Membership Survey 2016

Report

European Society of Anaesthesiology

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The Research Programme

Introduction

The European Society of Anaesthesiology (ESA) commissioned Enventure Research to carry out a survey of its entire membership, consisting of 27,582 members. This includes active members, affiliate members, trainee members, associate members, student members, retired members and honorary members. The ESA wanted to better understand its membership and ensure that the organisation continues to reflect members’ needs, views and opinions so that it can provide relevant activities, benefits and support for them in the future.

Research Objectives

The survey aimed to provide the ESA with an up to date understanding of the views of its members on certain topics, particularly focusing on:

- Interests and current areas of work
- Communication
- Education
- ESA strategy and future priorities
- Membership benefits
- Relevance of the ESA professionally
- The future of Anaesthesiology

Important information relating to members’ professional and employment status was also collected to place the findings into context.

Methodology

Enventure Research and the ESA developed a questionnaire in partnership to ask questions around the topics listed above. A copy of the survey can be found in Appendix A.

The survey was hosted online by Enventure Research. The ESA provided a database of 27,024 working email addresses of its membership. These members received an email inviting them to take part, along with three reminder emails if they did not respond. The initial invitation email was sent on 17 March 2016, with reminders following on 1 April 2016, 11 April 2016 and 18 April 2016. To encourage them to complete the survey, members were offered the chance to take part in a prize draw to win either free registration at the Focus Meeting 2016 or free registration at Euroanaesthesiology 2017.
Survey Output

In total 2,621 responses were received from ESA members. Six in ten took part in the survey using a desktop or laptop computer (62%) and the rest used a smartphone (9%) or tablet (29%). Figure 1 shows the breakdown of device types that were used to access the survey.

Figure 1: How ESA members responded to the survey

<table>
<thead>
<tr>
<th>Method</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online – desktop or laptop computer</td>
<td>1,618</td>
<td>62%</td>
</tr>
<tr>
<td>Online – smartphone</td>
<td>243</td>
<td>9%</td>
</tr>
<tr>
<td>Online – tablet</td>
<td>760</td>
<td>29%</td>
</tr>
</tbody>
</table>

Based on the survey invitation being sent to 27,024 members this is a response rate of 10%.

Interpretation of the Data

This report contains several tables and charts that present survey results. In some instances, the responses may not add up to 100%. There are several reasons why this might happen:

- The question may have allowed each respondent to give more than one answer
- Only the most common responses may be shown in the table or chart
- Individual percentages are rounded to the nearest whole number so the total may come to 99% or 101%
- The respondent may have skipped over the question
- A response of between 0% and 1% will be shown as <1%

As routing was used in the questionnaire (i.e., certain questions skipped depending on respondents’ answers to other questions) base sizes may vary slightly by question.

For the analysis of some questions, we have amalgamated some of the responses together in order to interpret the data. We have done this in cases where responses can be added together to indicate a level of satisfaction or relevance with something e.g. “Very satisfied” and “Somewhat satisfied”, and “Very relevant” and “Somewhat relevant”.

Subgroup analysis has been undertaken to explore the results provided by key subgroups such as membership category, gender, professional status, place of work, and years working in Anaesthesiology. This analysis has only been carried out where the sample size is seen to be sufficient for comment (over 20). In order to compare results between subgroups, statistical analysis has been undertaken. This allows us to be confident that any difference between scores is real and is not due to chance. Results between subgroups have been tested at a 95% confidence level. Only those differences that are statistically significant according to the z-test have been commented on within this report. The z-test is a commonly used statistical test to highlight whether differences in results are ‘significant’. By ‘significant’ we mean the likelihood that two results would still be different if all members had responded to the survey.

There were also a number of open-end questions in the survey which allowed respondents to write their own response rather than tick a box. To analyse these answers and present them in an understandable way, responses to each open-end question have been sorted into a number of categories and themes, allowing them to be visually presented as charts and tables.
Key Findings

Positive response numbers from a range of different countries

A total of 2,621 ESA members responded to this year’s membership survey. This is a base size that allows for a confident level of analysis to be conducted on the survey results, meaning that results drawn are valid.

Nearly six in ten respondents (56%) were active members, one in seven (14%) were affiliate members, a tenth (10%) were associate members and a further one in ten (9%) were trainee members.

Respondents were from a range of different countries, with the largest proportions currently working or practicing in Germany and Italy (12% and 9%). There were also a number of respondents who currently work or practice outside of Europe who took part in the survey.

Most members work or practice in public hospitals

Nearly all respondents (97%) said they worked or practiced in a hospital, with over half (52%) saying this was in a university hospital and three in ten (28%) in another kind of teaching hospital. Nine in ten (90%) said that this was a public hospital or provided a combination of public and private healthcare.

Accessing information

The ESA website was the most popular method for accessing information from the ESA with more than six in ten (63%) using it, highlighting the continued importance of keeping it up to date with the latest news and information. Almost six in ten (58%) used the online newsletter to keep up to date and over half (52%) used e-communication.

The use of social media to access information from the ESA was generally low, with Twitter, Facebook and LinkedIn all being mentioned by less than 5% of respondents, suggesting that these methods of communication could be further promoted to increase their impact. However, it should be noted that trainees are most likely to use Facebook to access information about the ESA, with one in nine (11%) saying they used it for this purpose, and so the usage of social media to keep up to date with information about the ESA may increase in future years.

Positive rating of interaction with the ESA

More than four in five respondents (87%) rated their experience of interacting with the ESA as either ‘good’ or ‘excellent’. Satisfaction was particularly high for active members. This should be seen as a positive result for the ESA as it shows that members’ needs are being met when they need to get in touch with the Society, and is a result which could be promoted throughout the organisation.

Attendance at and participation in ESA activities

The survey results show that the Euroanaesthesia Congress is the most popular event, attended by more than half of respondents (51%) within the last three years. This was particularly high for active members of the ESA. A quarter of respondents (23%) participated in European Diploma exams and related activities and a fifth in e-learning (21%), the latter being particularly popular amongst students and trainees (27%).
A quarter of respondents (26%) indicated that they had not attended or participated in any ESA activities in the last three years, but it is important to remember that this percentage is largely driven by associate members.

The main factors which prevent members from attending or participating in ESA activities include not being able to secure time off from work, budget constraints, and lack of awareness. The latter highlights a need for the ESA to further promote its activities and events to its membership in order to increase participation rates amongst members.

**CME / CPD**

The survey results show that the most common way of funding CME / CPD activity per annum is self-funding, with half of respondents (49%) funding it this way. A third (34%) said it was funded by a combination of self-funding and employer funding. Only a tenth (10%) rely solely on study leave budget allocated by their employer.

On average, around a quarter of respondents’ CME / CPD is achieved via medical journals (26%), local and regional meetings (25%), and training at the workplace (23%). Only a fifth is achieved via e-learning (20%), suggesting there is scope to significantly increase the amount of CME / CPD achieved via this method.

Two-thirds (67%) of those who use e-learning do so via a laptop computer and half (49%) do so using a desktop computer. However, significant proportions also use mobile devices including tablets (41%) and mobile phones (33%), highlighting the importance of these methods and the potential to increase their use in the future. Undertaking e-learning using a mobile phone is particularly important for trainees and students, almost half of whom (48%) used this method. It is, therefore, important to ensure that any access and compatibility issues are taken into consideration for future e-learning to ensure that those who wish to complete their CME and CPD via these devices are not discouraged.

**Important issues for the ESA to focus on**

Guidelines (65%), education at all levels (54%), and patient safety and quality of care (54%) were the most commonly selected important issues for the ESA to focus on. To ensure that the ESA continues to represent the interests of its members and the wider profession, these areas and issues should be taken into consideration, particularly given that the majority of members work in the provision of healthcare.

**Membership benefits**

The most valued benefits of ESA membership were subscriptions to various publications, such as the European Journal of Anaesthesiology (85% valuable), Current Opinion in Anaesthesiology (81% valuable), Current Opinion in Critical Care (78% valuable) and the online ESA newsletter (78% valuable). These were followed by availability of post-Congress educational material (78% valuable), access to the e-learning platform and ESA educational activities (76% valuable), and discounts to ESA meetings and educational activities (74% valuable). Therefore it is recommended that these benefits are the focus of future promotion of the ESA membership package to new members to grow membership, emphasising their importance and value to those working within the profession.

Subgroup analysis highlights that trainee members give more importance to quite a few membership benefits, particularly those related to training and education. Therefore, specifically tailored promotion focusing on these benefits to trainees and students may be of use when trying to attract new members.
When trainee members were asked specifically, e-learning (48%), basic sciences anaesthetic courses (47%) and journals (41%) were suggested as being the most valuable aspects of membership. By contrast, networking (13%), masterclasses (18%), refresher courses (19%) and Euroanaesthesia scientific sessions (18%) were suggested by much smaller proportions of trainee respondents.

The most commonly suggested reason by associate members for not becoming active members was the cost of membership (44%), followed by not knowing enough about the benefits of membership (35%). It is recommended that the ESA focuses on a campaign of raising awareness of membership benefits in order to attract new active members.

**ESA performance and relevance**

The survey results show that respondents reported the highest satisfaction levels with the ESA’s performance in relation to guidelines, general information about the ESA, publications and clinical information, with seven in ten reporting they were satisfied with each (74%, 72%, 71% and 69% respectively). This should be seen as a positive result, given that members see publications and information as some of the biggest benefits of ESA membership and that guidelines was suggested as the most important issue for the ESA to focus on.

However, the ESA should take into account that more focus should be placed on how the Society promotes the profession to the public and media, as more than a fifth of respondents (22%) expressed dissatisfaction with this. This was particularly high for active members (25%). The ESA may also want to investigate how research opportunities are promoted and communicated with members, as one in seven (15%) reported dissatisfaction with the ESA’s performance in relation to these.

Positively three-quarters (74%) said the ESA was relevant to their professional life and this was particularly high for active members and those who had been working in the field of Anaesthesiology for a long time. There is, however, scope for the ESA to raise its profile in order to increase relevance for members. When asked about what would make the ESA more relevant to them, three-quarters of respondents (75%) said clinical practice guidelines and half (49%) said keeping members informed about top issues in the field. Those who said that the ESA was not relevant to them were most likely to say that ultrasound imaging (26%), and a library of medications and interaction with anaesthesia (27%) would make it more relevant. It is recommended that the ESA continues to focus on these in the future.

**ESA membership in the future**

The survey results indicate that the majority of members want the ESA to continue to be a society for individual membership, national societies and specialist societies as it is today, with almost two-thirds saying this (65%). This is especially high for those working in the field for less than three years highlighting that this is important for the newer members of the Society.

**Important areas in developing the specialty of Anaesthesiology**

In relation to developing the specialty of Anaesthesiology over the next 10 years, the survey results show that the most important area for members is ‘defining Perioperative Medicine and the role of the Anaesthesiologist’ with more than half suggesting this (54%). This was followed by ‘improved education and training’ and ‘a particular qualification on top of a primary specialty’ which were both suggested as important areas by more than four in ten respondents (47% and 44%). These latter two areas were particularly important for student and trainee members. It is recommended that the ESA considers its role and contribution in relation to these three areas over the next 10 years.
Respondent Profile

Membership category

At the beginning of the survey, respondents were asked to identify their ESA membership category. As shown in the chart below, almost three in five (56%) respondents said that they were an active member and one in seven (14%) said they were an affiliate member. A tenth (10%) said they were an associate member and 9% identified themselves as being a trainee member. One in twelve (8%) said they did not know their membership category.

Figure 2: Membership category
Base: All respondents (2,621)
Current professional status, work / practice & gender

When asked their professional status, as shown in the chart below, the largest proportion of survey respondents indicated that they were a consultant or staff (37%). Almost three in ten (28%) said they were a specialist, one in seven (15%) were heads of department, one in eight (13%) were trainees, and 5% worked in academic roles. Very few respondents were students (1%) or retired (1%).

Figure 3: Current professional status
Base: All respondents (2,621)

- Consultant / Staff: 37%
- Specialist: 28%
- Head of department: 15%
- Trainee: 13%
- Academic: 5%
- Retired: 1%
- Student: 1%
- Other: 1%

‘Other’ responses included medical research, clinical trial management, private consulting work and currently being out of work.
The chart below presents the breakdown of where respondents said they currently worked or practiced. Just over half of respondents indicated that they worked in a university hospital (52%), followed by almost three in ten (28%) saying they worked in a teaching hospital that was not university affiliated and one in six (17%) worked in a non-teaching hospital. Very few respondents worked in academia with no hospital affiliation (1%) or said they did not work in a hospital (1%).

**Figure 4: Place of current work or practice**  
*Base: Those who were still in work (2,584)*

<table>
<thead>
<tr>
<th>Place</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>University hospital</td>
<td>52%</td>
</tr>
<tr>
<td>Other teaching hospital</td>
<td>28%</td>
</tr>
<tr>
<td>Non teaching hospital</td>
<td>17%</td>
</tr>
<tr>
<td>Academia (no hospital affiliation)</td>
<td>1%</td>
</tr>
<tr>
<td>Not in a hospital</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
</tr>
</tbody>
</table>

Respondents were also able to provide ‘other’ responses to this question. Responses included a combination of different hospitals, clinics, hospices and academic institutions.

Respondents who said that they worked in a hospital were asked whether the hospital was private or public. As can be seen in the chart below, eight in ten (79%) said that it was a public hospital, one in ten said it was a private hospital (10%) and a further tenth (11%) said it was a combination of both public and private.

**Figure 5: Hospital status**  
*Base: Those who worked in a hospital (2,487)*

- Public: 79%
- Private: 10%
- Combination of private & public: 11%
The chart below shows the country breakdown of where respondents said they currently worked or practiced. The top 20 countries selected are shown in the figure below. As can be seen, Germany had the largest proportion of respondents currently working or practicing there (12%), followed by Italy (9%).

**Figure 6: Country of work or practice**  
**Base: All respondents (2,621)**

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>12%</td>
</tr>
<tr>
<td>Italy</td>
<td>9%</td>
</tr>
<tr>
<td>France</td>
<td>5%</td>
</tr>
<tr>
<td>Spain</td>
<td>5%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>5%</td>
</tr>
<tr>
<td>Switzerland</td>
<td>5%</td>
</tr>
<tr>
<td>Portugal</td>
<td>4%</td>
</tr>
<tr>
<td>Poland</td>
<td>4%</td>
</tr>
<tr>
<td>Romania</td>
<td>4%</td>
</tr>
<tr>
<td>Belgium</td>
<td>3%</td>
</tr>
<tr>
<td>Netherlands</td>
<td>3%</td>
</tr>
<tr>
<td>Sweden</td>
<td>3%</td>
</tr>
<tr>
<td>Greece</td>
<td>3%</td>
</tr>
<tr>
<td>Austria</td>
<td>2%</td>
</tr>
<tr>
<td>Norway</td>
<td>2%</td>
</tr>
<tr>
<td>Turkey</td>
<td>2%</td>
</tr>
<tr>
<td>Russia</td>
<td>2%</td>
</tr>
<tr>
<td>Lithuania</td>
<td>2%</td>
</tr>
<tr>
<td>Serbia</td>
<td>2%</td>
</tr>
<tr>
<td>Hungary</td>
<td>1%</td>
</tr>
</tbody>
</table>

A number of respondents also said they currently practiced or worked outside of Europe, with the most common non-European countries mentioned being Egypt, Brazil, Japan, Australia, Saudi Arabia, the USA and India.

When asked to indicate their gender, as shown in the figure below, six in ten (62%) respondents said they were male and four in ten were female (38%).

**Figure 7: Gender**  
**Base: All respondents (2,621)**
Country of diploma achievement and years in the field

Respondents were asked which country they achieved their diploma in. As can be seen in the figure below, again Germany was the most selected country (14%), followed by Italy (9%). Please note that the chart below only shows the 20 most selected countries.

**Figure 8: Country of achieving diploma**

*Base: All respondents (2,621)*

A number of respondents mentioned non-European countries in which they achieved their diploma. Egypt, Brazil, India and Japan were the most commonly mentioned.
When asked about how long they had worked in the field of Anaesthesiology, just over a third of respondents (36%) said they had worked in the field for more than 20 years. One in three (32%) had worked in the field for between 10 and 19 years and a quarter (24%) for between four and nine years. One in twelve (8%) had worked for less than three years in the field of Anaesthesiology. This is shown in the chart below.

Figure 9: Years in the field of Anaesthesiology
Base: All respondents (2,621)

Those who had worked in the field of Anaesthesiology for more than twenty years were most likely to be active members of the ESA (43%), be heads of department (72%) and be male (40% compared to 29% of females).

Respondents who had worked in the field for less than three years were most likely to be trainees or students (43%) and be female (10% compared to 6% of males).
Membership of other societies

Respondents were asked if they were members of any other medical societies and were able to select multiple options from a list. This is shown in the figure below. As can be seen almost seven in ten (68%) said they were members of a national society1, which was by far the most selected option. One in eight (12%) were members of the European Society of Regional Anaesthesia and Pain Therapy (ESRA) and one in nine (11%) were members of the European Society of Intensive Care Medicine (ESICM). One in six (17%) respondents said they were not a member of any of the societies listed.

Figure 10: Membership of other medical societies
Base: All respondents (2,621)

<table>
<thead>
<tr>
<th>Society</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Society</td>
<td>68%</td>
</tr>
<tr>
<td>ESRA</td>
<td>12%</td>
</tr>
<tr>
<td>ESICM</td>
<td>11%</td>
</tr>
<tr>
<td>ASA</td>
<td>9%</td>
</tr>
<tr>
<td>SSAI</td>
<td>5%</td>
</tr>
<tr>
<td>EACTA</td>
<td>5%</td>
</tr>
<tr>
<td>ESPA</td>
<td>4%</td>
</tr>
<tr>
<td>EAMS</td>
<td>1%</td>
</tr>
<tr>
<td>LICAGE</td>
<td>1%</td>
</tr>
<tr>
<td>EuroSIVA</td>
<td>1%</td>
</tr>
<tr>
<td>ESPCOP</td>
<td>1%</td>
</tr>
<tr>
<td>ESTAIC</td>
<td>1%</td>
</tr>
<tr>
<td>WSACS</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>EMHG</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>None of the above</td>
<td>17%</td>
</tr>
<tr>
<td>Other</td>
<td>16%</td>
</tr>
</tbody>
</table>

As can be seen in the figure above, a quarter (16%) provided an ‘other’ response to the question. The top five ‘other’ societies listed were:

- IARS (International Anaesthesia Research Society)
- IASP (International Association for the Study of Pain)
- ERC (European Resuscitation Council)
- OAA (Obstetric Anaesthetists Association)
- DAS (Difficult Airway Society)

1 In the survey 58% chose the response ‘National Society’ to this question. However, some respondents chose the response ‘Other’ and named a national society. This is perhaps because some respondents missed the response ‘National Society’ in the question or they did not realise that the society they named was a national society. Those who named a national society as ‘Other’ have been coded as saying they were a member of a national society in the chart above and they have been removed from the percentage of those saying ‘Other’.
Specialist interests

When asked about which specialist interests they worked in, unsurprisingly the majority of respondents (94%) said that they worked in Anaesthesia. As shown in the figure below, over half (55%) also worked in Intensive Care Medicine, three in ten (29%) in Critical Emergency Medicine and a quarter (25%) in Pain Management.

Figure 11: Specialist interests
Base: All respondents (2,621)

- Anaesthesia: 94%
- Intensive Care Medicine: 55%
- Critical Emergency Medicine: 29%
- Pain Management: 25%
- Other: 4%
- None of the above: <1%

Four per cent of respondents also provided ‘other’ responses to this question. These included prehospital emergency medicine repatriation, palliative care, paediatric care, education, research and cardiology.
Respondents who said they worked in Anaesthesia were then asked which area within this discipline they worked in. As can be seen in the chart below, three-quarters (74%) said they worked in General Anaesthesia, just over half (53%) in Regional and Orthopaedic Anaesthesia and four in ten (40%) in Obstetric Anaesthesia. The responses to this question are shown below.

**Figure 12: Specialist Anaesthesia interests**

*Base: Those who worked in Anaesthesia (2,437)*

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>74%</td>
</tr>
<tr>
<td>Regional and Orthopaedic</td>
<td>53%</td>
</tr>
<tr>
<td>Obstetric</td>
<td>40%</td>
</tr>
<tr>
<td>Trauma</td>
<td>36%</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>34%</td>
</tr>
<tr>
<td>Vascular</td>
<td>30%</td>
</tr>
<tr>
<td>Paediatric</td>
<td>29%</td>
</tr>
<tr>
<td>Neurosurgical</td>
<td>24%</td>
</tr>
<tr>
<td>Thoracic surgery</td>
<td>23%</td>
</tr>
<tr>
<td>Cardiac surgery</td>
<td>16%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
</tr>
</tbody>
</table>

Of those that said they worked in Pain Management, the majority indicated that this was in Acute Pain Management (86%), over half said it was in Chronic Pain Management (53%) and a quarter (24%) said Palliative Care Medicine. This is shown in the chart below.

**Figure 13: Specialist Pain Management interests**

*Base: Those who worked in Pain Management (660)*

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Pain Management</td>
<td>86%</td>
</tr>
<tr>
<td>Chronic Pain Management</td>
<td>53%</td>
</tr>
<tr>
<td>Palliative Care Medicine</td>
<td>24%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
</tbody>
</table>
Those who indicated that they worked in Intensive Care Medicine were asked for more detail. As can be seen in the chart below, the majority said they worked in Multidisciplinary Intensive Care Medicine (84%), three in ten (30%) said it was in Trauma, and a fifth said in Cardiac Intensive Care Medicine (18%) and in Neurosurgical Intensive Care Medicine (20%).

**Figure 14: Specialist Intensive Care Medicine interests**

*Base: Those who worked in Intensive Care Medicine (1,443)*

Out of those who said they worked in Critical Emergency Medicine, the majority (95%) said that this was in General Critical Emergency Medicine and 8% said it was something else within the field.

‘Other’ responses included:

- Prehospital emergency medicine
- Air ambulance and ambulance
- Trauma
- Emergency department
- Paediatrics
- CPR / resuscitation
Research Findings

Communications

Accessing information

Respondents were asked to state how they usually accessed information from the ESA and were able to select multiple options. As shown below in the chart, just over six in ten (63%) respondents indicated that they accessed information via the ESA website, followed by a further six in ten (58%) using the ESA online newsletter to access information. Just over half (52%) said that they used e-communication. Relatively few respondents said that they accessed information through social media such as Facebook (5%), LinkedIn (4%) and Twitter (1%). Two per cent of respondents said they did not access information about the ESA using any of the options listed.

Figure 15: Methods of accessing information from the ESA

Base: All respondents (2,621)

Subgroup analysis shows that a larger proportion of active members accessed information about the ESA via the website (68%), E-communication (56%) and the online newsletter (64%) than all other membership categories.

Comparison between male and female respondents shows that males were more likely to access information via e-communication (54%) than females (47%) and in regards to years in the field of Anaesthesiology, those who had worked in the field for more than 20 years were most likely to access information via the online newsletter (64%).

Subgroup analysis of professional status highlights that trainees and students were least likely to state that they accessed information via e-communication at 41% when compared with respondents of other professional statuses. A larger proportion of heads of department indicated that they accessed information via the ESA online newsletter (69%) when compared
to respondents of other professional statuses. Trainees, on the other hand, were most likely to use Facebook for information (11%).

‘Other’ responses of accessing information about the ESA, suggested by 1% of respondents, included the ESA journal and newsletter and emails.

Interaction with the ESA

When asked to rate their experience of interacting with the ESA, almost two-thirds of respondents (64%) stated that it had been ‘good’, followed by a quarter (23%) who said that it was ‘excellent’. One in ten (11%) indicated that their experience of interacting with the ESA had been ‘fair’ and just 2% said that it had been ‘poor’. This result is shown in the chart below.

![Figure 16: Experience of interacting with the ESA](chart.png)

Analysis by subgroup shows that almost a fifth (18%) of associate members rated their experience of interaction with the ESA as ‘fair’ which was the highest out of all the membership categories. Associate members were also least likely to rate their experience of interaction as ‘excellent’ (11%). In comparison, 26% of active members rated their interaction with the ESA as ‘excellent’.

A higher proportion of female respondents rated their experience as ‘excellent’ compared to males (26% compared to 21%) and heads of department were the most likely professional subgroup to give their experience of interaction the same rating (29%). When it came to experience in the field of Anaesthesiology, those who had worked for less than three years in the field were least likely to say that their experience of interaction with the ESA had been ‘excellent’ (17%).

Those who worked in a university hospital were most likely to rate their experience of interaction with the ESA as ‘excellent’ or ‘good’ (89%) in comparison to respondents working in other hospital types or those not working in hospitals. By contrast, 83% of those working in Academia gave the same rating.

When comparing the results of this question with results from the previous question we can see that those who used Facebook to access information about the ESA were most likely to rate their experience of interaction with the ESA as ‘excellent’ (34%).
ESA activities

Survey respondents were asked to indicate which ESA activities, if any, they had attended or participated in during the last three years. As shown in the chart below, the most common ESA activity attended or participated in was the Euroanaesthesia Congress, with half of respondents (51%) saying they had attended it. This was followed by European Diploma exams and related activities, with almost a quarter (23%) saying they had participated in them, and a further fifth had taken part in e-learning (21%). A quarter (26%) of respondents said that they had not attended or participated in any ESA activity in the last three years.

Figure 17: ESA activities attended or participated in during the last three years
Base: All respondents (2,621)

The membership category of respondents had an impact on their attendance or participation in these activities in the last three years. For example, a larger proportion of active members attended the Euroanaesthesia Congress (65%) than any other category and trainee or student members were most likely to have participated in e-learning (27%) or European Diploma exams and related activities (32%).

Professional status analysis indicates again that larger proportions of trainees and students had undertaken e-learning (27%) and European Diploma exams and related activities (32%) than other professions and three-quarters (76%) of academics had attended the Euroanaesthesia Congress. By contrast, only 30% of students and trainees said they had attended the Congress.

There was little difference in responses between male and female respondents, but in relation to years spent in the field of Anaesthesiology, those who had worked within the field for more than 20 years were most likely to have attended the Euroanaesthesia Congress (62%) in the last three years. By contrast, only a quarter (26%) of those who had worked within the field for less than three years had attended the Congress during this time.

Those who worked in university hospitals were more likely to have attended the Euroanaesthesia Congress than respondents who worked in other hospital types, with 55%
saying they had attended it in the last three years. By contrast, only 43% of respondents who worked in a non-teaching hospital said they had attended the Congress.

In relation to those who said they had not attended or participated in any of the activities listed, it should be noted that a large proportion of these were associate members, 48% of whom said they had not attended or participated in any of the activities.

‘Other’ responses, suggested by 2% of respondents, included:

- National activities and national Congresses
- Patient safety courses
- Subcommittee meetings and activities
- Trainee activities and trainee exchange programme
- Reading ESA publications (including the EJA)
- Refresher courses
- Regional anaesthesia courses

Respondents who indicated that they had participated in European Diploma exams and related activities were asked to specify which ones they had taken part in. As can be seen in the chart below, three in four respondents (76%) had taken part in EDAIC Part I and over half (53%) had taken part in EDAIC Part II. Two in ten (20%) had taken part in Online Assessment (OLA) and one in seven (14%) in In-Training Assessment (ITA).

**Figure 18: Participation in European Diploma exams and related activities**

**Base: Those who had taken part in European Diploma exams and related activities (563)**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDAIC Part I</td>
<td>76%</td>
</tr>
<tr>
<td>EDAIC Part II</td>
<td>53%</td>
</tr>
<tr>
<td>Online Assessment (OLA)</td>
<td>20%</td>
</tr>
<tr>
<td>In-Training Assessment (ITA)</td>
<td>14%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
</tr>
</tbody>
</table>

Sub-group analysis shows that affiliate members were most likely to have participated in EDAIC Part I (91%) and active members were most likely to have participated in EDAIC Part II (66%). Trainee and medical students saw the largest proportions saying they had participated in In-Training Assessment (27%) and Online Assessment (32%).

Of the ‘other’ responses, the majority said that their involvement in European Diploma exams and related activities had been through hosting or organising the exams.
Those who had been in the field of Anaesthesia for more than 20 years were most likely to have taken part in EDAIC Part II (72%). By contrast only 23% of those who had been in the field for less than three years said the same.

Respondents who had not attended or participated in specific activities in the last three years were asked to indicate what factors stopped them from attending or participating. The chart below presents the results to this question.

**Figure 19: Reasons for not attending/participating in ESA activities in last three years**

*Base: Those who did not attend / participate: 2,195 / 2,019 / 2,033 / 1,746 / 2,129 / 1,135 / 1,730 / 2,111 / 2,151 / 2,174*
As can be seen, being unable to take time from work appears to be the biggest driving factor behind why large proportions of respondents did not attend most events or participate in most courses (Basic Sciences Anaesthetic Course 33%, CEEA Courses 32%, Focus Meeting on Perioperative Medicine 35%, Euroanaesthesia Congress 38%). This was of particular note amongst heads of department, 47% of whom said that they had not attended Euroanaesthesia Congress and 44% of whom said they had not attended the ESA Focus Meeting on Perioperative Medicine for this reason. Being unable to take time from work to attend an event was also a particular problem for those who said they worked in a non-teaching hospital (Basic Sciences Course 40%, ESA Focus Meeting on Perioperative Medicine 40%, European Diploma exams and related activities 36%, Teach the Teacher course 31%).

Lack of awareness was another commonly suggested reason for not attending, particularly in relation to e-learning (42%) and the Clinical Trial Network (32%). This lack of awareness was particularly prevalent amongst trainees and students, 49% of whom said that this was the reason they had not participated in e-learning and 43% said the same in relation to the Clinical Trial Network.

Budget constraints were also mentioned by quite a few respondents (Basic Sciences Anaesthetic Course 22%, Focus Meeting on Perioperative Medicine 23%, Euroanaesthesia Congress 39%). Again this was particularly high for students and trainees, with 34% giving this as the reason for not attending the Basic Sciences Anaesthetic Course, 30% the Focus Meeting on Perioperative Medicine and 42% the Euroanaesthesia Congress.

Content being of little or no interest was suggested by a larger proportion of those not participating in European Diploma exams and related activities (20%) and Grants (19%).

‘Other’ responses provided in relation to not attending or participating were wide-ranging, and included:

- Living outside of the European Union
- Not being eligible
- Workplace constraints
- Lack of interest / the activity not being a priority
- Activity being based too far away / difficulties in obtaining a visa
- Being too old
- Lack of awareness
- Complicated application processes
- Being unemployed or retired
- Activities being poor value for money
Education

Survey respondents were asked to state how their CME (Continuous Medical Education) or CPD (Continuous Professional Development) activity was funded per annum. The chart below shows that half of respondents (49%) said that they used self-funding to pay for their CME / CPD activity and a third (34%) said they used a combination of two or more sources of funding to pay for their CPD activity. One in ten (10%) said that they used only their study leave budget allocated by their employer, and only 1% said that their CME / CPD activity was funded by industry.

Figure 20: Funding for CME / CPD activity per annum
Base: All respondents (2,621)

A larger proportion of specialists stated that their CME / CPD activity was self-funded than other professions (57%), as did a larger proportion of females in comparison to males (53% compared to 46%).

Heads of department and those who said they were active members were more likely to have their CME / CPD activity funded by a combination of two or more sources (44% and 37% respectively). Consultants and staff, on the other hand, were the most likely professional group to say that their activity was funded by their employer (13%).

Respondents who worked in non-teaching hospitals were more likely to say that their CME / CPD activity was self-funded (60%) than those who worked elsewhere.

‘Other’ responses provided in relation to CME and CPD funding included a combination of sources, grants, being a speaker or lecturer, scholarships and government reimbursements.
Continuing on the topic of CME and CPD, survey respondents were asked to specify what proportion of their CME / CPD is achieved by different methods, including e-learning, reading journals and textbooks, conferences, meetings and training at the workplace.

The table below shows the mean score for each method, also commonly known as the average, and the mode which is the most commonly provided percentage.

On average, respondents achieved 26% of their CME / CPD via medical journals, followed by 25% for local and regional meetings and 23% on the job training. By contrast, international scientific meetings received a mean score of 16%.

As can also be seen, 10% was the most commonly suggested percentage (mode) for all methods of achieving CME / CPD, with the exceptions of medical journals which was 20% and ‘other’, which was zero.

**Figure 21: Mean and mode percentage of CME / CPD achieved by method**

*Base: All respondents (2,621)*

<table>
<thead>
<tr>
<th>Method of achieving CME / CPD</th>
<th>Mean</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical journals</td>
<td>26%</td>
<td>20%</td>
</tr>
<tr>
<td>Local and regional meetings</td>
<td>25%</td>
<td>10%</td>
</tr>
<tr>
<td>Training at the workplace</td>
<td>23%</td>
<td>10%</td>
</tr>
<tr>
<td>Medical textbooks</td>
<td>21%</td>
<td>10%</td>
</tr>
<tr>
<td>National scientific meetings</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>e-learning</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>European scientific meetings</td>
<td>19%</td>
<td>10%</td>
</tr>
<tr>
<td>International scientific meetings</td>
<td>16%</td>
<td>10%</td>
</tr>
<tr>
<td>Other</td>
<td>15%</td>
<td>0%</td>
</tr>
</tbody>
</table>

The chart below the table also presents these mean scores.

**Figure 22: Mean percentage of CME / CPD achieved by method**

*Base: All respondents (2,621)*

Subgroup analysis highlights certain differences in these mean scores by professional status. Firstly, medical textbooks and training at the workplace were more likely to have been given higher percentages by trainee respondents with means of 30% and 38% respectively.
Conversely, consultants and staff gave a mean of 16% for medical textbooks and 18% for training at the workplace. The latter was also low for academics, with a mean score of 16%.

Retired respondents gave the highest mean for e-learning (24%) which was also high for specialists (23%). In contrast, the mean for this method was only 11% for academics.

The main difference to note between male and female respondents was that females gave a higher mean for training at the workplace than males (26% compared to 22%).

Respondents who indicated that they had used e-learning to achieve their CME / CPD were additionally asked to state what device or devices they used to do this. As shown in the chart below, two-thirds (67%) of respondents used a laptop and half (49%) used a desktop computer. Four in ten (41%) said they used a tablet when completing CME / CPD via e-learning and a third (33%) said that they used a mobile phone.

**Figure 23: Device(s) used for e-learning**

*Base: Those who undertook e-learning (1,208)*

![Bar chart showing device usage](chart.png)

Subgroup analysis of the results to this question highlights that trainee and medical student members were significantly more likely to use laptops and mobile phones when doing their e-learning at 80% and 48% respectively. By contrast only 29% of associate members said they used a mobile phone.

Looking at the results by profession, again students and trainees were most likely to use a laptop (78%) and this was also high for those who were retired (73%) and academics (74%). In relation to gender, females were more likely than males to use a mobile phone (37% compared to 31%) and males were more likely to use a desktop computer (54% compared to 41%). Almost half of trainees and students said that they used mobile phones (48%), which was the largest proportion of all the professional groups.

Analysis of the results by length of time spent in the field of Anaesthesiology highlights that those who had been the field for more than 20 years were most likely to use a desktop computer for e-learning (58%) and least likely to use a mobile phone (21%). By contrast, six in ten (60%) respondents who had worked in field for less than three years used a mobile phone for e-learning.
ESA Strategy

Areas of focus

Respondents were asked what they thought the most important issues were for the Society to focus on, and were able to select up to three options. The most popular response was ‘guidelines’, selected by almost two-thirds of respondents (65%). This was followed by ‘education at all levels’ and ‘patient safety and quality of care’ selected by over half (54% for both). ‘Implement continuity of perioperative care to improve patient outcome’ was selected by almost four in ten (38%) and three in ten (29%) chose ‘research’.

Figure 24: Most important issues for the ESA to focus on
Base: All respondents (2,621)

A larger proportion of retired members suggested ‘patient safety and quality of care’ and ‘education at all levels’ were important issues to focus on at 66% and 71% respectively which were the largest proportions out of any of the membership groups. By contrast only 41% of trainee or medical student members thought ‘patient safety and quality of care’ was important. However, when it came to guidelines only 43% of retired members felt this was important; in contrast more than six in ten respondents from each of the other membership categories felt this was important.

Female respondents were more likely to suggest ‘guidelines’ and ‘education at all levels’ were important (67% and 57%) when compared to male respondents (63% and 53% respectively). Conversely, male respondents were more likely to suggest ‘develop and promote the professional role’ was important at 20%, compared to 16% of female respondents.
‘Other’ responses provided were wide-ranging, and included continued education / revalidation, improving networking opportunities, initiatives to support developing countries, global health education, improving Congress and meetings, reducing bureaucracy, refreshing the leadership, focusing on paediatric care and implementing European standards or guidelines for Anaesthesia.

Trainees

Trainee ESA members completing the survey were additionally asked to state which aspects of their ESA membership were most valuable to trainee members, selecting up to three options. The chart below shows that two aspects were seen as significantly more valuable than others. E-learning was the most popular benefit, selected by almost half of respondents (48%) and 47% selected ‘Basic sciences anaesthetic courses’. Four in ten selected Journals (41%), and EDAIC and Euroanaesthesia workshops were both selected by 37%. Networking was the least valuable aspect to trainee members, with only 13% choosing this option.

Figure 25: Most valuable to trainee members
Base: Those who said they were trainee ESA members (335)

Subgroup analysis highlights that females were more likely to select CEEA courses at 26% when compared with males at 15%.

A larger proportion of members who had worked in the field of Anaesthesiology for between four and nine years selected EDAIC (42%) in comparison to those who had been in the field for less than three years (29%). Although Networking was the least valuable overall, it was more valuable for members who had been in the field for less than three years (17%) than those who had been in the field longer (10%).
**ESA Membership Benefits**

Respondents were asked to indicate how important various ESA membership benefits were to them on a scale from 'not at all valuable' to 'very valuable'.

Most importance was given to the subscription to the European Journal of Anaesthesiology, with a total of 85% rating this option as ‘very’ or ‘somewhat’ valuable. This was closely followed by the subscription to the Current Opinion in Anaesthesiology, seen as valuable by 81% of respondents. Almost four in five (78%) suggested that the subscription to the online ESA newsletter, the subscription to Current Opinion in Critical Care and the availability of post-Congress educational material were all important. The benefit of voting rights for Council representatives was seen as the least valuable, with 35% saying it was ‘not’ or ‘not at all’ valuable, followed by 34% saying the same about voting rights at the General Assembly. A further third felt that opportunities to contribute to the ESA leadership and opportunities to apply for the mentorship programme were not valuable (32% for each). The full range of responses can be seen in the chart below.

*Figure 26: Importance of ESA membership benefits*

**Base: 2,474 / 2,460 / 2,454 / 2,427 / 2,446 / 2,458 / 2,460 / 2,425 / 2,430 / 2,424 / 2,419 / 2,410 / 2,412 / 2,414 / 2,415**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Valuable (very or somewhat)</th>
<th>Not valuable (not very or not at all)</th>
<th>No opinion / not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscription to the European Journal of Anaesthesiology</td>
<td>85%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Subscription to the Current Opinion in Anaesthesiology</td>
<td>81%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Subscription to the Current Opinion in Critical Care</td>
<td>78%</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td>Subscription to the online ESA newsletter</td>
<td>78%</td>
<td>15%</td>
<td>7%</td>
</tr>
<tr>
<td>Availability of post-Congress educational material</td>
<td>78%</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>Access to e-learning platform</td>
<td>76%</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Discounts to ESA meetings</td>
<td>76%</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>Discount / access to ESA educational activities</td>
<td>74%</td>
<td>14%</td>
<td>12%</td>
</tr>
<tr>
<td>Access to Clinical Trial Network</td>
<td>60%</td>
<td>20%</td>
<td>19%</td>
</tr>
<tr>
<td>Opportunities to apply for fellowships</td>
<td>50%</td>
<td>28%</td>
<td>22%</td>
</tr>
<tr>
<td>Opportunities to apply for grants</td>
<td>48%</td>
<td>28%</td>
<td>23%</td>
</tr>
<tr>
<td>Opportunities to apply for mentorship programme</td>
<td>44%</td>
<td>32%</td>
<td>24%</td>
</tr>
<tr>
<td>Opportunities to contribute to ESA leadership</td>
<td>44%</td>
<td>32%</td>
<td>24%</td>
</tr>
<tr>
<td>Voting rights at General Assembly</td>
<td>44%</td>
<td>34%</td>
<td>22%</td>
</tr>
<tr>
<td>Voting rights for Council representatives</td>
<td>44%</td>
<td>35%</td>
<td>22%</td>
</tr>
</tbody>
</table>
The chart shows that around a quarter of respondents said they did not have an opinion or the benefit was not applicable to them in relation to opportunities to apply for grants (23%) and the mentorship programme (24%), and opportunities to contribute to the ESA leadership (24%). This perhaps indicates that awareness of these benefits might be lower for some members than for others.

For quite a few benefits, particularly those related to training and education, trainee members were the most likely membership group to rate them as valuable. For example, 80% rated access to the e-learning platform as valuable, 80% discount and access to educational activities, 75% opportunities to apply for fellowships, 70% opportunities to apply for grants and 65% opportunities to apply for the mentorship programme. This was also true for those who worked in university hospitals, 58% of whom rated opportunities to apply for grants as valuable and 77% of whom rated discount and access to educational activities as valuable.

Active members, on the other hand, were more likely than other membership groups to rate voting rights at the General Assembly (53%) and for Council representatives (52%) as valuable.

Unsurprisingly for most benefits, retired members were least likely to say they were valuable probably owing to the fact that these benefits were more valuable when they were in employment. For example, a quarter (24%) thought that access to the e-learning platform was not valuable and 34% said the same in regards to opportunities to apply for grants. However, the online newsletter was an exception. Three-quarters (76%) of retired members said they found it valuable, perhaps indicating that this is an important method for keeping in touch with the profession for those who are retired. However, it should also be noted that a fifth (20%) said it was not applicable, meaning there is scope to improve the relevance of this publication for retired members.

Looking at the results between male and female respondents, for the majority of benefits females felt that they were more valuable than males. For example, 80% of females felt that access to the e-learning platform was valuable compared to 73% of males, 83% felt availability of post-Congress educational material was valuable compared to 75% of males and 57% felt that opportunities to apply for fellowships were valuable compared to 46% of males.
Barriers to being an active member

Respondents who indicated that they were associate members of the ESA were asked why they had chosen not to become an active member. As shown in the chart below, just over four in ten (44%) said it was because the cost of the membership was too high and just over a third (35%) said they did not know enough about the benefits of becoming an active member. A further quarter (23%) said they felt that the benefits of being an active member of the ESA were limited compared to those of their national society.

Figure 27: Reasons for not becoming an active member
Base: Those who said they were associate members (255)

There were a few notable differences in responses between male and female respondents. For example, males were more likely than females to cite the benefits being limited compared to a national society (28% compared to 14%), whereas females were more likely to cite language barrier as being a problem (23% compared to 9%).

In relation to profession, consultants and staff were most likely to say the benefits were limited compared to a national society (32%) and a quarter of associate members who were specialists (23%) said there was a language barrier.

‘Other’ responses provided included living outside of Europe or too far away and that associate membership is sufficient for respondents’ needs.
ESA performance and relevance

ESA performance

Respondents were asked about their satisfaction with the ESA’s performance on providing different activities, benefits, courses, publications, educational opportunities, and information. As can be seen in the chart below, respondents reported highest satisfaction levels with guidelines, with 74% saying they were satisfied with the ESA’s performance in relation to these (38% ‘very satisfied’ and 36% ‘somewhat satisfied’). This was closely followed by general information about the ESA, with 72% saying they were satisfied and 71% said they were satisfied with publications. The highest level of dissatisfaction was expressed in relation to promoting the profession to the public and media, with 22% saying they were not satisfied. This is shown in the chart below.

Figure 28: Satisfaction with ESA performance

<table>
<thead>
<tr>
<th>Activity</th>
<th>Satisfied (very or somewhat)</th>
<th>Not satisfied (not very or not at all)</th>
<th>No opinion / not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidelines</td>
<td>74%</td>
<td>12%</td>
<td>14%</td>
</tr>
<tr>
<td>General information about ESA</td>
<td>72%</td>
<td>8%</td>
<td>19%</td>
</tr>
<tr>
<td>Publications</td>
<td>71%</td>
<td>9%</td>
<td>20%</td>
</tr>
<tr>
<td>Clinical information</td>
<td>69%</td>
<td>8%</td>
<td>23%</td>
</tr>
<tr>
<td>General information about our profession</td>
<td>66%</td>
<td>13%</td>
<td>21%</td>
</tr>
<tr>
<td>e-learning</td>
<td>60%</td>
<td>9%</td>
<td>31%</td>
</tr>
<tr>
<td>CME / CPD opportunities</td>
<td>59%</td>
<td>10%</td>
<td>31%</td>
</tr>
<tr>
<td>Refresher courses</td>
<td>57%</td>
<td>9%</td>
<td>34%</td>
</tr>
<tr>
<td>Promoting our profession to the public and media</td>
<td>45%</td>
<td>22%</td>
<td>33%</td>
</tr>
<tr>
<td>Basic Science Courses</td>
<td>43%</td>
<td>5%</td>
<td>51%</td>
</tr>
<tr>
<td>Research opportunities</td>
<td>43%</td>
<td>15%</td>
<td>43%</td>
</tr>
<tr>
<td>Masterclasses</td>
<td>37%</td>
<td>11%</td>
<td>52%</td>
</tr>
<tr>
<td>Fellowships</td>
<td>35%</td>
<td>12%</td>
<td>53%</td>
</tr>
</tbody>
</table>
As can be seen in the chart there were large proportions of respondents who said they did not have an opinion or that the activities listed were not applicable to them. This was particularly high for fellowships (53%), masterclasses (52%) and Basic Science Courses (51%) indicating that not all activities, opportunities, events and benefits offered by the ESA are relevant to all members.

Sub-group analysis highlights that in the majority of cases active members reported the most satisfaction with the different activities listed, particularly in relation to clinical information (76%), CME and CPD opportunities (65%), general information about the ESA (78%) and guidelines (81%). However, it should be noted that a quarter (25%) of active members expressed dissatisfaction in relation to the ESA promoting the profession to the public and media, which was the highest out of any membership category. This was also high for those who worked in university hospitals (24%) and those who said they were academics (26%).

Amongst the different professions of respondents, heads of department were most likely to say they were satisfied with promoting the profession to the public and media (53%), refresher courses (69%), masterclasses (47%), guidelines (82%), fellowships (41%) and Basic Science Courses (51%).

Female respondents were more likely than males to be satisfied in most cases, particularly in relation to clinical information (74% compared to 67%), CME / CPD opportunities (62% compared to 57%), fellowships (39% compared to 33%), general information about the ESA (77% compared to 69%), and general information about the profession (70% compared to 63%).

Those who had been in the profession the longest (20 years or more), were most likely to express satisfaction with clinical information (72%), guidelines (78%), and publications (73%).
Relevance of ESA to professional life

Respondents were asked how relevant the ESA is to their professional life. As can be seen in the chart below, almost half (46%) said that it was ‘somewhat relevant’ and a further three in ten (28%) felt it was ‘very relevant’. One in five (20%) felt that it was ‘not very relevant’ and three per cent felt it was ‘not at all relevant’.

Figure 29: Relevance of ESA to professional life
Base: All respondents (2,621)

Sub-group analysis shows active members were most likely to say that the ESA is relevant (‘very’ and ‘somewhat’) to their professional life with eight in ten (81%) saying this. There was little difference when it came to profession, but in relation to gender, females were more likely to say that the ESA is relevant to them professionally (79%) than males (71%).

Those who had been in the field of Anaesthesiology for less than three years were least likely to say that the ESA was relevant to them professionally (69%). By contrast, around three quarters of respondents with four to nine years’ experience (74%), 10 to 19 years (75%) and 20 years or more (74%) said the ESA was relevant to them.

Over half (52%) of those who did not work in a hospital said that the ESA was not relevant to them professionally. By contrast, three-quarters of respondents who worked in a university hospital (76%) felt that the ESA was relevant to them.
Comparing professional relevance of the ESA and rating of interaction with the ESA there appears to be a direct correlation. Those who said the ESA was relevant to them professionally were more likely to rate their experience of interaction as 'excellent' (91%) and those who said the Society was not relevant to them were more likely to rate their experience of interaction as 'poor' (53%). This is shown in the figure below.

**Figure 30: Relevance by experience of interaction with the ESA**

*Base: All respondents (2,621)*
Respondents were then asked what would make the ESA more relevant to them professionally and were able to select up to three responses. As can be seen in the chart below, ‘clinical practice guidelines’ was by far the most popular response with three quarters (75%) of respondents choosing this. This was followed by ‘keeping members informed about the top issues in the field’ selected by almost half (49%) and ‘links to e-learning platforms’ selected by just over a quarter (27%). A further fifth (18%) chose ‘library of medications and their interactions with anaesthesia’ as a factor to make the ESA more relevant.

Figure 31: Factors to make the ESA more relevant professionally
Base: All respondents (2,621)

Sub-group analysis highlights that in relation to clinical practice guidelines, active and affiliate members were more likely to say this would make the ESA more relevant to them (77% for both). In contrast, only 59% of retired members said this would make it more relevant. Instead, retired members were most likely to say that being kept informed about the top issues in the field would make it more relevant (57%).

Unsurprisingly, academics were most likely to say that information about research grants in Europe would make it more relevant (32%). Consultants and staff (30%), and specialists (31%) on the other hand were most likely to say links to e-learning platforms would make it more relevant. By contrast only 16% of academic respondents gave this answer.

Comparing this question with the previous question we can see that those who said the ESA was not relevant to them were most likely to say that a library of medications and interaction with anaesthesia (27%) and ultrasound imaging would make the ESA more relevant to them (26%).

‘Other’ responses, suggested by 1% of respondents, included providing more economic support and specialist training for anaesthetists, introducing more guidelines and support for working abroad, defining European standards, providing more support for other local and regional societies, and providing more translations.
The future of the ESA

Respondents were asked what type of society they thought the ESA should aim to be in the future. As can be seen in the chart below, almost two-thirds of respondents (65%) felt that the ESA should be a society for individual membership, national societies and specialist societies, as it is today. A tenth (9%) thought it should be a scientific society including specialist societies in the field of Anaesthesiology and 8% thought it should be a society with national societies as members, like a federation.

Figure 32: ESA in the future
Base: All respondents (2,621)

Sub-group analysis highlights that those who had worked the least number of years in the field (i.e. three or fewer) were most likely to say they thought the ESA should stay as it is (71%). One in eight (12%) respondents who had worked in the field for 10 to 19 years felt that the ESA should be a scientific society including specialist societies. A larger proportion of females thought that the ESA should include specialist societies (12%) than males (8%).

‘Other’ responses provided included mentions of WFSA and calls for the ESA to become a more powerful society with greater influence.
Future of Anaesthesiology

Finally respondents were asked to consider the next 10 years and asked to identify what they felt would be the most important areas in developing the speciality of Anaesthesiology and were able to select multiple options from a list. As can be seen in the chart below, over half of respondents (54%) felt that ‘defining Perioperative Medicine and the role of the Anaesthesiologist’ was the most important area, followed by almost half (47%) saying ‘improved education and training’ was the most important. Just over four in ten (44%) felt that a ‘qualification on top of primary speciality’ was the most important and just over a third (35%) said ‘primary speciality’. A further third (32%) felt that ‘implementation of electronic patient data management systems for setup of valid clinical and research databases’ was important and three in ten (31%) felt the same about ‘improved scientific knowledge and better organisation of clinical trials’.

**Figure 33: Important areas in developing the specialty of Anaesthesiology**

**Base: All respondents (2,621)**

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defining Perioperative Medicine and role of Anaesthesiologist</td>
<td>54%</td>
</tr>
<tr>
<td>Improved education and training</td>
<td>47%</td>
</tr>
<tr>
<td>Qualification on top of primary speciality</td>
<td>44%</td>
</tr>
<tr>
<td>Primary speciality</td>
<td>35%</td>
</tr>
<tr>
<td>Implementation of electronic patient data management systems for setup of valid clinical &amp; research databases</td>
<td>32%</td>
</tr>
<tr>
<td>Improved scientific knowledge &amp; better organisation of clinical trials</td>
<td>31%</td>
</tr>
<tr>
<td>Stronger health care quality measurements</td>
<td>27%</td>
</tr>
<tr>
<td>Tech advancements shifting procedures to outpatient centres</td>
<td>21%</td>
</tr>
<tr>
<td>Healthcare payment</td>
<td>13%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
<tr>
<td>None of the above</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5%</td>
</tr>
</tbody>
</table>

Sub-group analysis shows that trainees and medical student members were most likely to say that a ‘particular qualification on top of a primary speciality’ was an important area, with 51% saying this. In contrast, only 39% of associate members said the same. Over half of trainee and medical student members (55%) also said that ‘improved education and training’ was important, which was the highest of any membership category. Active members, on the other hand, were most likely to say that ‘stronger healthcare quality measurements’ were important (30%).

In relation to professions, heads of department were most likely to say that ‘defining Perioperative Medicine and the role of the Anaesthesiologist’ was important (66%), while...
academics were more likely to say that ‘improved scientific knowledge and better organisation of clinical trials’ was important (42%). In relation to the latter, this was important for only 27% of specialists and 29% of trainees and students.

Analysis of the results by gender highlights quite a few differences in the importance attached to different areas by males and females. For example, females felt that a ‘particular qualification on top of a primary specialty’ was more important (46% vs 42%), as well as ‘improved scientific knowledge and better organisation of clinical trials’ (34% vs 29%) and ‘improved education and training’ (51% vs 44%). Males, on the other hand, felt that ‘defining Perioperative Medicine and the role of the Anaesthesiologist’ was more important (56% vs 51%).

Those who had been in the field of Anaesthesiology for more than 20 years were most likely to say that ‘defining Perioperative Medicine and the role of the Anaesthesiologist’ was important (64%), that ‘stronger health care quality measurements’ was important (30%) and that ‘implementation of electronic patient data management systems’ (35%) was important.

‘Other’ responses, suggested by 1% of respondents, included:

- Improvements in Perioperative Care
- Improvements in patient outcomes and patient safety
- Defining and maintaining the roles of anaesthetists and other related professionals
- Development of ultrasound supported techniques
- More support for anaesthetists and other specialists
- Standardisation of training
- More specialist training in the field
Additional comments

At the end of the survey, respondents were asked if they had any other additional comments regarding the ESA and their experience. As can be seen in the chart below, there was a wide range of responses with almost a fifth (18%) from respondents saying they had nothing else to add. The second most common theme was in regards to the ESA being a global society that should be providing more opportunities outside of Europe (12%). A tenth (11%) of comments were positive about or appreciative of the ESA and a further tenth (9%) were from respondents expressing their gratitude for having been asked to participate in the survey. The full range of themes is shown in the figure below.

Figure 34: Is there anything you would like to add?
Base: All respondents who provided a response (265)
Conclusion

This survey has provided a wealth of interesting and useful results regarding the needs, views and opinions of members in relation to the European Society of Anaesthesiology, its role and the support and benefits provided to its members. The results and findings will be used by the ESA to inform its future strategy and ensure that the organisation continues to reflect the needs of its members so that it can continue to provide activities, benefits and support for them in the future.
Acknowledgments

Enventure Research would like to express its gratitude to everyone who took part in the survey. We would also like to thank Daniela Filipescu, Dan Longrois, Ann De Groot, Marc Gheeraert, Zeev Goldik, and Jannicke Mellin-Olsen from the European Society of Anaesthesiology for their help throughout the survey process.
Appendix A - questionnaire
Welcome to the European Society of Anaesthesiology (ESA) Membership Survey.

Please take time to complete our survey. Your responses are vital in helping the ESA to provide activities and membership benefits to meet the requirements and expectations of our members.

To say thank you for taking part, you will be entered into a prize draw to win either free registration at the Focus Meeting 2016 or free registration at Euroanaesthesia 2017.

You can navigate through the questionnaire using the 'Next' and 'Back' buttons. To remove your answers to a question click on the 'Reset' button. Should you wish to save your responses and return to the questionnaire, click the 'Save' button.

If you have any questions about completing the questionnaire, please call the survey helpline on +44 800 0092 117 or email info@enventure.co.uk

The survey will take no longer than 10 minutes to complete. Please complete this survey by Wednesday 20th April 2016.

Confidentiality - This survey is being carried out independently on behalf of the ESA by Enventure Research, a market research agency based in the United Kingdom, bound by the Market Research Society’s Code of Conduct. This ensures that your personal details and other information will only be used for the purposes of the survey and will not be disclosed to any third parties.

About You

Q1 What is your membership category of the ESA?

- Active member
- Affiliate member
- Trainee member
- Associate member
- Registered non-physician health professional member
- Medical student member
- Retired member
- Honorary member
- I am not a member
- Don't know
Q2 Which of these best describes your current professional status?
- Head of Department
- Consultant / Staff
- Specialist
- Academic
- Trainee
- Student
- Retired
- Other (please specify)

Other

Q3 Which of these best describes where you currently work or practice?
- Academia (with no hospital affiliation)
- University hospital
- Other teaching hospital
- Non teaching hospital
- Not in a hospital
- Other Please specify

Other

Q4 Is this hospital public or private?
- Public
- Private
- Combination of both public and private
In which country did you achieve your diploma / certificate of specialist in anaesthesiology?

Please select from the dropdown list

- Albania
- Andorra
- Armenia
- Austria
- Azerbaijan
- Belarus
- Belgium
- Bosnia and Herzegovina
- Bulgaria
- Croatia
- Cyprus
- Czech Republic
- Denmark
- Estonia
- Finland
- France
- Georgia
- Germany
- Greece
- Hungary
- Iceland
- Ireland
- Israel
- Italy
- Kazakhstan
- Kyrgyzstan
- Latvia
- Lithuania
- Luxembourg
- Malta
- Monaco
- Montenegro
- Netherlands
- Norway
- Poland
- Portugal
- Republic of Moldova
- Romania
- Russia
- San Marino
- Serbia
- Slovakia
- Slovenia
- Spain
- Sweden
- Switzerland
- Tajikstan
- The former Yugoslav Republic of Macedonia
- Turkey
- Turkmenistan
- Ukraine
- United Kingdom
- Uzbekistan
- Outside of Europe Please specify
- Other Please specify

Outside of Europe


Q6 In which country do you currently work / practice in? Please select from the dropdown list

- Albania
- Andorra
- Armenia
- Austria
- Azerbaijan
- Belarus
- Belgium
- Bosnia and Herzegovina
- Bulgaria
- Croatia
- Cyprus
- Czech Republic
- Denmark
- Estonia
- Finland
- France
- Georgia
- Germany
- Greece
- Hungary
- Iceland
- Ireland
- Israel
- Italy
- Kazakhstan
- Kyrgyzstan
- Latvia
- Lithuania

Other

Outside of Europe

Please specify

Other Please specify
Q7 What is your gender?
- Male
- Female

Q8 For how many years have you worked in the field of Anaesthesiology?
- Less than three years
- 4-9 years
- 10-19 years
- More than 20 years

Q9 Are you a member of any other medical societies? Please select all that apply
- ASA
- EACTA
- EAMS
- EMHG
- ESICM
- ESPA
- ESPCOP
- ESRA
- ESTAIC
- EuroSIVA
- LICAGE
- National Society
- SSAI
- WSACS
- Other Please specify
- None of the above

Other
Q10 From the list of specialist interests below, please indicate the area(s) in which you work. Please select all that apply

- [ ] Anaesthesia
- [ ] Critical Emergency Medicine
- [ ] Intensive Care Medicine
- [ ] Pain management
- [ ] Other Please specify
- [ ] None of the above

Other

Q10 From the list of specialist Anaesthesia interests below, please indicate the area(s) in which you mainly work. Please select all that apply

- [ ] Ambulatory
- [ ] Cardiac Surgical
- [ ] General
- [ ] Neurosurgical
- [ ] Obstetric
- [ ] Pediatric
- [ ] Regional and Orthopedic
- [ ] Thoracic surgery
- [ ] Trauma
- [ ] Vascular
- [ ] Other Please specify

Other

Q10 From the list of specialist Pain management interests below, please indicate the area(s) in which you mainly work. Please select all that apply

- [ ] Acute pain management
- [ ] Chronic pain management
- [ ] Palliative care medicine
- [ ] Other Please specify

Other
From the list of specialist Intensive Care Medicine interests below, please indicate the area(s) in which you mainly work. Please select all that apply

- [ ] Cardiac (surgical)
- [ ] Multidisciplinary
- [ ] Neurosurgical
- [ ] Trauma
- [ ] Other Please specify

Other

From the list of specialist Critical Emergency Medicine interests below, please indicate the area(s) in which you mainly work. Please select all that apply

- [ ] General
- [ ] Other Please specify

Other

Communications

How do you usually access information from the ESA? Please select all that apply

- [ ] E-communication
- [ ] ESA On-line newsletter
- [ ] ESA website
- [ ] Facebook
- [ ] LinkedIn
- [ ] Twitter
- [ ] Other Please specify
- [ ] None of the above

Other

When you interact with the ESA, how would you rate your experience?

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor
Q13  Which of the following ESA activities have you attended / participated in during the last three years? *Please select all that apply*

- Basic Sciences Anaesthetic Course
- Committee for European Education in Anaesthesiology (CEEA) Courses
- CTN (Clinical Trial Network)
- E-learning
- ESA Focus Meeting on Perioperative Medicine
- Euroanaesthesia Congress
- Other

Q13a. Which of the following European Diploma exams and related activities have you attended / participated in in the last three years? *Please select all that apply*

- EDAIC Part I
- EDAIC Part II
- In-Training Assessment (ITA)
- On-Line Assessment (OLA)
- Other *Please specify*

Other
Below are the activities which you have not attended / participated in. Why did you not attend / participate in any of the following ESA activities in the last three years? Please select all that apply

<table>
<thead>
<tr>
<th>Activity</th>
<th>Venue</th>
<th>Unaware when it was happening</th>
<th>Poor value for money</th>
<th>Unable to take time from work</th>
<th>Content is of no interest</th>
<th>Week days are not convenient</th>
<th>Budget constraints</th>
<th>Other</th>
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<td>Basic Sciences Anaesthetic Course</td>
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<td>ESA Focus Meeting on Perioperative Medicine</td>
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<td>Euroanaesthesia Congress</td>
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<td>Teach the Teacher course</td>
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Other reason for not attending / participating in an ESA activity

Q15 How is your CME / CPD activity funded per annum? By CME we mean "Continuous Medical Education" and by CPD we mean "Continuous Professional Development".

- Study leave budget allocated by my employer (my employer covers all my study leave costs)
- Self-funded (I pay all costs myself)
- Industry (industry covers all costs)
- Combination of two or more of the above
- Other Please specify
- Not applicable

Other
Q16 What proportion of your CME / CPD is achieved by the following means? Please type your percentages in the relevant boxes below ensuring that the total adds up to 100%. Those which you do not use should be left blank.

- E-learning
- European scientific meetings
- International scientific meetings
- Local and regional meetings
- Medical journals
- Medical textbooks
- National scientific meetings
- Training at the workplace
- Other

TOTAL

Q17 What device(s) do you use when you do e-learning? Please select all that apply

- Mobile phone
- Tablet
- Laptop
- Desktop computer

ESA Strategy

Q18 From the list below, which three issues do you think are the most important for the ESA to focus on? Please select up to three options below

- Patient safety and quality of care
- Implement continuity of perioperative care to improve patient outcome
- Education at all levels
- Guidelines
- Research
- Innovation
- Develop and promote professional role
- Promote the ESA’s identity
- Other Please specify
- None of the above
- Don’t know

Other
Q19 Which of the following do you think are the most valuable to trainee members? Please select up to three options below

- Basic sciences anaesthetic courses
- CEEA courses
- EDAIC
- E-learning
- Euroanaesthesia scientific sessions
- Euroanaesthesia workshops
- Journals (EJA and Current Opinion)
- Masterclasses
- Networking
- Refresher courses
- Other Please specify
- Don’t know
- None of the above

Other

Q20 How valuable are the following ESA membership benefits to you? Please select an answer for each

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Not at all valuable</th>
<th>Not very valuable</th>
<th>Somewhat valuable</th>
<th>Very valuable</th>
<th>No opinion / not applicable</th>
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<tbody>
<tr>
<td>Access to Clinical Trial Network</td>
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<td>Access to e-learning platform</td>
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<td>Availability of post-congress educational material</td>
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<td>Discounts to ESA meetings</td>
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<td>Discount/access to ESA educational activities</td>
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<td>Opportunities to apply for fellowships</td>
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<td>Opportunities to apply for grants</td>
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<td>Opportunities to apply for mentorship programme</td>
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<td>Opportunities to contribute to ESA leadership</td>
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<td>Subscription to the Current Opinion in Anaesthesiology</td>
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<tr>
<td>Subscription to the Current Opinion in Critical Care</td>
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<tr>
<td>Subscription to the European Journal of Anaesthesiology</td>
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<tr>
<td>Subscription to the On-line ESA Newsletter</td>
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<td>Voting rights at General Assembly</td>
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<tr>
<td>Voting rights for Council representatives</td>
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</table>
ESA and you

Q21 You indicated earlier in the survey that you are an associate member. Why have you chosen not to become an active member? Please select all that apply

☐ I do not know enough about the benefits of membership
☐ The cost of membership is too high
☐ The benefits of being an active member of the ESA are limited compared to my National Society
☐ I am a member of another international anaesthesiology society
☐ The ESA is not widely known within my National Society
☐ There is a language barrier that prevents me from taking advantage of all of the benefits
☐ Other Please specify
☐ Don’t know
☐ None of the above

Other

Q22 How satisfied are you with ESA's performance on providing the following? Please select an answer for each

<table>
<thead>
<tr>
<th>Basic Science Courses</th>
<th>Not at all satisfied</th>
<th>Not very satisfied</th>
<th>Somewhat satisfied</th>
<th>Very satisfied</th>
<th>No opinion / not applicable</th>
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</thead>
<tbody>
<tr>
<td>Clinical information</td>
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<tr>
<td>CME / CPD opportunities</td>
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<td>E-Learning</td>
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<td>Fellowships</td>
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<td>General information about ESA</td>
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<td>General information about our profession</td>
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<td>Guidelines</td>
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<td>Masterclasses</td>
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<td>Promoting our profession to the public and media</td>
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<td>Publications</td>
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<td>Refresher courses</td>
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<tr>
<td>Research opportunities</td>
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</table>
Q23  How relevant is the ESA to your professional life?
- Very relevant
- Somewhat relevant
- Not very relevant
- Not at all relevant
- Don't know

Q24  Today the ESA is a society for individual members, national societies of anaesthesiology and specialist societies in the field of anaesthesiology (e.g. EACTA, ESPA, EuroSIVA etc). In your opinion, what do you think the ESA should be in the future? Please select one option only
- As today, a scientific society for individual membership, national societies and specialist societies
- A scientific society for individual members only
- A scientific society including only members from national anaesthesiology societies (associate members)
- A society with national societies as members (like a federation)
- A scientific society including specialist societies in the field of anaesthesiology
- Other Please specify
- Don't know

Q25  What would make the ESA more relevant to you professionally? Please select up to three options below
- Clinical practice guidelines
- Information about research grants throughout Europe
- Keeping members informed about the top issues in the field
- Library of medications and their interaction with anaesthesia
- Links to e-learning platforms
- List of classic papers
- More CME / CPD opportunities
- Patient education
- Preparatory courses for EDAIC
- Publication space for practical clinical issues
- Stronger professional advocacy
- Technical guides to regional anaesthesia
- Ultrasound imaging
- Other Please specify
- None of the above
- Don't know

Other
The future of Anaesthesiology

Q26 During the next 10 years, what do you think will be the most important areas in developing the specialty of Anaesthesiology (Anaesthesia, Intensive Care Medicine, Critical Emergency Medicine and Pain Management)? Please select all that apply

- Particular qualification on top of a primary speciality in: Intensive Care Medicine, Pain Medicine, Critical Emergency Medicine, Perioperative medicine
- Primary speciality in: Anaesthesiology, Intensive Care Medicine, Pain Management, Emergency Medicine
- Defining Perioperative Medicine and the role of the anaesthesiologist
- Stronger health care quality measurements
- Technology advancements shifting procedures to outpatient centres
- Healthcare payment
- Improved scientific knowledge and better organisation of clinical trials
- Improved education and training
- Implementation of electronic patient data management systems for the setup of valid clinical and research databases
- Other Please specify
- None of the above
- Don’t know
- Other

Thank You

Q27 Is there anything else you would like to add? Please type your response in the box below

Thank you for taking part in the ESA Membership Survey. We value the information you have provided. Your responses are vital in helping the ESA to provide activities and membership benefits to meet the requirements and expectations of our members.

Click the 'Submit' button below to send your response.