# RESIDENT EYE

THE MAGAZINE FOR INTENSIVISTS IN TRAINING

ISSUE 23 | AUTUMN 2025

# Alternative career paths for Intensivists

The Faculty of Intensive Care Medicine

In this issue

PAEDIATRIC CRITICAL CARE

ORGAN DONATION

PARENTAL LEAVE AS AN IiT

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This and back issues available online at www.ficm.ac.uk

# Reflections from the Lead Representative for IiTs

**Dr Rosemary Worrall**
Consultant in Anaesthesia and ICM

This is my final edition of *Resident Eye* as the Lead Representative for Intensivists in Training (IiTs). At the end of the year I will demit from this role. We will welcome a new Deputy Representative and Taqua Dahab will take over as Chair of the IiT Subcommittee. With the current Deputy election underway, I wanted to take a moment to reflect on what I've learned in this role and why I would encourage other IiTs to get involved in national representation.

## Behind the scenes

Joining a national organisation like FICM comes with a steep learning curve. There are complex relationships to navigate, between internal and external stakeholders, alongside governance processes and politics.

My first year as Deputy was all about understanding the structure of FICM and its relationship with other Faculties and Colleges (who set curricula), the GMC (which approves them), the Statutory Education Bodies and Postgraduate Deans (who oversee delivery), and, of course, the NHS as a whole. In addition, FICM collaborates closely with organisations such as the Academy of Medical Royal Colleges and the intensive care societies of the devolved nations.

Many people take on these roles with a strong desire to make change, but one of my biggest lessons has been that meaningful change often takes longer than expected. It's important to celebrate small wins along the way and accept that not everyone will always agree with your approach. Setting realistic goals, understanding where your role fits within the wider organisation, and recognising the limits of FICM's remit are all key to making progress.

Another crucial aspect of the role is representing all IiTs, not just one's personal views. Balancing those perspectives can be challenging, but it ensures our collective voice remains fair and representative. Holding the IiT Representative role also comes with the responsibility of being a full member of the FICM Board meaning that you have to balance your own views, with those of your peers and that of the organisation.

Over the past two years, I've focused on strengthening two-way communication between IiTs and FICM, broadening diversity within the IiT Subcommittee and its representation across other FICM committees, and ensuring that Regional Representatives are involved in developing our workstreams. I've also aimed to increase transparency by feeding back the rationale behind decision-making and the compromises sometimes required.

## Leadership and management experience

It's been a privilege to work alongside inspiring colleagues who have modelled the kind of leader I aspire to become. I've learned how to navigate meetings effectively, to speak up even when it's uncomfortable (often discovering others share the same view), and to chair discussions in an inclusive and balanced way — even when

the agenda is contentious. This role has given me opportunities I never expected: leading projects, contributing to working groups, collaborating on training materials, editing GPICS chapters, presenting webinars, authoring articles, speaking at conferences, and even organising my own events.

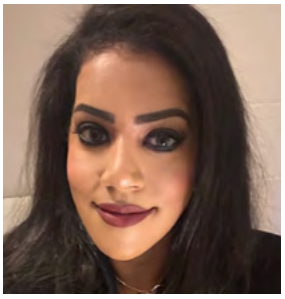
As an introvert, public speaking has never come naturally to me—but in this supportive environment, I've found my voice. I've learned to manage conflict more constructively, to delegate effectively, and to recognise the value of teamwork and perspective.

## Time management and personal growth

The IiT Representative role is far more involved than it might first appear. Balancing it over the past two years alongside Stage 3 training, consultant applications, and family life, has been demanding, but deeply rewarding. This experience has encouraged self-reflection, taught me how to manage my own expectations as well those of others, and given me exceptional role models. Most importantly, it has shaped the kind of clinician and leader I hope to be.

The role is what you make of it — and it offers rich opportunities for personal and professional growth (as well as excellent consultant interview material!).

# Your Deputy Intensivist In Training Representative



**Dr Taqua Dahab**
Deputy IiT Representative

I hope everyone has had the opportunity to enjoy the summer sunshine, relax, and recharge their batteries as we prepare for the usual pressures that winter brings. As we continue to support one another within the IiTs team, let us focus on training, share best practices, and address disparities.

These themes will come together on 10 November in Birmingham, where we will gather to update ourselves on advancements in ICM knowledge, acquire new skills, and prepare to become the future leaders in Intensive Care Medicine.

It has now been a year since my esteemed colleagues Waqas and Rosie took the stage at the inaugural FICM Conference for Future Intensivists. This remarkable milestone marks the beginning of what we aim to make a larger and more impactful event. We invite everyone to convene under one roof to learn, share, and discuss our collective challenges. Booking remains open for online attendance, and Rosie and I would be delighted to meet with you all in person to discuss the matters that are important to us.

## Finishing School Project

### Consultant interview workshop

One of the workshops at the conference will focus on preparing for ICM consultant interviews. As these positions become increasingly competitive, it is vital that we equip ourselves adequately for job applications and interview processes. We have assembled a faculty with extensive experience in consultants' interviews, with one member having participated in nearly 100 of them across the four nations. The rest of the faculty comprises Clinical Directors who will share their top tips to help you impress the interview panel and secure your job. We believe this will provide excellent value as it is included in the basic conference fees.

### A festive webinar

To ensure that everyone has access to valuable information, we are also planning a complimentary online evening session on 4 December 2025. This will focus on essential strategies for those preparing for their first consultant roles, covering topics such as tailoring your CV, job planning tips, and challenges you may encounter in your first year as a consultant. We will feature speakers from the FICM Board and early-career ICM consultants to provide their best insights to help you navigate what appears to be a bottleneck in the jobs market for ICM consultants.

### Stage 3 resources

Over the summer, we launched Stage 3 resources on the FICM website. This includes example job plans

> We listened to your feedback, and the predominant themes identified were fairness in training, burnout, and overall wellbeing.

from various ICM consultant backgrounds and pertinent articles to aid your understanding of the consultant job landscape. We will also record the winter webinar and make it available on this page as a reference for you as you advance to this stage.

### Consultant in Transition

In May, I attended the Consultant in Transition two-day course in Cardiff, which proved to be an eye-opener regarding the management of clinical and professional issues that may arise during the initial years as a consultant. It also provided valuable insights into planning your Stage 3 placement to maximise your experience as you approach the end of training. The next course will be held in Manchester in 2026, and I highly recommend it, as it counts towards Leadership and Management training for your Stage 3 HiLLO.

## Differential Attainment

In line with my commitment to addressing differential attainment in training and examinations within the FICM, we have developed the following:

### Peer advice for FFICM candidates

This blog provides guidance on navigating challenges faced by those taking the FFICM, including tips that have been beneficial to me as a non-native English speaker. It gathers insights from expert examiners experienced in addressing differential attainment in the FFICM exams, along with contributions from our training manager.

### FICM Exams Glossary

Recognising the linguistic complexities of the FFICM exams, we have collaborated with the chair of examiners and the Training Quality Assessment team to develop a glossary. This resource aims to clarify the expectations of examiners regarding the phrases used in OSCE/SOE, and it will also underpin the forthcoming version of the ACRE exams.

### Diversity, Equality, and Inclusion (DEI)

In June, we launched the DEI Subcommittee, of which Luke, Mayur, and I are members. Our objective is to advocate for fairness in clinical practice, education, and examinations. In the recent National Training Survey, we included crucial questions to gauge the demographics of our IiTs community and explore experiences related to differential attainment throughout training. Additionally, we have data from the IiTs Census Report, which I finalised earlier this year and is due for publication in November 2025. Using these resources, I aim to present a statement in 2026 that will provide an overview of our standing concerning fairness in ICM training and outline how we can address any existing gaps. This will be the focus of my work on the FICM Board in 2026.

## National Training Survey

Thank you to the 30% of Intensive Care Trainees (IiTs) who completed this year's survey. You may have noticed that we explored various themes this year. We listened to your feedback, and the predominant themes identified were fairness in training, burnout, and overall wellbeing. The insights gleaned from the remaining themes will be instrumental in tailoring the efforts of the Faculty of Intensive Care Medicine (FICM) to address the matters that are most relevant for the future of intensivists. Rosie and I are currently analysing the raw data and aim to provide the report to you in the coming months.

## IiT Census

The census has provided us with valuable insights into the current landscape of

Intensive Care Medicine (ICM) training. While the majority of respondents expressed satisfaction with their roles, significant concerns regarding the sustainability of working patterns and overall well-being require prompt attention and action from relevant stakeholders. You highlighted several areas for improvement, including wellbeing, the burden of assessments, the burden of rotations, and rota management. You can access the full report here.

### What have we done with these census results?

While we recognise the burden of surveys, it is essential that you continue to share your experiences with us. The more responses we receive, the stronger our evidence base to advocate for change becomes. In light of the findings, Rosie and I dedicated our summer to contributing to chapters for the forthcoming third edition of *Guidelines for the Provision of Intensive Care Services* (GPICS). We have made recommendations concerning rota management, the composition of resident ICU teams, and the importance of addressing differential attainment for doctors from diverse backgrounds working in ICU. Additionally, we highlighted essential wellbeing standards. We hope our advocacy effectively represents your needs and sets a standard for ICUs across the UK.

## FICM leadership

### How can we expect change without being part of the process?

Throughout the year, numerous leadership roles have been advertised for IiTs, including positions on the IiT Subcommittee, FICM Board IiTs Role, and various other subcommittees within FICM, such as Education and Equality, Diversity, and Inclusion (EDI). Upcoming advertisements will include roles for Anaesthetic ICM Representatives and Single ICM Representatives. Engaging in these roles has greatly contributed to my personal and professional growth as an intensivist. These experiences offer insights that are often not covered in the curriculum or day-to-day practice.

Participating in FICM leadership is an excellent way to understand the workings of our specialty, appreciate the challenges we face, and contribute to shaping the future. I highly encourage all of you to consider joining FICM leadership; together, we can work as one cohesive team to create the best possible outcomes for us all!

# IiT Subcommittee Updates

The IiT Sub-committee consists of core members representing each stream of training, LTFT IiTs, Academic IiTs, International Medical Graduates as well as an Equality Diversity and Inclusion Rep and a Lifelong Learning Platform Rep. In addition, we have co-opted members representing the intensive care societies of each of the Devolved Nations and Military IiTs.

The national representatives are appointed for a maximum of 2 years, via a national resident doctor election, which will be occurring in November 2025. The lead representatives chair the IiT Subcommittee, oversee the Regional Representative Network and represent IiTs at FICM Board, the Careers, Recruitment and Workforce Committee and the Training Assessment and Quality Committee, as well as liaising with the Intensive Care Society and Academy of Royal Medical Colleges, collating articles for *Resident Eye* and organising the Intensivists in Training annual conference.

The core IiT Sub-committee members are appointed via a competitive process after a declaration of interest. They liaise with their partner specialty organisations (RCoA, RCEM, RCP) as well as having the opportunity to join other FICM committees (Professional Affairs and Safety Committee, Legal and Ethical Policy Unit, Smaller and Specialist Units Advisory Group, Education Subcommittee, Exams Subcommittee or Diversity, Equality and Inclusion Subcommittee).

The maximum term is 2 years, and posts are advertised throughout the year as representatives demit. In Winter 2025 we will be advertising for the dual Anaesthesia and ICM Representative and the Single CCT ICM Representative.

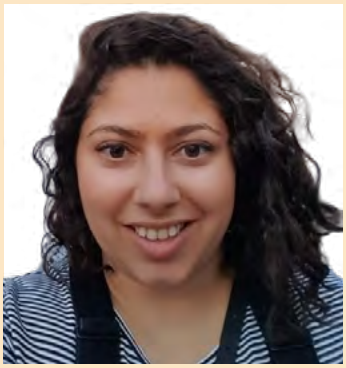
I would like to start by welcoming all the new intensivists in training intending to complete a single CCT in Intensive Care Medicine! It is the start of a challenging but exciting journey and comes at a time when intensive care in the UK is going through a phase of transformation with the formation of the new College of Intensive Care Medicine. If I can help in any way then please get in touch! I would be especially interested in any feedback on the 'on-boarding' process, particularly for those trainees who are new to the FICM/RCoA LLP.

**Dr Alex Maidwell-Smith**

Single ICM IiT Representative, Co-opteee FICM PAS Committee

In terms of developments specific to the single CCT pathway — access to airway training and how to record progression on the LLP has been a topic that has been brought to our attention by a number of different people. This is a particular issue for those completing ICM training from a medicine background. The committee has worked hard to produce an interim statement and continue to work with the Training, Assessment and Quality Committee to produce a more formalised IAC type process for those who haven't completed it before. Hopefully this will reduce the variability that is seen around the country and make it easier to understand what is required!

Please get in touch with any issues you may have encountered or even if you would like to share something that is done particularly well in your region!



**Dr Giada Azzopardi**

Triple Medicine / ICM IiT Representative

Welcome to any new starters! Please make sure you've joined your relevant specialty WhatsApp group to stay up to date with any training updates. We've been putting together statements of good practice over the last few months, including one for those from medical backgrounds undergoing Stage 1 anaesthesia placements, which will hopefully be published soon. Hopefully, this will guide residents smoothly through this period and support you with your airway skills.

Additionally, I am looking for representatives from each medical specialty to ensure your views are equally represented at meetings so please get in contact if you would be interested in this. As always, I can be contacted on giada.azzopardi@nhs.net.

**Kumaran Selvarajah**

LLP Representative

Hello! I'm an ST7 dual trainee in anaesthesia and Intensive Care Medicine in London, currently Chief Registrar at University College London Hospitals. I've recently joined the FICM Intensivists in Training Subcommittee as the Lifelong Learning Platform (LLP) representative. I have a background in medical education and PoCUS and also serve as the Digital Education Content Fellow at the Royal College of Anaesthetists, contributing to digital learning strategy and content curation. I'm particularly interested in how digital innovation can improve access to high-quality educational resources and ensure the LLP continues to support trainees effectively throughout their training. I'm looking forward to representing trainees' views on the LLP, helping to improve its usability, and ensuring it remains relevant, accessible, and aligned with the needs of intensivists in training.

Please do get in touch if you have feedback or suggestions. Remember the RCoA and FICM LLPs are run by different teams and if an assessor is not on the ICM LLP you can have them added by contacting LLP@ficm.ac.uk.

**Mayur Murali**

DEI Representative

Over the past few months, work is ongoing with the FICM Diversity, Equity and Inclusion Subcommittee to support the development of the Faculty's first EDI strategy. As part of this, we will be analysing data from the recent Intensivists in Training (IiT) survey, focusing specifically on questions relating to equity, fairness, and inclusion in training. The findings will help inform targeted actions in the forthcoming strategy.

In addition, I have been involved with preparations for the IiT Conference in November, reviewing and marking submitted abstracts. The quality of submissions has been exceptionally high, and I look forward to seeing these presented as posters and oral presentations at what promises to be an engaging and thought-provoking meeting.

**Mark Oakey**

SSUAG Representative

**Amy Fox**

SSSUAG Representative

We would like to introduce ourselves as the new Intensivists in training members of the FICM Smaller and Specialist Units Group (SSUAG); Amy Fox is an ST5 in the Northern Deanery and Mark Oakey also ST5, working in Wales. We are both dual trainees with anaesthesia.

SSUAG is dedicated to supporting the unique needs of smaller and specialist critical care services across the UK. These units, which play a vital role in delivering high-quality care to local populations, face distinct challenges in workforce development, training opportunities, and long-term sustainability. A major focus of the Group has been staff training and retention. Recognising that maintaining clinical skills can be more difficult in lower-volume environments, some units are partnered with larger centres. Through paired arrangements, training provision and staff are able to rotate between sites, ensuring exposure to a wide range of cases while preserving expertise within the smaller unit.

SSUAG has also worked to ensure that the latest edition of the *Guidelines for the Provision of Intensive Care Services* (GPICS) accurately reflects the realities of smaller and specialist settings. Their input has helped shape standards and recommendations that are both ambitious and achievable, supporting high-quality care without imposing impractical requirements.

Another key concern is the training pathway for future consultants. Trainees in Intensive Care Medicine rarely rotate through smaller or remote units during their residency, leaving them unfamiliar with both the rewards and the challenges of these environments. This lack of exposure can reduce the likelihood of seeking permanent consultant posts in such units, exacerbating recruitment difficulties. By highlighting these issues and advocating for more inclusive training experiences, the sub-committee aims to secure a skilled, stable workforce and equitable care for patients in all settings.

**Michael Stewart**

LEPU Representative

I'm Michael Stewart, the new IiT representative on the Legal and Ethical Policy Unit subcommittee (the committee which produces the fantastic resource Midnight Law). This is a new role and, at the time of writing, I haven't yet been involved in any meetings of the committee so please watch this space for any interesting updates in the months to come.

As the established committee all have formal legal qualifications and extensive experience in the area my role will be purely observational and won't involve creation of any policy. What I do imagine, though, is that I'll be able to take any questions, concerns or interests from trainees to the committee so please do get in touch if you have anything you want me to discuss.

**Dr Luke Flower**
Academic Representative

It's been another busy but exciting few months for the FICM IiT Subcommittee. The programme for the upcoming FICM IiT Conference is now confirmed, with a fantastic line-up of internationally renowned speakers. Sessions will cover everything from infectious diseases and major trauma to the challenges of delivering critical care in conflict zones. This year also marks a first for the conference — a dedicated ICM resident doctor research workshop. It'll be a great opportunity to hear from academic experts, get practical advice on your own projects, and connect with other research-minded trainees.

Looking ahead, the next TRIC project — TRIC-BLOCK — will be launching soon. This study will look at the use of neuromuscular blockade in critical care, an important but under-explored area of UK practice. We'll be looking for regional and site leads, as well as local collaborators, so there will be plenty of ways to get involved – please do get in touch via tricnetwork@gmail.com if you're interested.

Alongside this, we're working to strengthen connections across the academic ICM resident doctor community — so watch this space. In the meantime, if you have a project idea, a question, or just want to learn more about academic training, please get in touch — I'm always happy to help!

**Lara Latif**
SICS Co-optee

As Chair of the Scottish Intensive Care Society (SICS) Intensivist in Training (IiT) committee, I am delighted to sit as a co-opted member on the FICM IiT Subcommittee. I am proud to represent Scottish IiTs at FICM and believe that collaboration between all four nations of the UK is essential for our specialty, so I was glad to hear that this is a priority for FICM as they make the transition to CICM in 2026.

One particular highlight of my time on the FICM IiT subcommittee has been organizing the abstract competition for the inaugural Future Intensivists conference held in London in 2024. The standard of work submitted was so high and the projects so interesting and varied that judging was quite difficult, but this speaks to the ingenuity and talent of IiTs across the UK.

Closer to home, we were also thrilled to host the first SICS Trainee Conference in several years in Glasgow in December 2024. Our excellent lineup of speakers spanned topics such as the future of mechanical circulatory support in Scotland and preventing burnout in healthcare, and we were particularly pleased to be joined by Dr Sarah Clarke (Chair of FICMTAQ) who spoke about the future of training in intensive care. Our next SICS IiT meeting will be held on the 16th of January 2026 and all resident doctors interested in intensive care are most welcome — regardless of whether you are based in Scotland!

I will be stepping down from SICS and FICM IiT committees in early 2026 as I complete training, however I can honestly say that involvement with these committees has been one of the most valuable things I have done in the later stages of my specialty training. There have been many changes in ICM and healthcare at large in the last few years, so it's a really exciting time to contribute to the conversation around matters affecting IiTs. Particular thanks must go to Waqas and Rosie for their excellent leadership of the FICM IiTs. As our specialty continues to grow and change at pace, I would thoroughly recommended getting involved to any interested IiTs.

**Dr Gemma Talling**

Less Than Full Time (LTFT) Representative, Co-optee FICMPAS Committee

During my own LTFT training I have witnessed significant improvements in the equity of access to LTFT training alongside enhanced guidance and support for LTFT training at local, regional and national level.

This year FICM published guidance on Maximising training opportunities and minimising the impact of rotational training within the ICM CCT Programme. Rotational training plays a vital role in delivering the wide-ranging experience required to complete Intensive Care Medicine (ICM) training.

LTFT trainees are particularly vulnerable to the unintended consequences of frequent rotations, particularly as they may rotate out of sync with their full-time counterparts. These consequences include logistical challenges, disruptions to personal life and childcare arrangements etc. Trainees are impacted by the requirements for repeated team integrations, the negative effects upon education and ability to contribute to the non-clinical domains of the FICM curriculum such as research and quality improvement. The aim is that those with a role in training the Intensivists of the future will take note of the recommendations in this document and consider what can be adjusted for improvement.

NHS England have just released their 10-point plan to improve the working lives of resident doctors. Many residents will have experienced first-hand the issues raised by this document and so I would encourage trainees and their representatives to collaborate locally with their employing trusts to highlight the changes that they wish to see.

I am privileged to represent the LTFT residents on the IiT Subcommittee so please do get in contact via the WhatsApp group (link below) or email (g.talling@nhs.net) if you have any ideas, queries or issues relating to LTFT training. Equally we would love to hear from you if have any LTFT related information to share from your own region.


Bookings will open by the end of December 2025 and places will be limited. Check out our website and X/Twitter for further updates!

**There is a series of online pre-recorded lectures to aid FFICM Exam revision available at [www.ficm.ac.uk/events](www.ficm.ac.uk/events)**

# FFICM EXAMINATION CALENDAR

| FFICM FINAL OCSE/SOE | |
|---|---|
| **Exam applications open** | 8 December 2025 |
| **Exam applications close** | 6 February 2026 |
| **EXAM DATE** | 16 - 19 March 2026 |
| **Fee** | Both £735<br>OSCE £410<br>SOE £365 |
| **Results** | 14 April 2026 |

| FFICM FINAL MCQ | |
|---|---|
| **Exam applications open** | 9 March 2026 |
| **Exam applications close** | 23 April 2026 |
| **EXAM DATE** | 25 June 2026 |
| **Fee** | £595 |
| **Results** | 14 July 2026 |

**For full details please see the FFICM Examination Calendar.**

# TROD role: Guiding your local Organ Donation Project to a National Accreditation

**Dr. Taqua Dahab**
ST9 ICM/AIM/GIM
NW TROD, NHSBT
FICM Deputy Lead IiT

One day, I had the opportunity to assist a colleague, a Specialist Nurse in Organ Donation (SNOD), by translating from English to Arabic for the family of a young man who had sadly suffered a catastrophic subarachnoid haemorrhage and ended up in our ICU. The differences in culture, social perspectives, and languages can be vast when dealing with families from different backgrounds.

It was not merely about the literal translation of what organ donation means; fortunately, since the family shared a similar cultural background, we were able to delve deeper into what organ donation signifies within their culture.

Thankfully, after some initial resistance, that family not only consented to organ donation for their young deceased son but also became strong advocates for the positive impact organ donation has on humanity, regardless of one's background or ethnicity.

That evening, I left feeling inspired. The concept of gifting life is truly a remarkable idea that we could promote and advocate for. Being an intensivist is a privilege as we often lead the organ donation processes and look after transplant recipients.

From that moment on, I decided to apply for the 'TROD' role, which stands for Trainee Representative in Organ Donation. In this position, you work under the auspices of NHS Blood

and Transplant, alongside the regional Clinical Lead for Organ Donation (CLOD) and a fantastic group of SNODs. It's a wonderfully supportive community with a positive mindset, allowing you to engage in projects both regionally and nationally, and even present at international platforms. This support encompasses time, financial resources, moral encouragement, innovative ideas, and leadership.

If you are an Intensivist in Training (ST5+), you are eligible to apply for TROD roles. Your Regional Clinical Lead for Organ Donation (RCLOD) will know when the position next becomes available in your region. You can hold the role until you complete your CCT, with many of us progressing to CLOD roles when we start our consultant positions.

## My TROD project

My colleague, Dr. Kamal Berechid (former NW TROD and current MSF consultant), and I decided to collaborate on a project that we believe could assist the wider multidisciplinary team in enhancing the organ donation and retrieval process from the ICU bed to the operating theatre.

We soon realised there is an existing knowledge gap among anaesthetists in training (AiTs), Intensivists in Training (IiTs), ICU Nurses, and Operation Department Practitioners (ODP) regarding the anaesthetic management of deceased organ donors and the retrieval process. Hence, we conducted a study day for North West resident doctors and the wider MDT, rotating biannually between Manchester and Mersey, combining lectures and high-fidelity theatre simulations. Pre- and post-course confidence levels were assessed using a Likert scale across three components:

1. Theatre management for DBD
2. Theatre management for DCD
3. Diagnosis of death by neurological criteria.

Additionally, qualitative feedback was gathered through thematic analysis of delegates' experiences.

## Results

In one year, we trained:

- 42 AiTs & IiTs
- 11 ICU nurses
- 8 ODPs

Significant improvements in confidence were noted across all components post-simulation, particularly regarding theatre management of deceased organ donors following DBD (See Figures 1-4, overleaf). Delegates reported enhanced understanding of the intensivists and anaesthetists roles in both donation pathways, highlighting the structured processes involved.

## NHSBT accreditation

Kamal and I presented our project results at the Annual BTS/NHSBT conference in Brighton in early 2025, where we emphasised the key initiatives required by NHSBT, RCoA, and FICM to further enhance education in the Organ Retrieval process.

We received overwhelmingly positive feedback from the NHSBT operation managers and Regional Leads from Newcastle, Wales, Yorkshire, and London. In the following months, we held meetings with the education leads at NHSBT, obtained approval for the accreditation of our course, and began planning for a national rollout

## Sharing good practice

In any educational initiative, sharing effective practices and

## Theatre Management of DCD Organ Donor Pre- and Post-course confidence level

**Thinking about your care of patients donating after circulatory death DCD, before and after the course, how confident are you in the following areas:**

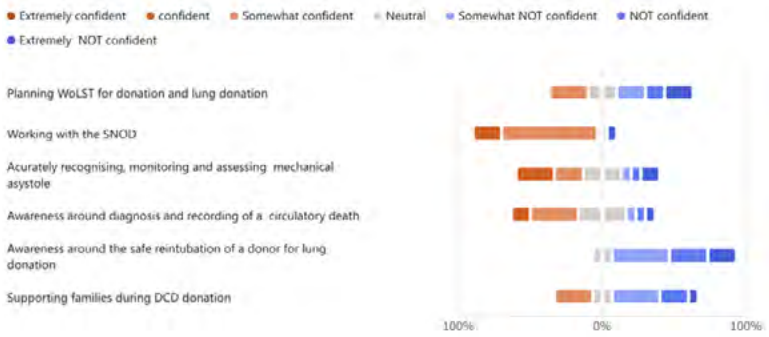



**Figure 1.** *Pre-course confidence level in management of organ retrieval in DCD*

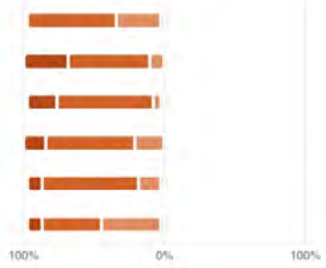



**Figure 2.** *Post-course confidence level in management of organ retrieval in DCD*

## Theatre Management DBD Organ Donor Pre- and Post confidence level

**Thinking about your care of patients donating after circulatory death DBD, before and after the course, how confident are you in the following areas:**


**Figure 3.** *Pre-course confidence level in management of organ retrieval in DBD*

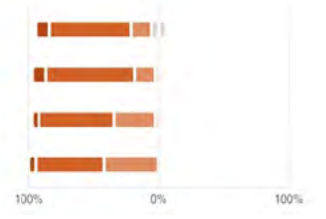



**Figure 4.** *Post-course confidence level in management of organ retrieval in DBD*

resources to apply in different contexts is crucial for the dissemination of knowledge.

We have created a SharePoint platform where regional CLOD and TROD colleagues can access all our course materials for local use, including feedback mechanisms to accurately assess progress. We plan to launch the course in 2026 across Wales, Newcastle, Yorkshire, and possibly London. If you're a TROD or anyone with an interest in organ donation, I invite you to join me at our upcoming course at Salford Royal, Mayo Building, on 14th November to observe how we operate.

## Summary

- The role of TROD presents a fantastic leadership opportunity in the field of organ donation.
- When planning your project, involve the SNODs and the Educational Lead at NHSBT; they are very approachable and can provide insights into what they are specifically looking for.
- Establish a statistical method to measure the impact of your project to persuade stakeholders to offer additional support and funding.
- Present your initial findings at the annual NHSBT/BTS conference.
- Seek feedback from other Regional CLODs and TRODs to assess if your findings could be applicable in other regions.
- Involve the National NHSBT Education Lead if you believe your project addresses key areas that need to be covered nationally.
- Good Luck supporting Organ Donation!

You can email the Course Director via: nw.anaesthetic.odt.course@gmail.com

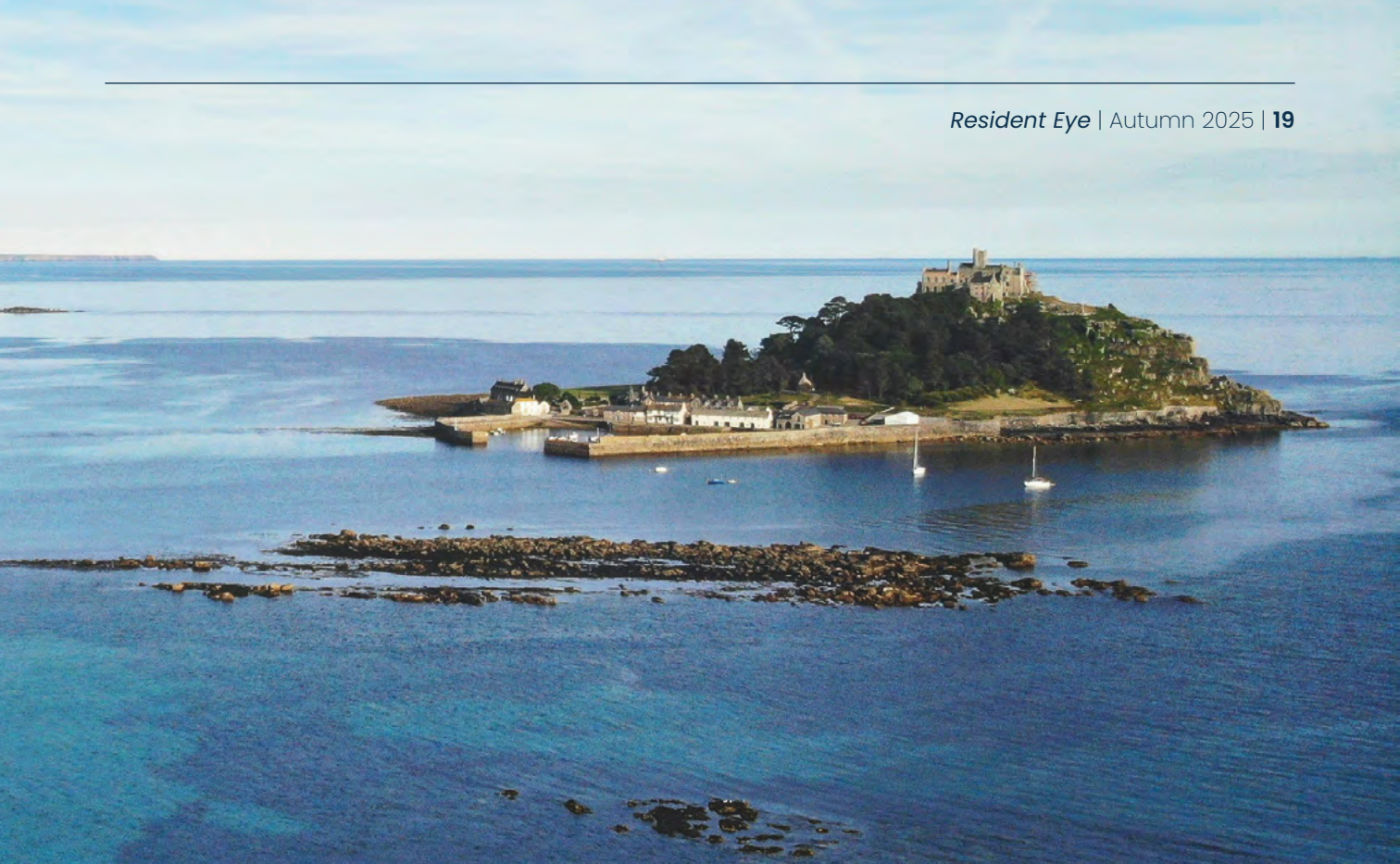

**Above, Left to Right:** *Kamal Berechaird, Taqua Dahab, and Andrew Mawson-Lee (NHSBT), BTS/NHSBT Conference, Brighton 2025.* **Below:** *Kamal presenting at the Conference.*

# Stage 3 training in the Peninsula Deanery

**Carla O'Hagan**
Intensivist in Training

In Stage 3 ICM trainees are expected to develop a broader understanding of the ICM consultant role — both in terms of clinical leadership and longitudinal management of our patients. Many regions appear to provide this by offering opportunities for 'acting up' perhaps utilising study leave or SPA, however in the Peninsula deanery for over a decade this has been provided by Stage 3 trainees (Advanced Trainees – AT) working a consultant pattern.

Our hospitals have residents on the unit, medics, anaesthetists and critical care practitioners, with airway top-cover available. In the MTC, there are several seniors to provide this — a mix of anaesthetic and Stage 2 ICM trainees, covering theatres and the ICUs, on site and on shift, in smaller units, perhaps only someone on for theatres and obstetrics. In contrast the ATs mainly work daytimes and on-call, resulting in longer periods on the unit. It gives us an opportunity to get to know our patients and their families in greater depth and really get a feel of how to manage pathology in the longer term. In the MTC it is possible for a few ATs to work in different parts of the unit, in the smaller hospitals we write our rota to avoid overlapping and maximise our experience. The flexibility from being supernumerary means I can contribute to staff



education at all levels and gives me the opportunity to get involved in projects.

## Leading

For a day on the unit, I lead the resident handover. The intention is that I manage the ward round with supervision from the consultant in charge, however this varies from acting independently, with remote supervision and discussion afterwards to having someone over my shoulder at each step, adding their own thoughts and education. This brings in a lot of skills — not just the ability to synthesise and prioritise the relevant clinical information but getting to know the team to enable task prioritisation and allocation, managing the MDT and visiting teams to encourage optimal progress of all the patients under your care.

Whilst there are still procedures happening on the unit, my role now is to delegate and teach rather than necessarily perform. There are intermittently difficult ones, and thankfully the years of doing these have meant those skills don't feel rusty. For many of my patients and their families, I will be the face of the unit for that period, guiding them along their journey.

## On-call

We do also cover weekends and nights, some units work 24 hours, others separate nights and days, but the nights start around 5pm with an expected onsite presence until the evening resident doctor handover. Adjusting to being on-call is an ongoing process. It's easy to leave the unit when it's calm and everyone is following their plan, but deciding what is acceptable variation and making a new plan is difficult. Being woken up in the night to give advice is challenging, as is learning how to ask different trainees for the information you need and deciding when to go in yourself. There are no rules for calling the consultant, all are happy to be contacted; I could if I felt out of my depth and I would if there was a major incident, as when I am a consultant I would want to know and be present for these. The resident team and senior nurse know they can ring as well. Most of the time when I do call, it's because events haven't proceeded according to plan and they act as a sounding board; often the only problem is that the patient's pathology hasn't read the literature.

## Sustainable

This is an incredibly useful transition year. When you are running between resus and the unit, it's hard to get a feel for a department, it doesn't feel like a sustainable career. Different units have different personalities; our Stage 3 acts as a year-long two-way interview! I can't think of a more useful way to work out if I would enjoy working as a consultant somewhere than to have this year where I get to try it out.

# My placement with the West Midlands KIDS Transfer Team

**Rachel Olive**

Stage 3 ICM Training: Paediatric Transfer Medicine

Here in the West Midlands, Stage 3 trainees that are dual intensivists in training (ICM and Anaesthetics) undertake a 2-month placement in either paediatric intensive care or with the KIDS transfer team (based at Birmingham Children's Hospital).

KIDS-NTS (Kids Intensive Care & Decision Support & Neonatal Transfer Service) is a combined neonatal and paediatric critical care advice and transport service for neonates and children within the West Midlands. Stage 3 intensivists in training work as part of the KIDS team with involvement in the care of neonates, all the way up to older teenagers.

## Why did I choose KIDS?

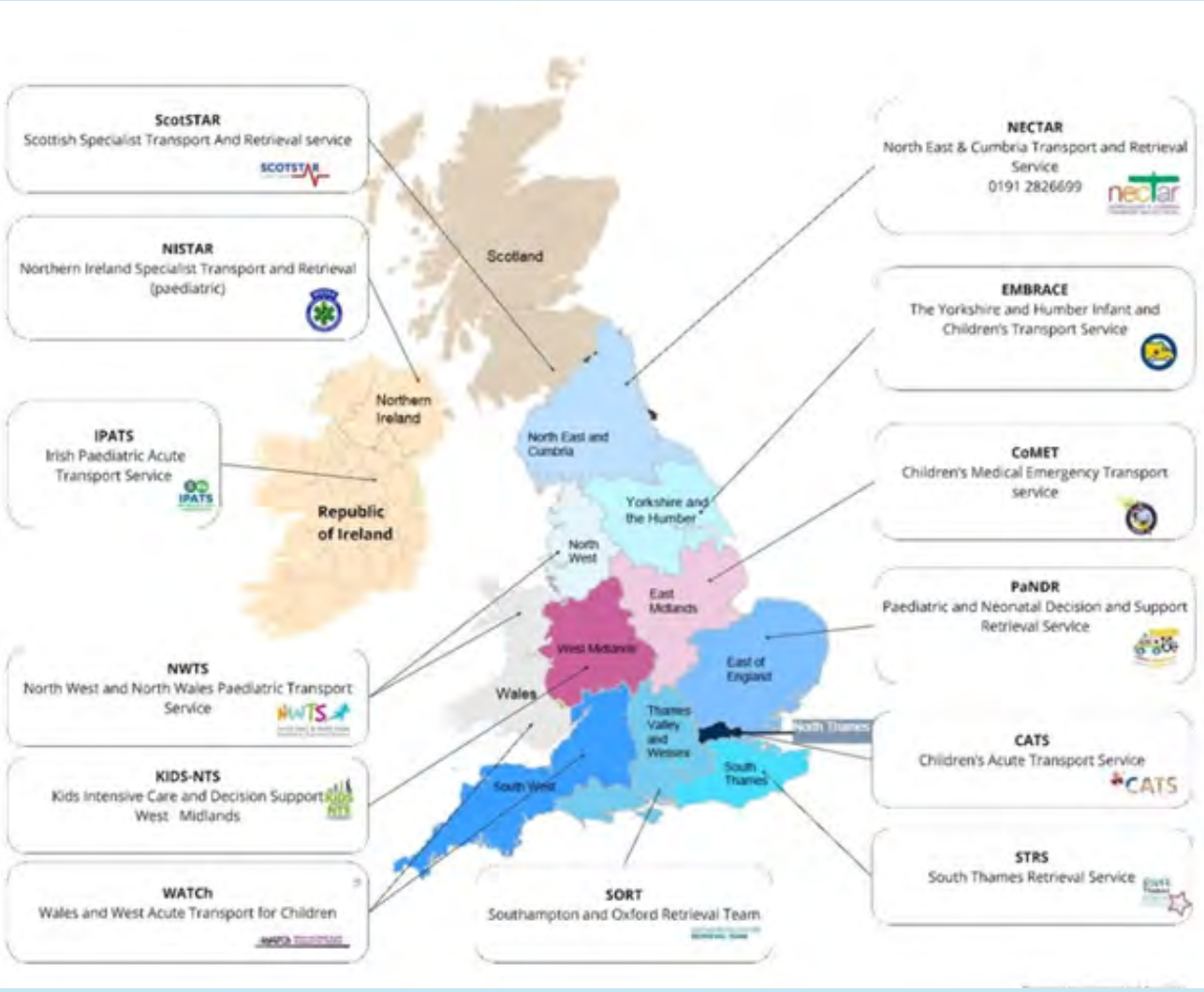
Having been involved with critically ill paediatric patients in a DGH before, my first experience with the KIDS team goes back a number of years. On one occasion, a critically ill infant with methaemoglobinaemia required referral. A telephone conference call with metabolic, toxicology and paediatric intensive care teams provided advice on treating with methylene blue. On another occasion, the team came out to support the stabilisation and transfer of a child intubated in A&E. Intravenous access was particularly challenging and the team helped to secure central access and to initiate further treatment before they could safely transfer.

As someone whose ambition is to work as a DGH consultant, the opportunity to work with the KIDS team and gain further insight and experience was really appealing and good preparation for my future role.

## What does the job involve?

The clinical shift pattern involves long days and night shifts. Most days, I would take a handover of the open referrals on arrival, alongside the duty consultant and nurse, then check the ambulances and equipment before following up on referrals by phone. It's also possible to come on shift and go straight out for a transfer or to be involved in a team swap between the day and night teams looking after a patient. My first day on the job involved a long-distance repatriation transfer from an out-of-region paediatric intensive care unit (PICU) to a regional PICU. This was a great opportunity to learn the ropes on day one, alongside a very supportive consultant.

Each KIDS transfer involves at least one medic (doctor or advanced nurse practitioner) and a specialist KIDS nurse, as well as an ambulance technician. A consultant also comes along to supervise until you are signed off as transfer competent but will also attend if needed or requested by any member of the team. Transfers vary in nature and could be PICU to




*Overview of PIC Transport Services from the Paediatric Critical Care Society. Download full version here.*

PICU or DGH to PICU, by road or occasionally by air! Not all referrals require attendance for stabilisation or transfer, but involve advice and follow-up over the phone, with other specialist input as necessary.

## Would I recommend it?

Yes! The experience has enhanced my knowledge, skills and confidence in managing a critically ill child. Understanding better how the KIDS transfer team works and what the service offers will be useful for future referrals and such cases. The placement fulfills the requirements for the Stage 3 ICM paediatric emergencies HiLLO as an alternative to a placement in PICU. There's also office time for educational development and there are opportunities to get involved with teaching and courses, such as ultrasound-guided vascular access and stabilisation of the critically ill child.

## Any advice?

If you'd like to do a placement with a regional transfer team, make your interest known early to both the team rota lead and your TPD for planning rotations.

Check out your local transfer team's website for more information, available courses and handy reference tools such as clinical guidelines and drug calculators.

# Sharing the Load:
## Reflections on Taking Shared Parental Leave as an Intensivist in Training

**Dr Alex Maidwell-Smith**
Single ICM IiT Representative, Co-optee FICMPAS Committee

I am currently an ST5 in Intensive Care Medicine. Last year, I was fortunate enough to become a father for the first time — a wonderful milestone that also marked a major period of adjustment and reflection on priorities, both personal and professional.

From the outset, my wife and I agreed that sharing the responsibilities and challenges of early parenthood was important to us both. This led us to explore the option of Shared Parental Leave (SPL). However, the practicalities of arranging it proved more complex than expected. As two doctors in separate training programmes, we were well aware of NHS administrative hurdles, and discovered that useful information about SPL was tucked away in the depths of our trusts' intranets.

Fortunately, I had supportive colleagues who had previously taken SPL and an understanding Training Programme Director (TPD), which made the process far smoother. I hope that by sharing my experience, I can help other intensivists in training navigate it more easily.

## Work/life balance

Shared Parental Leave was introduced in 2015 to promote shared parenting and work/life balance, allowing parents to share up to 50 weeks of leave and 37 weeks of pay in flexible blocks.

Nationally, uptake remains low — with around 2–5% of eligible fathers and non-birthing parents taking SPL — although the figure is thought to be slightly higher within healthcare. Financial and cultural barriers remain the main deterrents.

Encouragingly, training programmes within ICM and other specialties are increasingly recognising the importance of flexibility and well-being. Colleges, faculties, departments, and training schools are generally supportive, and TPDs should accommodate shared parental leave requests in the same way as maternity leave. Early and open communication is important: placements are often planned well over a year in advance, so providing as much notice as possible makes a significant difference. I found this part of the process quite daunting — asking for 'time off' was not something I had done before — but the reality was much more straightforward and my TPD was very accommodating.

From an administrative perspective, the process is simpler if both parents work within the same organisation. If not, coordination between HR departments is required — something that took us multiple emails and a fair amount of patience. Each trust's intranet will have its own policy and a lengthy list of forms, so start early and expect at least one round of revisions! It is also possible if one of you doesn't work in the NHS but it can be even more challenging. This aspect brought some frustration but we found the individuals working in the HR departments wanted to make it work — but navigating the bureaucracy was time consuming!

After much form-filling and back and forth communication, I was able to take 14 weeks of Shared Parental Leave — two weeks at my son's birth (in addition to statutory paternity leave) and 12 weeks over the summer. This time was invaluable. Neither of us had taken any prolonged period out of training previously and we used the time to spend two months travelling through Europe. The third month allowed my wife to return to work knowing our son was at home, and gave me the rare opportunity to slow down, recharge, and focus on family life.

## Adjustment

Returning to work was more of an adjustment than anticipated, but I would wholeheartedly recommend SPL to others. I returned a more rested, balanced and healthier doctor, and our family's transition to nursery and dual working life was far smoother as a result.

Shared Parental Leave remains underused, but for those able to take it, it offers an exceptional opportunity — one that benefits not only families, but also the teams we work in and the patients we treat. If anyone would like any advice or is experiencing challenges in accessing SPL then feel free to send me an email at alexander.maidwell-smith@nhs.net and I will endeavour to help!

# Navigating a return to Intensive Care Medicine training

**Gemma Talling**

Less Than Full Time (LTFT) Representative, Co-optee FICM PAS Committee

Returning to work as a SAS Anaesthetist after maternity leave was a challenging adjustment as I juggled professional and family commitments. After a phased return, I quickly got back into my former role. However, the sweeping changes in both my personal life and job plan, largely driven by the COVID pandemic, made me seriously rethink my decisions — particularly the choice to give up my training number. After a lot of reflection about what I wanted from my life and career I decided I wanted to finish training. But then came the big, almost overwhelming question — how on earth was I going to make that happen?

## Introduction

Returning to training after a break, a transition or shift in clinical practice can feel daunting. I write this article to offer guidance for those considering completing specialty training, specifically in Intensive Care Medicine.

As a SAS doctor or Clinical Fellow, your role in this environment is pivotal. Workforce data states that in Anaesthesia this group of doctors collectively make up more than 20% of the UK workforce, yet no data is publicly available for the exact percentage working in ICM. Resident doctors not in a training programme are a heterogenous group of doctors with varied levels of experience, they provide a unique contribution to intensive care teams. Both in terms of direct patient care, clinical leadership and contributing to the training and teaching of junior staff.

The importance of ongoing professional development is well documented. Completion of training in ICM can be a step towards furthering your skills and expertise. Coupled to this there is growing demand for Intensive Care capacity and the workforce required to staff such beds.

## Completion of training – CCT vs Portfolio pathway

My first question when considering how to complete training was CCT vs Portfolio pathway. Which route to choose is a big question. It requires time, thought, advice and reflection before you can come to a decision that best suits you. A helpful analogy I read likened it to comparing a drive on country roads vs the motorway to a distant destination. (See Figure 1)

The standard pathway (CCT) is well established and structured. There is guidance from Training Programme Directors, Faculty Tutors and Educational Supervisors and a specific topic-based portfolio to complete. In the absence of major incidents, you can be fairly sure how long it is going to take even if you decide to work less than full time.

| Training Post (CCT) | Portfolio Pathway (CESR) |
|---|---|
| **Foundation Training;** followed by:<br><br>**Core Training**<br>Acute Care Common Stem (ACCS), Core Anaesthetics, Emergency Medicine, Internal Medicine Training; followed by:<br><br>**Higher Specialty Training (ST4-7)** | This is the alternative option for those who have not completed a GMC approved programme but are capable of everything that would be expected of a UK-trained Consultant Intensivist. This would include:<br>• Those who have completed training abroad<br>• Those who have built significant experience outside of a training programme |
| You are only eligible to CCT if you have completed your training in an approved UK post | To apply for a CESR you require a portfolio that can be mapped to the standard pathway and can demonstrate your equivalence of experience and training. |

**Figure 1**

## Things to consider...

1. **Competition**
   - Training posts are highly competitive
   - Portfolio route is self-guided and doesn't have the same barriers to entry
2. **Work/life balance**
   - CESR lends itself to work life balance and geographical stability
   - Rotational training can disrupt current work life balance, geographical location varies and it is can take its toll on your mental health.
3. **Financial**
   - Moving into training on the Junior Doctors contract may result in a drop in pay
   - In training posts courses / training expenses are covered
   - Portfolio pathway applicants may have to self-fund CPD
   - Costs to apply for CESR are higher (£1902) than for CCT (£489)
4. **Admin**
   - Portfolio pathway (CESR) entails having to build your own portfolio. It requires organising your own training and seeking out posts in specialist departments if experience is required in these areas.
   - Training (CCT) is fixed pathway organised by a Training Programme Director (TPD) & overseen by a Regional Advisor (RA)
5. **Time**
   - Training (CCT) is fairly fixed at 9 years (more for dual training) and extended for LTFT or unexpected events
   - Portfolio pathway (CESR) is very variable. Potentially shorter if you have lots of experience already but potentially significantly longer.

**Figure 2**

With the portfolio pathway (CESR) route it might be quicker OR could take longer. You might have to pull over and check you are still on track occasionally, ask for directions etc. You might find that the sense of freedom and control it gives you could be the better option.

Common themes that I would recommend to aid decision making are summarised below. Seek out a mentor who will listen and provide support. For those considering the Portfolio pathway, considerable advice is published and the GMC provide Specialty Specific guidance. (See Figure 2)

## How to apply for ICM training post

Once you are through the decision-making process AND if you have decided to apply for a training post then the next step is to look at the application process. This process continuously evolves, I advise you to explore the evidence and timeframes involved well in advance of application.

- Check out the recruitment pages on the FICM website
- Speak to local doctors who have recently applied for training places for advice.
- Applications are currently managed through the Intensive Care Medicine National Recruitment Office (ICMNRO) system. Their website is full of useful links and information about applications.

## How to apply for an ICM or other training post if you have relinquished a previous training post

If you find yourself in the position of applying for a specialty training post having relinquished a previous training post. Firstly, take heart in the knowledge that it is possible and seek local advice from your local Regional Advisor in that Specialty. The process was more straightforward and successful than I had anticipated once I had compiled the confidence to ask the right people for guidance.

You need to reapply for a training post, which is a competitive process, this would involve a formal application and interview process. The application requires those that have previously left a training programme to declare this and have a "Support for Reapplication to a Specialty Training Programme" form of support signed. Further details on this process can be found on the ICMNRO ST3 ICM Application Guidance.

## Preparing yourself for the return to training

There are many sources of information aimed at new trainees recruited to Intensive Care Medicine but those recruited from a SAS or Clinical Fellow backgrounds can have different needs. (See Figure 3)

## Top tips

### Set realistic goals

Take small steps to ease into your training schedule without overwhelming yourself. Set your own achievable mini goals and a timeline.

### Maintain your physical and mental health

Maintain your own physical health through exercise, diet and rest. This can significantly impact upon your ability to manage the demands of intensive care work.

### Structured refresher courses/workshops

Various courses and workshops are available which are designed to update your knowledge of protocols and guidelines, familiarise you with technology and give you a hands-on

| Assess where you are now | Skills and knowledge gaps | Work/life balance and wellbeing |
|---|---|---|
| Personal Reflection<br><br>Where are you in your career and training? | Changes in guidelines | Time Commitment |

**Figure 3**

| | | |
|---|---|---|
| • Have you maintained any ICM experience?<br>• What are your strengths?<br>• Where are the gaps? | • It is important to stay up-to-date with recent guidelines and evidence<br>• Practice and systems changes during career breaks<br>• Integrating into new departments | • Consider the demands of balancing clinical duties with training requirements?<br>• Have you got time to fulfil the non-clinical domains of the ICM curriculum<br>• LTFT training options |
| **Clinical Competence**<br>• Assess the clinical skills that might need refreshing or updating - Procedures? Ventilation management? Haemodynamic monitoring? Resuscitation? Transfer?<br>• Specialist areas – Cardiac, Neuro, Paeds? | **Technological advancements**<br>• New equipment<br>• Software<br>• Monitoring systems<br>• Computerised records<br>• Electronic prescribing | **Mental Health**<br>• Consider how you manage stress and change?<br>• Set realistic goals<br>• Maintain your own physical health<br>• Seek support from colleagues or professional bodies if you experience stress or anxiety |

**Figure 4**

opportunity to practice essential skills in a controlled environment.

### Find a mentor who understands you and your background

A good mentor will focus on building capability, helping you develop your own wisdom, encourage you to broaden your horizons and provide career advice and emotional support as you navigate your return to training. Get someone who will guide you through challenging cases, review your performance and provide constructive feedback. (See Figure 4)

## Steps you can take to prepare for a smooth return to training

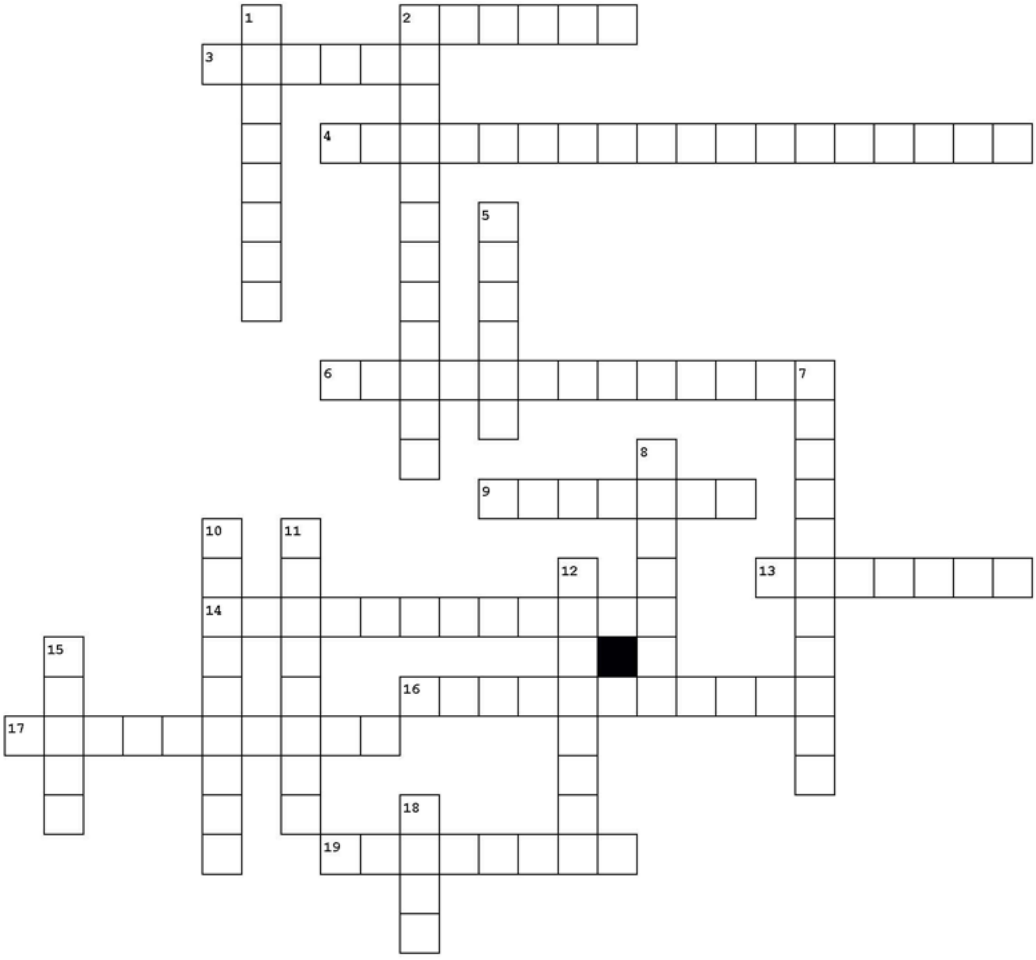
Returning to training in a high-intensity specialty like ICM requires careful planning to ensure that you don't burn out. Like all trainees you will face pressure to juggle clinical duties with your training commitments, along with other commitments that might exist outside of work. It is essential that you maintain your own well-being. Creating a balance between the demands of your work and your personal life will help you to stay energised and focused.

This article provides a roadmap for SAS doctors and Clinical Fellows who are considering completion of ICM training. I have aimed to balance practical advice with emotional support and encouragement. The emphasis on mentorship, skills development, and mental well-being can ensure that the transition back to ICM training if that is the path chosen can be as smooth and fulfilling as possible.

## Useful resources

- FICM Career and Workforce webpage: https://www.ficm.ac.uk/careersworkforce
- FICM CESR webpage: https://www.ficm.ac.uk/cesr
- GMC Specialty Specific Guidance on a Portfolio Pathway in ICM - sat---ssg---intensive-care-medicine---dc2308_pdf-48458089.pdf
- FICM Recruitment webpage: https://www/ficm.ac.uk/careersworkforce/recruitment
- ICMNRO ICM Specialty Recruitment page: https://icmnro.wm.hee.nhs.uk

# ACCU Rheumatology Crossword



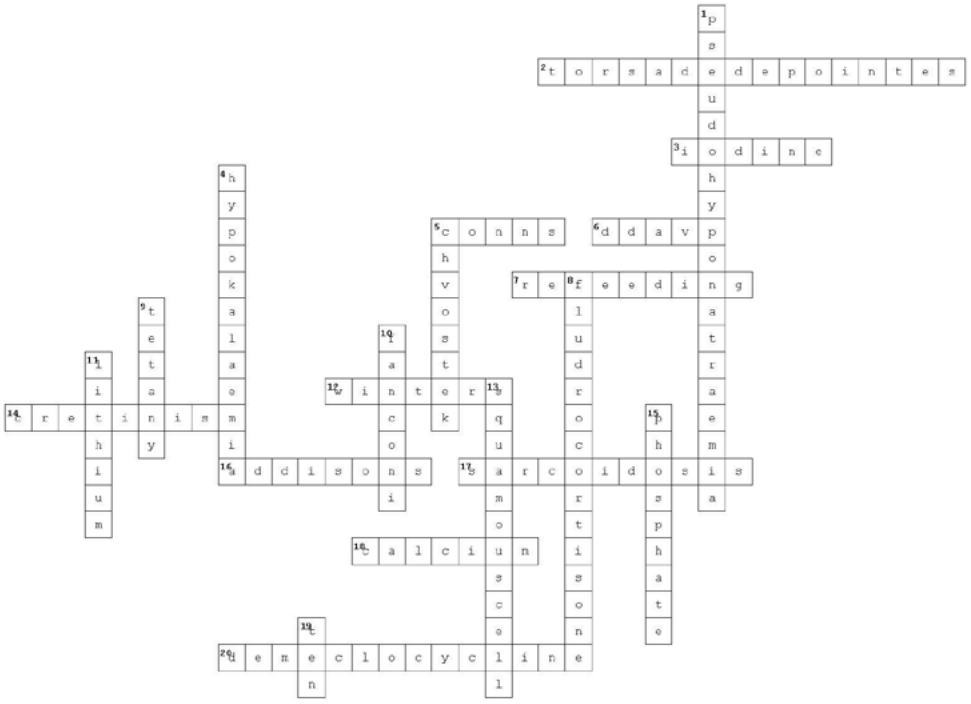
**Across**

**2.** Stimulatory autoantibody thyroid disease
**3.** Radiological description of a spine in Ankylosing Spondylitis
**4.** Immunosuppressant which can cause QT prolongation and arrhythmias
**6.** Extensor elbow dermatitis in Coeliac Disease
**9.** Autoimmune vasculitis which can present with a saddle nose deformity
**13.** Circular rash found in lupus
**14.** Immunosuppressant and dihydrofolate reductase inhibitor
**16.** SLE associated endocarditis (6,5)
**17.** Disease characterised by Anti-Hemidesmosome antibodies
**19.** Shape of crystals in pseudogout aspiration

**Down**

**1.** Autoimmune reaction against this organ is characterised by the presence of IgG4
**2.** Syndrome of haemoptysis and haematuria with Anti-GBM antibodies
**5.** Number of American College of Rheumatology diagnostic criteria for SLE
**7.** Hilar lymphadenopathy, hypercalcaemia and lung granulomas
**8.** Oral ulcers, genital ulcers and anterior uveitis
**10.** Disease presenting with multiple fragile blisters
**11.** Purple, scaly papules occurring over the joints in Dermatomyositis
**12.** Paediatric vasculitis with coronary artery aneurysms and palmar skin desquamation
**15.** Syndrome of calcinosis, Raynaud's, oesophageal dysmotility, sclerodactyly, telangiectasia
**18.** Metal which can be used in the treatment of rheumatoid arthritis

# ACCU Endocrinology Crossword: Answers



**Across**

**2.** Polymorphic ventricular tachycardia associated with low potassium, magnesium or calcium

**3.** Sudden introduction of this into a patient with thyroid disease can result in the Jod-Basedow and Wolff-Chaikoff phenomena

**5.** Hyperaldosteronism with hypertension, hypernatraemia, hypokalaemia and metabolic alkalosis

**6.** Synthetic analogue of a hormone secreted by the posterior pituitary, used to treat hyponatraemia

**7.** Syndrome of low potassium, magnesium and phosphate secondary to insulin production following starvation

**12.** Formula of (1.5 x Serum Bicarbonate) + 8 (+/-2)

**14.** Congenital iodine deficiency resulting in poor growth and neurological development

**16.** Characterised by hyperkalaemic, hyponatraemic metabolic acidosis

**17.** Cause of hypercalcaemia secondary to increased 1,25 hydroxylation of Vitamin D by type 2 alveolar macrophages

**18.** Drug used in the treatment of cardiac arrhythmias secondary to hypermagnasaemia by acting as a magnesium antagonist

**20.** Antibiotic used to block water re-absorption via increased expression of Aquaporin-2 molecules triggered by ADH

**Down**

**1.** Low sodium as a consequence of high glucose, protein or lipids

**4.** Electrolyte state characterised by PR prolongation, ST depression and prominent U waves on ECG

**5.** Sign of facial nerve irritability in hypocalcaemia

**8.** Mineralocorticoid used in the treatment of postural hypotension

**9.** Spasmodic muscle contraction in low calcium state

**10.** Syndrome of low potassium, chloride and phosphate due to impaired reabsorption in the proximal convoluted tubule

**11.** Mood stabiliser which can cause a nephrogenic Diabetes Insipidus

**13.** Form of lung cancer associated with paraneoplastic hypercalcaemia secondary to PTHrP

**15.** Electrolyte which is low in hyperparathyroidism due to increased renal excretion

**19.** Optimum number of mmol/l that a hyponatraemic patient hould have their sodium raised in a 24hr period (answer in letters)

Crosswords created by Dr Harry Yong

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