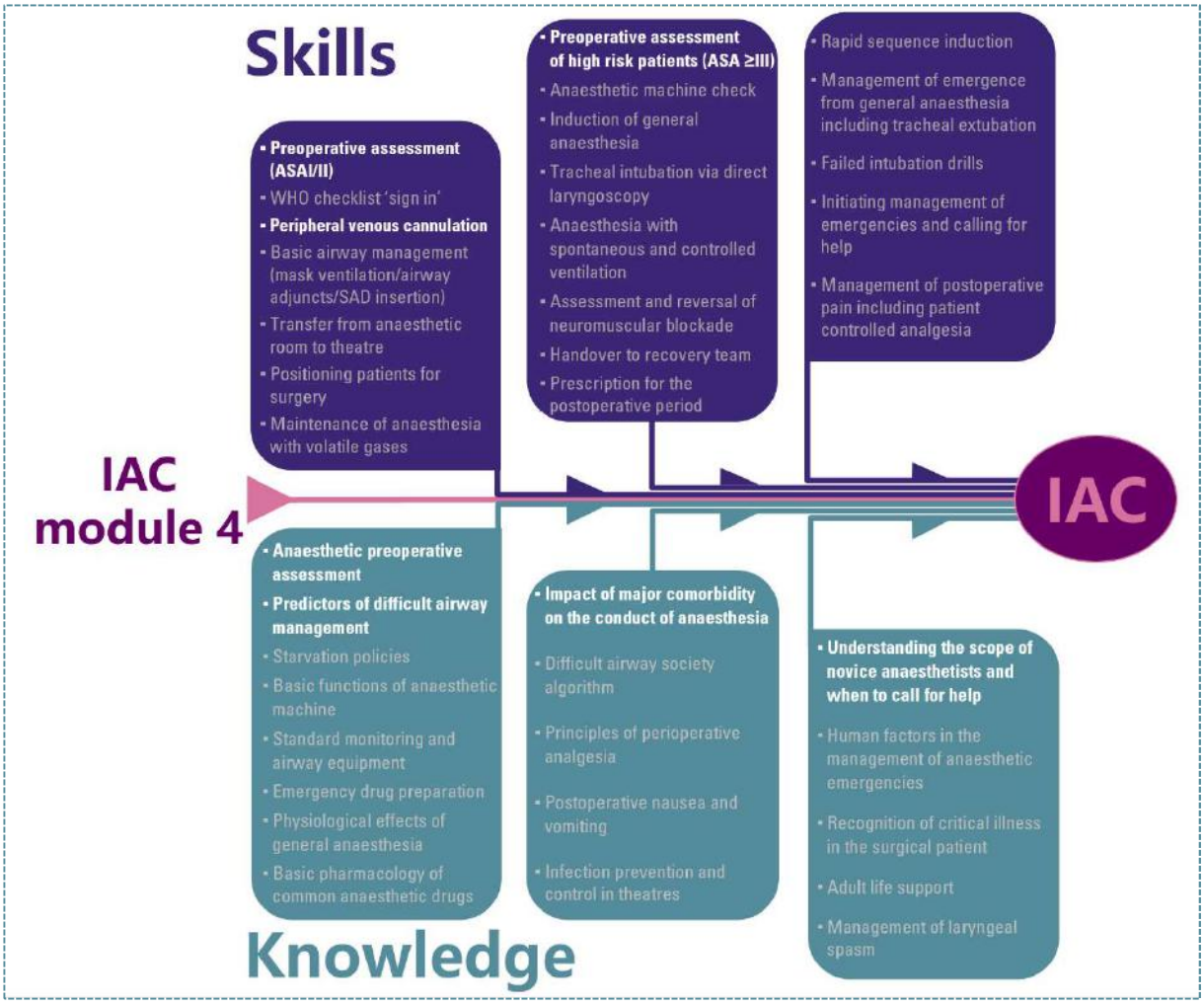
Learning outcomes

By the end of IAC Module 4 the learner will:

- Have used the preassessment knowledge gained in IAC module 1 in a virtual OSCE exam history taking station
- Have used the resuscitation knowledge gained in IAC module 3 in a virtual OSCE interactive resuscitation station
- Have preassessed a virtual emergency patient
- Know some commonly used risk assessment tools and have used these to risk stratify an virtual emergency patient
- Be able to describe the ASA-PS classes and give examples of these
- Know the NCEPOD classification of urgency of intervention
- Understand the principles of shared decision making and discussing risk with patients
- Use the information gained throughout the module to formulate an anaesthetic plan for a high-risk patient undergoing emergency surgery

Trainer information

During the module learners will be developing skills and knowledge mapped to the RCoA IAC curriculum (see figure bellow).



Please note: The previous IAC Modules provide background knowledge and platform familiarity which is desirable, but not essential to learners before undertaking IAC Module 4.

IAC Module 4 starts with a virtual OSCE. Learners undertake a History taking station with a mock patient undergoing an abdominal hysterectomy. They are required to take a targeted anaesthetic history and illicit relevant information from the patient. This station is followed by a virtual interactive resuscitation station on a 'sim man' in cardiac arrest. This is to be managed according to the Resuscitation Councils 2021 Resuscitation guidelines. Both elements of the exam are internally marked by the programme and bespoke feedback given via a 'results letter' at the end of the module.

Discussion of a trainee teaching session then includes a literature review summary providing information on assessing anaesthetic risk and the NCEPOD classification of urgency of intervention. Risk assessment tools introduced here include ASA-PS, POSSUM and P-POSSUM, the NELA calculator, SORT and ACS NSQIP.

The learner then undertakes a virtual 'night-shift' in a DGH where the supervising consultant is non-resident. A high-risk but stable patient with SBO is booked for emergency theatre. The virtual 'shift' develops with the assessment of this patient and ongoing management using both clinical evaluation and the risk assessment tools introduced earlier in the module. The NICE guideline 197 *Shared Decision Making* and the RCoA infographic on discussing risk with patients is incorporated into the narrative as well as information from the Sixth Patient Report of NELA on the importance of active consultant involvement in the diagnostic, surgical, anaesthetic and critical care elements of high-risk patients care pathways.

The learner is encouraged to consider how pre-existing comorbidities and the surgical pathology, influence the choice of anaesthetic agents, monitoring, and perioperative management of this patient, however this is not the focus of this module with the expectation that all learners at this stage of training will be developing skills surrounding making these sort of decisions in the context of being directly supervised by senior clinicians.

Trainer information - discussion

Discussion of the case should develop naturally according to the individual's learning needs in a similar fashion to a CbD in a clinical setting. The learner should be encouraged to develop their own professional judgment according to required curriculum competence areas. The learner should be aware of these as they are stated at the start and on completion of each Module.

Other points for discussion could include:

- Risk assessment tools and their use in practice
- How to support patients in shared decision making
- What are the key differences between emergency and elective patients?

Appendix 1: IAC Module 4 transcript

Jonus Dalby: *Thought I had a bug, ate something I shouldn't, took myself off to bed with a bucket, couldn't really see what all the fuss was about. Now some surgeon is here telling me I have to have a big operation because my innards are blocked. Can't really understand it. I'm fit as a fiddle me.*

Molly Dalby: *Tell them really been happening Jonus. He's been really poorly, not well, for two weeks at least, not been keeping anything down, not done number two for all that time, he's too light headed to stand up even, and not quiet right for months before that, a bit pale and sluggish. Loosing weight, he's not one to be off his food.*

Jonus: *Don't fuss Mol. I can tell the doctor. It is true I've been tired a lot lately, sleeping more. I've got an allotment and it's been hard work recently. I've still been going on my bike but half an hour with a spade and I'm fair done in, last season I'd spend the day there and stop off for a game of darts on the way home. Not now! The last week I've not even left my bed, it's not surprising though, I haven't eaten anything for days.*

Molly: *It's not like him. He doesn't bother the doctor for anything usually. Wouldn't set foot in a hospital if he could help it. Just gets his blood pressure checked once a year with the nurse. He's taken ramipril for donkeys years, never missed a day, and that's it.*

Jonus: *I had my tonsils out as a child, didn't have any problems but it was enough to put me off. I don't understand this all. I feel like I've done my bit, gave up smoking forty years ago when I met my Mol. Just a couple of halves of bitter when I'm playing darts, otherwise I don't drink. I like my dinner's, but who doesn't?*

Molly: *He's not even allergic to anything.*

Jonus: *No, nothing. All my own teeth too, dentist says I've got the teeth of a man half my age. One filling and all the rest sound as a bell. Not that their going to do me any good now. But once I've had this operation I'll be back to the allotment in no time.*