



TRAINEE EYE

13th Edition | Summer 2020



The Faculty of
**Intensive
Care Medicine**™

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We would welcome your thoughts on the content for trainees and topics you feel we should address in the future. Get in touch by emailing us at contact@ficm.ac.uk

WELCOME FROM THE LEAD TRAINEE

Dr Richard Benson

Lead Trainee Representative

The last few months have been difficult. As ICM trainees we have seen an upheaval both in our working and home environments. Our specialty has been under the spotlight with media coverage on ventilators and ICU capacity becoming front-page news.

The response across all four nations from ICM and its trainees has been incredible. You have adapted with the rapid escalation of rotas, coped with learning how to manage a novel disease and struggled through the grief and loss that has accompanied this. I know it has been hard. From a training perspective many of you will have been affected. It may be the cancellation of the exam you had been intensely preparing for, redeployment or a need to step back from clinical work entirely. It is a difficult and challenging time but I hope that we, as a faculty, can continue to do our best to support you.

Upcoming ARCPs will have significantly changed stipulations and ongoing discussions are occurring to ensure that trainees can continue to progress through the different stages. You will have been receiving regular updates from the FICM COVID Digest and as soon as information becomes available it will be put on the collaborative website [here](#).

Despite the difficulties, there is positive news as well. The spotlight on our specialty has shown the fundamental importance of ICM in acute patient care. This has been recognised with the creation of an extra 100 ICM training posts for England, 6 posts for Scotland and 4 posts each for Northern Ireland and Wales. I look forward to welcoming all the new trainees to ICM in August.

With the increased demands we have also had the opportunity to showcase critical care to a wider audience. Our colleagues will have had their first taste of ICM and I am sure many will realise what a diverse and rewarding specialty it is. Please share with them our #discoverICM campaign as we continue to grow.

This edition of Trainee Eye was prepared in the first few months of this somewhat turbulent year. After consideration, we have continued to include the articles on the FFICM examination. One of the areas that has received attention in recent years is the timing of the exam; this has been extensively discussed by the FFICM Examinations Sub-Committee. The Chair of the Sub-Committee is Dr Victoria Robson who has kindly written an article on this topic for this edition of Trainee Eye. I appreciate that the most recent exam sitting has been cancelled, but I feel it is important we represent the views of the Sub-Committee to the trainee body.

I will conclude as I started by re-iterating that times have been difficult but I have never felt prouder to be part of a specialty that puts itself at the forefront of acute patient care.

Thank you for everything you have done, keep in touch using the email or twitter handle below, and look after yourselves.

Richard.p.benson@gmail.com
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ICM TRAINING UPDATE including information on ARCPs for 2020

To support the management of ARCPs for 2020, we have developed COVID-19 specific national guidance and an ARCP Decision Aid for panels during this period.

These guidance documents, along with other important updates regarding ICM Training, can be found [here](#).

ONE YEAR AS A CLINICAL FELLOW IN ICM

Dr Manoj Wickramasinghe

Clinical Fellow in ICM at Leeds Teaching Hospital

I have spent the last year as a Clinical Fellow in Intensive Care Medicine at St. James's University Hospital, Leeds. Having come straight out of the Foundation Programme, it is safe to say that I was slightly apprehensive, but excited, about commencing this post in what was described as an 'incredibly busy ICU'. Although I had some rudimentary ideas about what I wanted to get done in this year, I was initially unaware of the wide scope of opportunities that were available to me. I have managed to fit a considerable amount into this year and hope to outline the opportunities that are available to those embarking upon a Clinical Fellow post in ICM, either post Foundation Programme or elsewhere in their training.

My previous interest in simulation meant that I was able to take on the position of the Simulation Fellow, a novel role in Leeds. Alongside a highly dedicated multi-disciplinary simulation faculty, I have been able to develop the Leeds Intensive Care Simulation (LICS) course which is a high-fidelity simulation course that now runs on a 2-monthly basis. I developed organisational and leadership skills through this by leading a faculty, organising all administrative tasks for the course, creating scenarios and running courses. The feedback for the course has been overwhelmingly positive. I was also successful obtaining £45,000 worth of funding which has allowed us to buy simulation equipment for both sides of the city to be able to run in-situ simulation. I have presented the work we have done at national conferences including the ICS State of the Art conference in December 2019. My contribution to simulation in Leeds was recognised through me being shortlisted as one of the final three for the Junior Doctor Awards for Innovation. Through this year I was able to complete a distance learning Postgraduate Certificate in Medical Education. Although this did take a considerable amount of time, I found it complemented my work within simulation well.

Before starting this job, I had heard of 'FICE' and it was something that I was interested in pursuing. I was lucky to be working with an ICM registrar who

was a FICE mentor and soon became accredited in both FICE and CUSIC, more recently named FUSIC. In the year I spent in ICM I was able to conduct around 400 echocardiograms, went onto become a FICE mentor and successfully 'mentored' two colleagues in their journey in attaining accreditation. Subsequently, I created and successfully ran the first Leeds FICE course in December, which I plan to run on an annual basis with next year's course encompassing all modules of FUSIC.

I found that having a whole year meant I could conduct a fairly long QIP which I otherwise wouldn't have been able to do through 4 or 6-monthly rotations. I was able to look at the introduction of an ICU-specific sepsis checklist that showed significant improvement in sepsis management and I am due to present work from this project at an international conference.

Whilst working on a busy ICU rota, I have been able to achieve all the skills that I had envisaged prior to this job, including becoming competent at line placement, assessing and managing sick patients, being able to have difficult conversations with families, and many more. However, something that I hadn't planned, and was much more profound, was the sense of belonging within a multi-disciplinary team. Having only ever done 4-month rotations prior to this job, I had never gotten the opportunity to work in a team for an extended period of time or get the sense of what being a 'core' part of a team was like.

This year has easily been the best year of a very short career so far. I have developed strong interests in ICM, ultrasound, simulation and medical education, all of which I hope to continue throughout my career. Although what I have achieved within this clinical fellow year is by no means an exhaustive list, with the prevalence of these roles becoming increasingly popular, I hope I have described an example of what can be achieved. I am extremely grateful for the team I have worked with and have to pay special thanks to Dr Claire Tordoff and Dr Lorna Eyre.

CRITICAL CARE IN ZAMBIA

Squadron Leader David Hall

South East Scotland

Safe critical care provision is increasingly being recognised as an important healthcare goal in low-and-middle income countries. Towards the end of my training in Intensive Care Medicine and Anaesthesia, and on the lookout for fresh challenges, a fellowship in Anaesthesia in Zambia was the perfect opportunity to contribute towards this goal whilst gaining some new skills and clinical experience. Supported by the Defence Deanery and my local Training Programme Director to undertake an OOPE, I applied to the Zambia Anaesthetic Development Programme (ZADP), which has a well-established programme for UK registrars undertaking teaching fellowships in University Teaching Hospital (UTH), Lusaka. ZADP was developed to support the provision of safe anaesthetic training in Zambia and the remit of ZADP fellows is to support quality-improvement and teaching, including clinical teaching in theatre and ICU. Following a successful interview, and sign-off from my ST6 ARCP, I relocated with my wife and 8-month-old son to Zambia in August 2019 for three months.

Adult Critical Care in UTH is provided by a 16-bed intensive care unit staffed by Zambian physician anaesthetists, most of whom are in their first few years of postgraduate training. The ICU admits a large volume of trauma, particularly severe neurotrauma, and offers an exposure to major trauma that is unlikely to be matched in UK training outside a very busy major trauma centre. There were also a very large number of patients with septic shock (often presenting very late, or with infective complications of HIV/TB). A smaller proportion of patients had tropical illnesses including trypanosomiasis, fulminant malaria, tetanus and on occasion injuries from wild animals. Compared to UK practice, there was limited senior medical review of patients or input into decision-making, which allowed me to take on a degree of clinical leadership that would be difficult to experience in the UK as a registrar. This was made possible by regular debriefs from a remote educational supervisor in the UK using Facetime, and I felt appropriately





mentored and supervised despite being on a separate continent to them. One of my interests within ICM is echocardiography focused ultrasound, and there were plenty of opportunities to develop this in Zambia. Alongside my co-fellow Jules Harrington, we developed a Zambia focused echocardiography course, which was accredited by the UK Intensive Care Society as a FICE course. We spent many happy teaching days scanning with Zambian doctors in the ICU, and the extent of sono-pathology was much greater and more advanced than typically found in the UK. Focused ultrasound also proved to be particularly useful diagnostically when the hospital's CT scanner and portable x-ray machine both became unserviceable.



There were naturally plenty of challenges to working in a resource-limited setting such as Zambia. Patients could be referred late, particularly with neurotrauma, at which point critical care was unlikely to make a meaningful difference to their overall outcome. Equipment was often unserviceable, including ventilators and airway equipment, and the monitoring could be unreliable. Drug availability was also inconsistent. Other pressures were more familiar from the NHS; bed capacity was always very limited, and sometimes the wait for admission from the Emergency Department could be measured in days. Despite these many challenges, the Zambian doctors and nursing staff were very committed to delivering compassionate, effective critical care and almost certainly taught us as much as we taught them.



Overall, the ZADP Fellowship offers training in ethical and pragmatic decision-making, clinical leadership and critical care in a resource-limited environment, whilst delivering teaching and gaining quality-improvement experience. I'd recommend it to anyone with a taste for adventure and the urge to expand your horizons in Anaesthesia and Critical Care.



Photographs by Squadron Leader David Hall

FFICM EXAM: THE RATIONALE BEHIND THE TIMING

Dr Victoria Robson
Chair, FFICM Examiners

Each component of the FFICM (final) exam is run twice per year, approximately 6 months apart. The MCQ is held in January and July (although it will move to June from 2021). The OSCE/SOE is held in March or April (depending on the date of Easter) and October.

The timing of exams is set within a number of constraints. The oral component venue (Churchill House) is also used for FRCA (primary and final) and FFPMRCA examinations, and there is physical capacity for only one examination at a time (some FRCA examinations need 6 consecutive days and FFICM uses 2-3 days). The same examinations department staff are used for all exam administration, which takes a number of days before and after the examination itself. We also try to avoid timing the exam with events that lead to lots of ICM staff being away from their departments (such as major ICM Conferences), so that both examiners and trainees can be released more easily.

Wherever possible, school holiday times are also avoided, for the same reason. To this end, the summer MCQ will be moved from July to the end of June (from 2021) to avoid it falling within the Scottish schools' summer holiday. However, school half term holidays vary around the UK, (including between English regions) so it is not always possible to avoid the October half-term holiday for all regions, without making the gap between the Autumn and Spring exam too short in some years.

Examination dates are published on the FICM website at least one year in advance.

The final FFICM exam standard is the end of Stage 2 training, i.e. 1 year before CCT, so that it includes the curriculum of Cardiothoracic ICM, Neuro ICM, Paediatric ICM as well as the sections that used to be called the 'complementary specialties' i.e. Anaesthesia and Acute Internal Medicine, and all of

the Stage 1 curriculum. Trainees can sit the exam at any time when in Stage 2 training, but not before. The expectation is that a trainee who is successful in the exam has the knowledge and skills to be only one year from CCT and starting a consultant post.

Trainees sometimes wish to sit the FFICM earlier than Stage 2 of their training; however, without the expected experience and training, trainees are less likely to pass. This may be particularly relevant for trainees in dual programmes who are acquiring transferable skills for the ICM programme in non-ICM posts and may end up with less total ICM experience. Dual CCT trainees, who start the ICM programme later in their partner specialty training, may ask for retrospective credit towards the ICM stage 2 curriculum from posts they did when in the partner specialty (eg neuroanaesthesia post being credited for neuro ICM curriculum competencies). At the time these trainees were not ICM trainees; so they will need to ensure that, in their exam preparation, they have adequately covered the ICM curriculum in this area.

The Board of Examiners wishes to discourage trainees from attempting the exam before they are fully prepared, both in terms of clinical experience and study; the ideal scenario is that trainees present only when fully prepared, so the pass rate is very high. Multiple attempts at an exam when poorly prepared is disheartening for trainees, expensive, and also encourages other trainees to think they too will need multiple attempts and so they try to sit the exam earlier and earlier (without success).

A pragmatic exception to the Stage 2 rule has been agreed by the Board of Examiners; the summer MCQ is held in June/July in order to avoid the summer holiday period, so the Board of Examiners has agreed that a trainee who is predicted to enter Stage 2 training a few weeks after the FFICM MCQ date may sit that MCQ.

FFICM FINAL EXAM: TIPS FROM AN EXAMINER

Dr Victoria Robson
Chair, FFICM Examiners

FFICM is a high-takes exam taken by ICM trainees and is mandatory before entry into Stage 3 training. This article aims to give some tips and pointers to trainees who are preparing for this exam, written by an experienced FFICM examiner.

Use the current curriculum to guide your preparation. The exam is set at the end of Stage 2 training, matched closely to the FICM curriculum. Hence it can include questions on any area of the curriculum, including what were formerly called the 'complementary specialties' (General Medicine for trainees with an Anaesthesia background and Anaesthesia for those from Medicine) and all the sub-specialties of PICM, neuro ICM and cardiothoracic ICM. Intensivists need to be able to deal with the critically ill from all specialties, and the curriculum (and hence the exam) reflects this. Relevant basic science is also included in the curriculum so is regularly tested in the exam.

After an exam sitting, the Chair of Exams writes a report that details the areas, as noted by the examiners, where a number of candidates have scored badly. These reports (available on the FICM website) can be useful for trainees preparing for future exams.

The Multiple Choice Examination

This is moving (at the request of the GMC) to become all single best answer questions. These questions have a stem and a number of responses, of which one is the best answer. There may be elements within the distractors which are correct, but one answer is superior. Some of these questions will test basic sciences, others will be clinical. These test knowledge, understanding and judgement. A good knowledge base is required, as well as practice at this type of question (which may be less familiar to candidates). It is important to read the stem of the question accurately in order not to be distracted by plausible but incorrect answers.

The Objective Structured Clinical Examination (OSCE)

This has thirteen 7-minute stations (including a test station), and usually includes stations on ECG interpretation, radiology, equipment, communication and simulation as well as clinical stations. A short statement outside the cubicle will guide the candidate as to the type of station and it may also have relevant clinical information. The instructions, questions and marking schedules are fixed, and the pass mark for each station has been predetermined. The OSCE tests knowledge and skills, including decision-making, prioritisation as well as communication and some practical skills.

ECG and Radiology stations: A 'report' on an investigation will be expected to demonstrate a systematic approach, and so for an ECG we would expect candidates to include comments on patient details and date (or absence of these), calibration as well as rate, rhythm, axis, P waves, PR interval, QRS morphology, QT interval, ST segment, T waves, any other findings, the location of abnormalities and interpretation of findings.

For a chest radiograph, a report would be expected to include comments on the patient details and date (or absence of these), orientation, position/side description, rotation, adequacy of the study as well as comments on the airway, mediastinum, cardiovascular structures, lungs including hilar, bones, diaphragm, upper abdomen, any pathology or iatrogenic structures. A candidate may not be required to give a full report

for all images - in this case the examiner will ask for 'important findings' (and in the interests of time will interrupt the candidate if they start a systematic report).

Trainees may find sources designed for general medicine trainees or medicine exams helpful in their preparation for these stations, as well as attending teaching sessions designed for medical specialty trainees.

Communication: This station involves communication with a mock patient, relative or healthcare professional, played by an actor who has been briefed as to what to say and what questions to ask. The instructions outside the station, and the actor's responses, will guide the expected content of the communication. The examiner does not interact in this station. Marks are awarded both for what is said, and the communication style (including use of lay terms, avoidance of jargon, body language etc). The actor should be treated as their role suggests e.g. a 'relative' would not be expected to understand medical terms (which should therefore be avoided or explained), and the level of detail expected is that which is appropriate for the simulated situation given. Trainees will find that observed practice at this in the clinical environment with feedback from a consultant is useful in preparation for this station.

Simulation: The simulation station includes a high-fidelity mannequin, with examiner(s) and/or actors in the role of 'helpers'. The role of the 'helper' e.g. ED core trainee, anaesthetic nurse etc. will be made clear to the candidate, either at the start of the simulation station or as the helper arrives. Helpers can be assumed to be competent in their role. There may also be artefacts (e.g. radiographs) introduced into the simulation scenario, either at a specific time point or when asked for by the candidate. Candidates are not required to be 'bare below the elbows'.

The simulation scenarios may include resuscitation from cardiac arrest or may be about the management of a patient who has been referred to, or is in critical care. Note that the level of performance expected is that of end of stage 2 ICM training (which is higher than that expected of candidates on life support or some other courses, and of candidates in core exams). Knowledge, data interpretation, integration of data within a rapidly evolving clinical scenario, situational awareness, integration of multiple changing inputs and conflicting priorities, decision-making, teamworking and leadership and communication can all be tested in this station, and the mark sheet reflects this. Candidates should behave as if in clinical practice and may find it useful to 'think out loud' during the simulation, to demonstrate some of these features. The simulation may be stopped by the examiner so that questions can be asked, in order to assess decision-making etc. In preparing for this station, a wide range of clinical experience is useful, as well as practice simulations with feedback, on courses or in hospitals, as long as the expected level of performance is appropriate.

Equipment station: This will involve an item of equipment (or a photo) with questions on its use, or the candidate may be asked to demonstrate an aspect of its use.

Clinical station: These include a short summary of a clinical situation outside the station, with a number of artefacts (e.g. blood results, radiographs) to be interpreted and questions to be answered. The clinical summary will also be available inside the station, so it is not necessary to 'memorise' it, however, do read it all in detail as it contains useful information for that station. Normal values for blood results etc will be given. Candidates should integrate all the available information, e.g. a question about the 'most likely diagnosis' which has already included clinical information, then arterial gases, then blood results, then an x-ray, may have a different correct answer to 'the most likely diagnosis' of the x-ray findings alone.

General tips for OSCE questions

Try to answer exactly the question being asked; in the question on the 'causes of X' there will be no marks for listing treatment options.

'Interpretation of data' requires explanation - not just a description of what the data shows.

Marks cannot be scored for previous questions within a station once the examiner has moved on, so candidates should not 'dwell' on previous questions, but try to focus on what is being asked.

Examiners do not 'hint' at answers. If a candidate does not know the correct answer, they will pause, and then move on. So, if the examiner is silent and does not move on immediately after your answer, try to expand. This is unlike the approach some candidates may have experienced in 'viva practice', where an incomplete answer is followed by broader and broader hints to guide the candidate's thinking. In the exam, the only prompts by the examiner will be those written into the question (to ensure the exam is delivered equally to all). The set pass mark for each question takes this into account.

Marks will not be scored if a 'scatter-gun' approach is used. For example, if a question on 'the most likely diagnosis' is asked, only the first answer will be taken (unless a candidate corrects themselves clearly).

A candidate can ask the examiner to repeat the question, if required. Examiners do not give feedback as to whether an answer is correct or not, except where the question requires this to avoid 'double-jeopardy'. Again, this may be different to the style of teachers giving exam practice.

Examiners interrupt, in order to ask sufficient questions to maximise the marks for each candidate. This occurs particularly if a candidate has scored the mark(s) available for a question so cannot gain any more marks on that question (however much they know!) and needs to move on.

Examiners move on as soon as a question has been answered; this is to maximise the number of questions asked, and so improve the candidates overall mark. This can feel like fast 'pressured' pace, but it is done to maximise candidate marks. Try to focus only on the current station. If a station seems to have gone badly, try to forget about it and move on. The 'pass mark' for each station varies (so more 'difficult' questions have a lower pass mark) and none require 100% to pass. Each station is weighted equally within the exam, so additional marks on one can compensate for a poorly answered station and there are no 'killer stations' that must be passed in order to pass the exam. Many successful candidates do not pass all stations. In addition, there is nothing to be done about a previous station, so to maximise marks, a candidate should try to focus only what is currently being asked.

Some stations do not use up the whole 7 minutes, and a high mark can be gained with time to spare.

The Structured Oral Exam (SOE)

This consists of 8 questions, asked in pairs (two examiners marking each question). The starting topic is listed on the wall outside the cubicle. Each question will have 5 sections, which may require answers with different levels of detail. Topics are drawn from the whole of the Stage 1 and 2 curriculum (including relevant basic sciences). This examination tests both knowledge and intellectual skills such as understanding, prioritisation, organisation of ideas. Answers are expected to be broader than in the OSCE.

In the SOE examination, the candidate will do most of the talking and many of the questions require answers that include a lot of items; use of a suitable classification or framework to organise the answer can assist a candidate maximising their marks for these questions.

Examiners may probe a candidate's knowledge and understanding, more so than in the OSCE - this can feel challenging; however, it is an important part of assessing the range and depth of understanding and maximising the opportunity for marks. Candidates should expect to feel 'stretched' in some areas of questioning; but

in fact, the questions that initially appear to be more challenging to a lot of candidates are often not the ones that score low marks. Using a suitable framework or classification to structure the answer can lead to remembering additional facts.

Try not to dwell on a 'bad' question; it may not have been as bad as you think, as the knowledge required for questions varies but is always lower than 100% (and there is nothing you can do about it after the event). There are no 'killer questions' in the SOE, so additional marks on other questions can compensate if needed. Examiners will not give feedback on the answers given, whether correct or not. This may feel strange to a candidate who has practised in a setting where feedback and 'hints' are given.

There may be silence; if a candidate does not immediately answer, or stops talking before the answer is complete, examiners can give a candidate a short time to think before moving on. Marks are not being scored during the silence, but the candidate can use this time to organise their ideas etc.

Examiners may interrupt a candidate in order to re-focus on the question being asked or to move them onto the next section, as marks are available in all sections. This happens particularly when a candidate has deviated from the question being asked or has scored the marks available for that section. Both of these strategies aim to maximise the candidate's chances of scoring marks.

A wide range of experience, study of texts and journals (using the curriculum as a guide) and viva-practice from consultants can all be useful in preparing for this exam.

A few practical tips

Arrive in plenty of time; allow for unexpected transport delays etc. You may choose to bring a snack/drink for the gap between exams (water is provided). Get as much practice as possible, both on formal courses and from consultants. It may be useful to remind those giving you practice that examiners do not prompt or give feedback during the exam.

The breadth and depth of knowledge on a topic that is expected of a successful candidate varies, according to the topic. Knowledge of those conditions which are commonly encountered or most important will be required in greater depth than those which are rarer or less important; however, an ICM specialist can be required to treat the sickest patients of all the specialties, so a very wide breadth of knowledge is also required.

And if you fail repeatedly, ask for a guidance interview. At this, an examiner will review your answer papers, and try to offer pointers to guide your further study. Each candidate can request one guidance interview, and then one is mandatory before the sixth attempt at a part of the exam.

In summary, sufficient breadth and depth of knowledge and clinical experience (guided by the curriculum) with realistic practice at the examination types (with feedback) should give candidates the best possible chance at success.

FINAL FFICM RESOURCES

Dr Bhaskar Narayan

Dual Trainee in Acute Internal Medicine and Intensive Care Medicine

Preparation for the Final FFICM was tough and consumed much of my free time for several months. However, I felt that it was, on the whole, a fair exam, and the revision (and first-time learning in some areas!) has definitely prepared me well for my Stage 3 training and beyond.

The curriculum is available on the FICM website and while at first it looks very superficial, scrolling down reveals much more, and this is an invaluable guide to revision topics. It is useful to be familiar with the format and marking scheme of each exam component, which is clearly explained on the FICM website.

Multiple Choice Question (MCQ)

The MCQ component is the first part of the exam and has to be passed before progressing to the SOE/OSCE. The pass mark is approximately 68% (although this varies slightly from year to year). I would say that the SBAs are much more difficult than the MTF questions and it is worth bearing this in mind when preparing and during the exam itself. In terms of preparation, the core revision method is to do lots of practice MCQs. I used the following resources:

1. Bennington et al – Intensive Care MCQs. This is a great all-round resource with both MTF and SBA questions, with helpful answers/explanations
2. Davies et al – Single Best Answers for the Final FFICM. This is really useful book to focus on the SBA format, which most people find more challenging.
3. BMJ OnExamination – there is now a dedicated FFICM question bank available, but this was released after I sat the exam. I used the Final FRCA question bank, with a filter set to only include ICM questions. It is a good way to do on-the-go revision, using the mobile app.

4. Crit-IQ – the question bank was variable in terms of its relevance for the FFICM exam, and the website is clunky and difficult to use.

While it is tempting to focus entirely on practice MCQs, with minimal additional reading, I would advise against this, as the breadth of the curriculum is such that it would be very difficult to cover all topics adequately using practice MCQs alone. It is definitely useful to do some reading around the topics. The BJA Education supplement (the online archive) is an excellent resource for this, and a search of the archive usually yields an article relating to almost any ICM topic. Many articles also include some MCQs at the end to test your understanding. I only occasionally used textbooks such as 'Oh's Intensive Care Manual' and the 'Oxford Desk Reference in Critical Care', but these can be useful to read up on certain topics.

I also think it is a good idea to approach the MCQ revision with half an eye on the upcoming SOE/OSCE component. This may not work for everyone, but it pushed me to learn topics in more detail and helped highlight weak areas. The SOE books (see below) are an excellent resource to read up on difficult areas on the curriculum, and this helps with answering tricky MCQs in the short term as well viva questions in the medium term.

Structured Oral Examination (SOE) & Objective Structured Clinical Examination (OSCE)

The SOE is a viva-style exam. Anaesthetic trainees may be more familiar with this type of assessment but, as a medic, the format was new to me. I think it is a fair exam overall, but it really does test the full breadth of the curriculum and there are inevitably going to be some questions you can answer better than others. Most topics are clinical, but there will occasionally be a question on basic sciences, ethical/legal or management issues so it is important to prepare accordingly. I would suggest a two-pronged

approach to preparing. Firstly, nothing beats practice! Spend as much time as you can constructing and rehearsing viva-style answers by yourself, with peers and with senior colleagues. And secondly, have bullet-proof answers for core material such as ARDS, pancreatitis, delirium and subarachnoid haemorrhage. You should also meticulously tighten up any gaps in your understanding of the less well-known parts of the curriculum by reading more whenever you come across something you think you are less familiar with. You need to ask yourself for each curriculum item, 'can I talk about this for a few minutes and sound sensible?' I used the following resources:

- FICM Curriculum
- Specific FFICM websites ("PINCER" and "PENNINE")
- BJA education supplement
- Books: Flavin et al - Questions for the Final FFICM Structured Oral Examination; Jeyanathan et al - Viva and Structured Oral Examinations in Intensive Care Medicine.
- FRCA SAQ resources are also useful – particularly Northern Ireland School of Anaesthesia Final FRCA website
- EBM/FOAMed online resources such as Bottomline and Critical Care Reviews
- FICM and ICS guidelines
- Podcasts – EmCrit/PulmCrit, Internet Book of Critical Care
- Courses – various ones available. I went to the official FICM one in Leeds and also the one in Stoke, both were excellent.

The OSCE is, in my opinion, the most difficult component of the exam, and has the lowest pass rate. Again, the format was unfamiliar (very different to medical school OSCEs or PACES; possibly some similarities with the primary FRCA). There is a heavy emphasis on data interpretation (e.g. ABGs, CSF results) although there are also communication, simulation and equipment stations. ECGs are a common stumbling block, and it is also important

to be familiar with basic X-ray, CT, ultrasound and echocardiography images. I found it very tight for time, so make sure your answers go straight to the point so you can progress quickly through the mark-scheme.

Many of the SOE resources served me well with OSCE preparation too. However, some of the more OSCE-specific resources I used were:

- Books: Nichani & McGrath – OSCEs for the Final FFICM; Jeyanathan et al - Objective Structured Clinical Examination in Intensive Care Medicine
- Life in the Fast Lane website (particularly ECG library)
- Intensive Care Network, Crit-IQ and Radiopaedia websites (radiology libraries)
- Intensive Blog (data interpretation)

FINAL TIPS

- Start preparation early and don't leave things to chance.
- Know the curriculum, exam format and marking system.
- Use print and online resources.
- Do lots of practice questions, supported by plenty of background reading.
- Go to a course.
- Test yourself (and others) and set yourself high standards.

If you do all of this then you have every chance of sailing through the exam!

FFICM EXAM DATES

The next sitting of the FFICM Final OSCE/SOE is currently due to take place the week commencing **19 October 2020**. Applications for this examination open on **20 July 2020** and close on **27 August 2020**. **PLEASE NOTE: DUE TO THE COVID-19 PANDEMIC, THESE DATES MAY BE SUBJECT TO CHANGE.** Dates for the next MCQ sitting will be announced in due course. We apologise for any inconvenience caused.

Details about the FFICM exam, including regulations and fees can be found [here](#)

Coronavirus COVID-19: specified countries and areas - Updated guidelines on attendance at FFICM examinations

In accordance with national guidelines on COVID-19 and advice from the Academy of Medical Royal Colleges, the Faculty has updated its guidance on attending FFICM examinations. If you are a candidate who is a returning traveller or a visitor arriving in the UK in the 14 days leading up to your examination from a COVID-19 specified country or area from the Public Health England list of affected countries, categories 1 and 2, including transit through these areas, you will not be able to sit an FICM examination. This applies to all FFICM examinations. Please see the following link for the list of countries/areas specified: <https://www.gov.uk/government/publications/covid-19-specified-countries-and-areas>

Candidates who have travelled from or through the list of affected locations in the 14 days leading up to their exam date, must contact the College at exams@rcoa.ac.uk to withdraw from their examination. Candidates travelling from these locations will be refunded their examination fee in full. Travel expenses cannot be refunded. All candidates attending an examination, must declare on arrival at the examination centre that in the past 14 days they:

- have not travelled to the countries/areas listed
- have not knowingly been exposed to those with the virus
- do not currently have and have not displayed symptoms of coronavirus
- have not treated affected or suspect patients.

Those candidates who cannot confirm all the points above, will not be allowed to sit the examination and will be refunded their examination fee. For further guidance, please contact the Examinations Department at exams@rcoa.ac.uk.

VERY RAPID UPDATES AND SAFETY (VIRUS)

The rapid learning and the huge volume of changes in practice that are needed to cope with the critical care of COVID-19 patients is meaning that many staff are having to adapt to continuous change. Inevitably issues and problems will arise. Our aim is to circulate lessons learned as quickly as possible to help care for patients and staff. Our COVID safety bulletins can be found [here](#).

TRAINEE EYE INTERVIEW: The Special Skills Year



Earlier this year, the Faculty's lead Trainee Rep Dr Richard Benson interviewed Dr Gilly Fleming, who has recently completed her Special Skills Year in Education.

Please introduce us to Dr Gilly Fleming

I'm Gilly Fleming, a single ICM CCT trainee working in South East Scotland. I was born and bred in Edinburgh and have worked there throughout my training and I have yet to find a reason to want to leave! I live with my radiology-trainee husband Derek, and our cat Ralph in beautiful countryside at the foot of the Pentland hills. Outside of my working life I'm a diehard American football fan, although I'm sad to report that my team, the Jacksonville Jaguars, have been going through a considerable rough patch of late.

What led you to a career in ICM?

I was curious about ICM as a medical student, and always wondered what happened to patients after they had been whisked away to critical care by the intensivists. I completed a foundation post in Intensive Care Medicine, and it was that experience which absolutely cemented my career aspirations. The things that I found I enjoyed then, still persist as the things I love most about ICM.

The things I love most about Intensive Care Medicine are being part of a large, diverse, multi-disciplinary team that works collaboratively to care for the whole patient, rather than a single organ. I enjoy the variety and pace of the job, but also find that the more intensive moments of the job are balanced well by continuity of care and attention to detail.

Often the most rewarding part of my job as an Intensive Care Medicine doctor comes from caring for patients and their families during challenging circumstances, using sensitive communication and compassion to guide them through what is often the most difficult experience of their lives.

Can you tell us what your SSY was in?

Throughout my undergraduate and postgraduate career, I have been fortunate to have received some really impactful learning experiences from some very inspiring educators that I am sure have positively affected the quality and safety of care I deliver to patients. As such, I made a conscious decision a couple of years ago to arm myself with the skillset necessary to deliver similar experiences for other healthcare professionals. Since this time, I have been involved in a variety of undergraduate and post-graduate education, and so it was a natural progression for me to undertake a special skills year in education.

I can imagine that it seemed daunting to arrange, how was the process of getting the year sorted?

It was actually very easy! Owing completely to an extremely supportive Training Programme Director and an enthusiastic Director of Medical Education in the region I work.

After identifying my educational needs, we approached the DME for their support, and I was able to join an established pool of Clinical Teaching Fellows, from a variety of clinical backgrounds, who were working as part of the Medical Education Directorate (MED) in NHS Lothian. As there was already an established support system for these clinical teaching fellows within the Medical Education Directorate, we were able to use the expertise of MED to ensure my development throughout the course of the year.

I continued to work a full out of hours commitment throughout my SSY, so it worked out that I spent about 24 hours a week developing and delivering education and 24 hours a week working clinically. During that time, I also continued working towards my Master's degree in Medical Education in my own time.

The SSY has seemed to enable you to design some exciting new teaching, could you tell us how this came about?

Through the SSY, I have had the opportunity to deliver and develop a variety of learning experiences for both undergraduates and postgraduates. A few highlights of my SSY are listed below:

- Undergraduates currently rotate through our critical care unit for one week. Working in collaboration with the module lead, we made a number of changes to the module, including new learning objectives mapped to the FICM/ RCoA Framework for Undergraduates, developing new online learning resources, videos and interactive quizzes and new innovative mixed-methods and major incident table-top simulations. We also addressed an important pastoral need of students through introduction of a weekly reflective practice group, to discuss challenging and distressing cases. Recently, following the changes made, I am very proud to say that the undergraduate module was awarded recognition of excellence by the national quality review board.
- I led the team of clinical teaching fellows in the delivery of immersive simulation sessions to all foundation doctors (around 200 in total) in NHS Lothian, in sessions emphasising A-E assessment of unwell patients, management of clinical uncertainty, escalation to seniors and communication with patients and relatives.
- I, alongside another trainee with an interest in medical education, also set up the TRAINED (Trainee Anaesthetists and Intensivists in Education) group, which brings together like-minded trainees with an interest in medical education. Our undergraduate #getTRAINED evenings, incorporating simulation, dynamic decision-making games, small group teaching on pain and fluids and a wellbeing station, have been attended by over 250 undergraduates in the last year. In addition, over 40 faculty have received personalised feedback, ensuring their development as educators, whilst satisfying both GMC Good Medical Educator domains and requirements for training portfolios. You can follow TRAINED on Twitter at @_getTRAINED to keep up with our next steps.
- In January of 2019, in collaboration with the Scottish Intensive Care Society (SICS), TRAINED ran an inaugural 'Inspiring Future Generations' day, which was designed to give undergraduates and foundation doctors a taster of what a career in ICM involves. The event was oversubscribed and attended by students from all Scottish universities and foundation deaneries, and received really fantastic feedback.

- I've worked closely with the team at the University of Edinburgh to develop and deliver some materials for the online MSc degree in Critical Care. It has been great to engage with these students, who are healthcare professionals delivering critical care all over the world, sometimes in challenging circumstances, and to learn from their experiences.

Do you have any recommendations for trainees looking at the SSY?

Here are my top 3 tips for the SSY (whatever your chosen area):

1. Use the year to develop your unique selling point – not many trainees have completed an SSY, and ICM training is relatively unique in offering single CCT trainees this development opportunity as part of their training. Use the time to mould yourself, make yourself appointable, and to gain a unique skillset that will benefit the place you would like to work in the longer term.
2. Learn how to say “No!” – I really struggled with this at first but had no choice but to learn to do it. You are only one person, and you can't do it all. It's better to do a few things well than twenty things badly.
3. Embrace the challenges – learn to do the things that are really useful skills as a consultant, but that are somewhat neglected during training. Initially you will have no idea how to do these things but embrace the challenge of learning how to write emails/minutes, chair meetings, influence people, and manage differing opinions and conflict.

What's next (future plans)?

I'm looking forward to spending the last portion of my training watching and learning from my consultant colleagues and other members of the MDT. Hopefully then someone will employ me – after which I am sure I will continue to be involved in the education of undergraduates and postgraduates. I also hope to be involved in the educational and pastoral support of trainees by becoming an educational supervisor.

CURRICULUM UPDATE

Dr Alison Pittard
FICM Dean

The curriculum has been submitted! This has been a mammoth project and the final submission went into many hundreds of pages. I hope you'll forgive me for a few lines of thank yous now, but I think they are well deserved. Thank you to Dr Tom Gallacher, Ms Natalie Bell and the whole Curriculum Working Party for the heavy lifting. Thank you to the Training, Assessment & Quality Committee and the ICM Regional Advisors for working through the Working Party's principles throughout. Finally, thank you to everyone who contributed to the various online consultations, focus groups and other activities during the project designed to ensure there were multiple opportunities for input. There will be challenges ahead introducing the new curriculum, but with a reworked assessment system and reduced assessment burden, I think this curriculum will be a boon for trainees going forward. And that is important as we had over 400 applicants for this year's national recruitment, which is a record for us. I'm so happy to hear how many people want to #DiscoverICM!

A Perspective from ACCP Trainees: The Good, the Bad and the Ugly

Emma Hannan & Kerry Spinks

Trainee ACCPs, Lancashire Teaching Hospitals

Advanced practice has developed immensely over the past 40 years and with the difficulties in medical staffing that resulted from the introduction of the working time directive (WTD), Advanced Critical Care Practitioners (ACCPs) were intended to address this issue. Developing advanced clinical assessment of the critically ill patient, endotracheal intubation and insertion of invasive lines it was thought this would complement the workforce and improve continuity of care. In 2015, the Faculty of Intensive Care Medicine developed a curriculum for training ACCPs, aligning this to the National Education and Competence Framework for ACCPs (Department of Health, March 2008) and the Advanced Practice Toolkit for Scotland (Scottish Government, June 2008) which has culminated in the publication of the National Competency Framework for Advanced Critical Care Practitioners. Our local hospital set out on its journey in 2017, finally investing in training two trainee Advanced Critical Care Practitioners, facilitating MSc level study, and adopting the framework in our hospital to develop a team fit for purpose.



Many comments were shared at the beginning of our journeys, “you’ll struggle”, “you should quit whilst your ahead” and to some extent they were right. We did struggle, both physically and emotionally, the pressure and sheer volume of work was a far cry from the good old days of nursing school. Working full-time, learning every single day, attending university two days a week, cramming our brains with newfound knowledge, whilst keeping a family going was truly exhausting. Stressors such as imposter syndrome only heightened those initial difficulties. The university workload was vast, with portfolios, clinical assessments, exams on top of the FICM portfolio expectations, however with effective organisation and prioritisation these were easily mastered, with support from each other.

Being the first two trainees, in a hospital we had never worked in before, was a challenge. A major

crisis of identity took over, who were we and where did we fit in? Being nurses we always felt drawn to the nursing hierarchy, be that through comfort or maybe a desire to maintain nursing credibility with our nursing peers. With no role model to guide us in a role that was not fully understood, we had to wind our way through the logistics, politics and differing views of many, to establish our purpose. Nothing was set in stone. How on earth could we integrate successfully, if those around us could not agree on what our role should and should not be? Over time, we quickly identified that we would be the ones that would carve the path, creating a role specific to the needs of the unit.

Within those two years’ training, we felt as if we had been hit by a concrete wall, learning clinical and technical skills alongside developing our own complex

clinical decision-making and accountability was quite difficult. Working with a regular turnover of junior medical staff required good communication skills, developing new working relationships, whilst also trying to define who we were and why we deserved to be in the roles we were in. With the increase in ACCP roles throughout the region, this need for clarity and proving our worth dissipated, with the majority of specialist trainees having already worked alongside an ACCP, fully accepting and celebrating our place within critical care units as a positive venture.

It had been suggested that the ACCP role had the potential to cause conflict with junior medical staff who are competing for skills practice and training opportunities. With the increasing numbers of trainee ACCPs and junior doctors on our unit, exposure to skills and maintenance of skills can be problematic. The publication from the British Medical Association in January 2020 disclosed some junior doctors' frustrations working alongside medical associate professionals due to a lack of training opportunities. In our experience, good working relationships and supportive colleagues allows for fair distribution that has not only strengthened working relationships, but provides opportunity for teaching and embedding good standards. In reality, within our unit the junior medical staff feel that the presence of ACCPs have provided them with advice, skills and support for their learning. This includes mentoring of clinical skills such as line insertions, the use of ultrasound and general intensive care skills and knowledge.

One of the most important and most influential attributes to ensure successful integration of ACCPs, we felt, was consultant and nursing body acceptance. Having both been successful external applicants, we had a lot of groundwork to cover in both areas. Personal resilience was key in breaking down these barriers, the more we worked with nursing staff gaining their trust and respect as ACCPs, came their acceptance and respect.

Our current workload includes the expected clinical assessment, diagnosis, management etc, however the list of clinical skills is steadily growing with additional skills like FUSIC, with the aim to complete the majority of modules. As a team, we collectively embarked on an improvement project relating to attaining quality data collection for ICNARC. This ensured, as a unit,

that we are able to have confidence in our data, providing a platform for effective and accurate quality improvement projects for patient management, care and safety.

Looking forward, we are growing with four trainees and the first two qualified ACCPs with ongoing workforce planning for a separate tier of 10 to cover an expanded unit of thirty four beds. We are hoping to expand our skill set and develop further in-house services to alleviate workload from specialists and improve access for our patients including and not limited to, transcranial dopplers and removal of intracranial pressure bolts.

The advantage of having ACCPs is that it provides the nursing staff with a vision of career progression, gone are the days of having to choose between education or management. With the introduction of this role, nursing staff now have the opportunity to further develop their vast knowledge and experience to become clinical experts, maintaining clinical contact with patients and still progress up the career ladder. ACCPs are able to act as that link between nursing and medical staff whilst being able to make clinical decisions effectively improving clinical patient care.

Moving to the future, there have long been issues regarding regulation, however ACCPs currently remain registered professionals under their original regulator, as opposed to other medical associate professionals. Although practitioners are covered through trusts' vicarious liability policies, many ACCPs are seeking independent indemnity insurance to ensure legal protection in this very grey cross boundary working environment.

In the last three years, we feel we have developed and integrated the ACCP role successfully within our unit, albeit this still remains in its early days with more opportunities for acquiring further clinical skills, service development and participation in critical care research. We believe the future is bright with ACCPs being recognised nationally for their positive contribution to critical care.

ENHANCED CARE: Guidance on service development in a hospital setting

The Faculty, in collaboration with the Royal Colleges of Physicians of the UK, has released guidance for the development of Enhanced Care in the acute hospital setting. The guidance outlines a framework to consider when creating a service for patients whose care needs fall into the gap between what can be provided on a normal ward and in critical care. The benefits of Enhanced Care are far reaching but most importantly, it will bridge the current gap to ensure that patients receive the right care, in the right place, at the right time and by the right people.

Implementation of Enhanced Care services also has the potential to improve patient flow, support operative scheduling and release capacity within critical care, which is absolutely vital in the current landscape.

You can find more information, including the full guidance and additional resources, [here](#).

#DiscoverICM –
GET INVOLVED

Those of you who are active on Twitter may have seen the #DiscoverICM campaign that first ran in the lead up to the 2019 recruitment round. The campaign was very well received and we have made these Twitter releases a regular feature to inspire and capture the interest of the Intensivists of the future.

We would love as many Intensivists as possible to be involved, if this sounds like something you would be interested in why not follow Richard's lead and tell us what you love most about working in ICM. Drop me an email at shall@ficm.ac.uk and I will send you the details.

#discoverICM
www.ficm.ac.uk/careers

"ICM combines diagnostic uncertainty and the intellectual challenge this brings with the ability to utilise practical skills, novel and exciting equipment and various medications to make a real difference. Best of all I get to do this as part of a team who strive to make a difference."

Downtime is important and days off during the week are fantastic at allowing me that important time with family. For me ICM gives that perfect work life balance."

Dr Richard Benson
FICM Deputy Trainee Rep

FICM LEARNING

Home Exam Resources e-ICM Blog Podcast Case of the Month Events

Tag: Blog

Who still believes in Santa and science?

Matt Morgan

June 2, 2020
Academy, FICM Activities,
Work & Careers
Blog



As I look through my office window at yellowing patches of summer grass, it may seem strange to talk about Christmas. But these are strange times. I remember being told that there are three stages of life – first you believe in Santa, then you



CATEGORIES

Select Category

Search...

FICMLearning.org has been running since February supplying brand new FOAMed content every week! It's been fantastic to see the range of resources created and the variety of topics covered. To name a few:

Podcasts: Difficult decision making in the ICU, Simulation and Resilience

Blogs: 5 Things I wish I'd know before COVID-19 series, Why district general ICM was the right choice for me, and Who still believes in Santa and science?

Case of the Month: Toxicology & Pharmacology, Neuro, and Respiratory

We're always updating so please make sure you check out FICMLearning.org every Thursday for new content each week! If you're interested in contributing to FICMLearning please do get in touch contact@ficm.ac.uk

CRITICAL WORKS

Our annual members' update is now live on our website. It will give you a brief overview of all the projects we have undertaken over the past year and all that we are currently planning to do for the year ahead. Do please read, partly so you have a fuller understanding of all we are hoping to do for the specialty under our 10 strategic objectives, but also so you can consider where you see gaps. What should we be doing that we are not already?

CRITICAL CARE QI RESOURCE - ADVERT

The Professional Affairs and Safety Committee is planning to provide an online QI resource for all clinicians and the wider multidisciplinary team within critical care. This will include an online library of suggested QI topics relating to day-to-day practice within critical care units. We are seeking contributors and e-group members to build the QI library. For more information about becoming a contributor or e-group member please contact us at dillbrook-evans@fcm.ac.uk

WELLBEING SURVEY

We would like to invite you to participate in a study on the Wellbeing of Healthcare and Hospital Workers During and After the Covid-19 Pandemic. This is a study to explore the experience and impact of COVID-19 on the wellbeing of healthcare and hospital staff working in hospitals during and after the pandemic. More information can be found [here](#).

BRIDGING GUIDANCE FOR CRITICAL CARE DURING RESTORATION OF NHS SERVICES

You may also want to review the bridging guidance for critical care we recently produced regarding the restoration of NHS services that includes key sections on doctors in training. More information can be found [here](#).

TOTUM PLUS: New Trainee Benefit

TOTUM PRO is the only discount card available for professional learners to purchase giving discounts from a wide range of high street and online retailers. Discounts range from travel and eating out, to health, technology and fashion. Professionals using the card are able to benefit from a whole host of exclusive discounts. To apply for this please e-mail: membership@rcoa.ac.uk



FICM OOPT/R Form

The Faculty have now produced a template form for both single and dual trainees wishing to count their OOPT/R experience towards their training for a CCT/CESR (CP) in ICM or a dual programme with ICM. Please use this new form. [It can be found here](#).

CRITICAL EYE

The latest, Critical Eye is now available on the FICM website. This issue can be found [here](#). If you would like to contribute to future issues (the next one is out in September 2020) please get in touch at contact@fcm.ac.uk

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