RESIDENT EYE

THE MAGAZINE FOR INTENSIVISTS IN TRAINING

ISSUE 22 | SUMMER 2025

What's it like going Out of Programme?

The Faculty of Intensive Care Medicine

In this issue

FUTURE INTENSIVISTS

FICM Intensivists in Training Conference

Monday 10 November 2025

Queen Elizabeth Hospital, Birmingham

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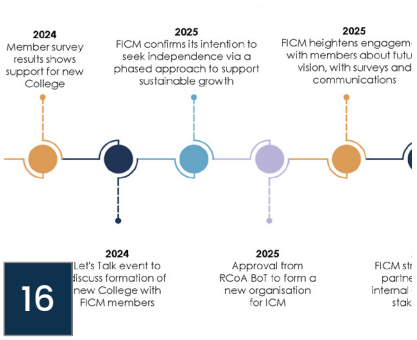

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Your Lead Intensivist In Training Representative

Dr Rosemary Worrall
Lead Intensivist in Training Representative

What an exciting 2025 the FICM Intensivists in Training (IiT) Subcommittee has had already! January involved final analysis and write up of the 2024 *Training Quality Report*, which has now been published. February was the first IiT conference planning meeting, where we confirmed that the date will be Monday 10 November 2025, and that it will be held in Birmingham (save the date!).

In March, we worked alongside the Academy of Medical Royal Colleges Resident Doctor Group and the Intensive Care Society, as well as meeting with the Director of Education and Training for NHSE regarding the MRCP exam results issue. April has seen the announcement that in 2026 FICM will become CICM (College of Intensive Care Medicine), the release of the latest Training Digest and the publication of the *Guidance on Rotational Training in ICM*. Finally, next month heralds the launch of the Training Capacity Assessment, which was a product of feedback from the Regional Representative network, and will encourage local departments to formally assess the training needs of their medical staff and whether they are meeting them with the learning opportunities available.

2024 IiT Survey

We have recently published the 2025 *Training Quality Report* which includes the IiT survey and Regional Advisors (RA) survey responses. Whilst the full text is extremely detailed and includes response rates, pooled themes and action plans, a broad overview of the IiT data is as follows:

1. Over half of our resident doctors are single specialty intensivists, dual CCT with emergency medicine or triple CCT with medical specialties.
2. Over a quarter of our resident doctors are now less than full time, with a variety of reasons cited, including better work-life balance, caring responsibilities or to pursue a specific non-clinical experience (research, fellowships, exams, non-medical interests).
3. Most IiTs have access to teaching, exam preparation and educational development time, but in some regions and specialties this is less embedded than others. For example, 62% reported access to EDT in Internal Medicine placements compared to 88% in emergency medicine placements.
4. Disappointingly 33% reported experiencing bullying, undermining or discriminatory behaviours due to either their training background or personal characteristics.

> There are examples of excellent ICM training all over the country that I am keen to share and encourage other regions to consider trialling.

5. Stage 1 placements were largely reported as positive and supportive, but this was overshadowed by a few comments around airway competences and the medical year.
6. Resident doctors enjoy the subspecialty exposure in Stage 2, but the short placements in addition to exam pressures were recognised as ongoing challenges.
7. Most Stage 3 IiTs felt that they were able to maintain their prior skills appropriately and were being given leadership/management opportunities, but there is still significant anxiety around the end of training and how to approach consultant job applications.

The overall response rate to the 2024 IiT survey was 33%, with all areas of the country represented but with a regional response rate ranging from 26% to 60%. The raw data from these exercises is reviewed by both IiT representatives (Lead and Deputy) as well as Chair of the Training, Assessment and Quality Committee, and in addition to the national report, anonymised data is sent out to each of the Regional Advisors from which we create both regional and national action plans. Responses to both this and previous surveys have fed into GPICS V3 updates, guidance on airway competences, wording changes to the curriculum, best practice statements as well as the soon to be launched Training Capacity Assessment. We have ongoing projects looking at further guidance on EDT, the Stage 1 medical year, how to evidence 'airway competence' and how we support Stage 3 IiTs with the hidden curriculum.

Planning for 2025

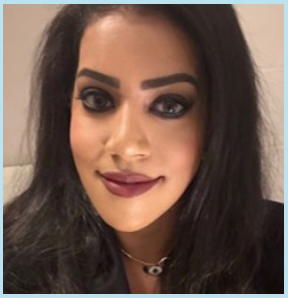
We are currently planning the questions for the 2025 Training Survey. We are looking at exploring in more detail some of the themes raised by regional representatives including the ongoing concerns around bullying and undermining behaviour, differential attainment in training progression and exams, burnout risk and wellbeing support.

Sharing good practice

There are examples of excellent ICM training all over the country that I am keen to share and encourage other regions to consider trialling. Some of these have been detailed in the recent *Guidance for Rotational Training in ICM*, e.g. experience with paediatric regional transfer services during Stage 2 or non-resident on-call rota patterns for Stage 3 IiTs, and others will be shared via best practice statements and *Resident Eye* articles.

Whilst I appreciate it can seem like things don't change quickly, we are listening and change is coming, so please do continue to tell us what is going well as well as what still has room for improvement. If you have a project or an example of regional excellence you would like to share please do email me via rosemary.worrall@nhs.net.

Your Deputy Intensivist In Training Representative



Dr Taqua Dahab
Deputy IiT Representative

I would like to express my heartfelt thanks for the vote of confidence you have placed in me. I am honoured and humbled to be elected as your Deputy Lead Representative on the Board.

I aim to represent your diverse interests and work on issues that resident doctors continue to encounter, particularly regarding exam difficulties, differential attainment (DA), career planning, and advocating for improvements in our training quality, aligning it with current advancements in technology.

Rosie and I face the challenging task of filling the void left by Waqas. What a legacy he has left us! We wish Waqas the very best as he transitions to joining the substantive consultant workforce.

Recruitment

The striking increase in the competition ratio for HST applications has affected all specialties, and Intensive Care Medicine (ICM) is no exception, even though it is among the least impacted specialties. This year, we experienced a 25% increase in ICM applicants. The FICM and ICMNRO have worked diligently to match this demand by increasing the number of interview slots by 25%. My sincere thanks go to all the senior IiTs who assisted the ICM consultants during the interview process that took place in the last week of March 2025. The training bottleneck remains a critical issue, and we are engaging with the Academy's Resident Doctors Committee (ARDC) and national postgraduate training reviews to support our future colleagues.

MRCP Results Error

We were disappointed to hear about the MRCP September 2023 results error reported in February 2025. This serves as an opportunity for us to reflect on our processes and ensure these incidents are recognised as 'never events.'

We are relieved to confirm that no current IiT in the ICM training programme is affected. Resident doctors who may be impacted outside of formal training programmes are strongly encouraged to contact us at FICM for support.

> The FFICM exam presents challenges for many of us, and we anticipate changes in the coming years. I am committed to updating exam resources and identifying gaps to bridge.

Exams

The FFICM exam presents challenges for many of us, and we anticipate changes in the coming years. I am committed to updating exam resources and identifying gaps to bridge. Linguistic exams can be affected by Differential Attainment (DA). I have had meaningful discussions with IiTs, including IMGs, about this matter. Consequently, we are exploring ways to establish national practice clubs early in training, sharing good practices from different regions, and preparing recommendations and guidance on how and when to approach exams from the examiners' perspective.

If you have any suggestions on how we can further ease the exam process, please feel free to reach out.

Finishing School

The Finishing School project aims to provide ongoing support for senior IiTs nearing the end of their training, facilitating their transition to consultancy.

We plan to host several webinars starting this summer covering pertinent topics for the first year in consultancy, alongside the FICM-endorsed Consultant in Transition course taking place in Cardiff in mid-May 2025.

There are updated Job Planning guidance and resources on the FICM website, including example job plans for working in single specialty ICM, plus ICM with a range of other partner specialties including anaesthesia, emergency medicine, acute internal medicine and respiratory medicine.

Independence

Rosie and I have had several meetings with the strategic lead for FICM independence to ensure that our future College maintains robust IiT representation and hears your voices. Mr Stephen Williams will provide updates on why FICM is transitioning to a College and how this will impact its members. We will continue this conversation throughout the year, and if you have any further views you would like to share, please let us know.

Save the date!

The second Intensivist in Training Conference will be held on 10 November 2025 in Birmingham.

We are in the process of organising a diverse programme and top-class speakers for the conference. The topics will range from disaster management to High Consequences Infectious Diseases, and from Medical Assistance in Dying to its implications for intensivists, alongside many other pressing topics and 'hands-on' workshops for developing critical skills. Keep your abstracts ready for submission, as there will be prizes on offer!

IiT Subcommittee Updates

The IiT Subcommittee currently consists of 10 core members representing each stream of training, LTFT IiTs, Academic IiTs, International Medical Graduates as well as an Diversity, Equity & Inclusion representative and a Lifelong Learning Platform representative. In addition, we have five co-opted members representing the intensive care societies of each of the devolved nations, and military IiTs.

Representatives

The national representatives are appointed for a maximum of two years, via a national resident doctor election, which occurs towards the end of the year (declarations of interest for this year will be October 2025 with the election itself 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 Medical Royal Colleges, and collating articles for *Resident Eye*.

The core IiT Subcommittee 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 or Exams Subcommittee). The maximum term is two years, and posts are advertised throughout the year as representatives demit — keep your eyes peeled for opportunities later in autumn 2025 when we will be advertising for a new dual ICM/Emergency Medicine Representative.

Since the last *Resident Eye* we have been busy behind the scenes with continued regular committee meetings to discuss and progress issues raised by IiTs. A recurring issue highlighted by IiTs during their Stage 1 anaesthetics year has been the inability to add RCoA-registered trainers to the ICM/FICM side of the LLP; this has now been rectified and going forward new trainers will be registered to both portfolios thanks to the help of those working on the LLP.

As a committee we are working on updating the FICM best practice statements, including incorporating feedback from the most recent IiT survey. I am committed to highlighting the ongoing need for equitable and fair training for IiTs from all specialty backgrounds. In this edition of the *Resident Eye* you can read more about a successful trainee led workshop we held to address a national training gap using trainee led initiatives.

With regards to the MRCP exam results error, we have released a statement of support to those affected as the IiT Subcommittee. If you are a resident planning on applying to ICM and have been affected by this then please do reach out and I can point you in the direction of further support if required. As always, please do continue to get in contact via giada.azzopardi@nhs.net if you have any ideas, queries or issues relating to dual/triple training.

Dr Giada Azzopardi

Triple Medicine / ICM IiT Representative

There have been a few things affecting single specialty trainees of note recently, however, the most exciting news has been the confirmation that FICM will become the College of Intensive Care Medicine in July 2026. This gives those of us training purely in intensive care the confidence that we have a dedicated college supporting and promoting our specialty with full autonomy.

It is also great to see the focus TAQ have placed on the development of dedicated logbook forms for the recognition of airway skills for those entering the ICM training programme having not completed any previous training in anaesthesia. I hope that this will make the situation more straightforward for trainees who have come across issues recently!

Dr Alex Maidwell-Smith

Single ICM IiT Representative

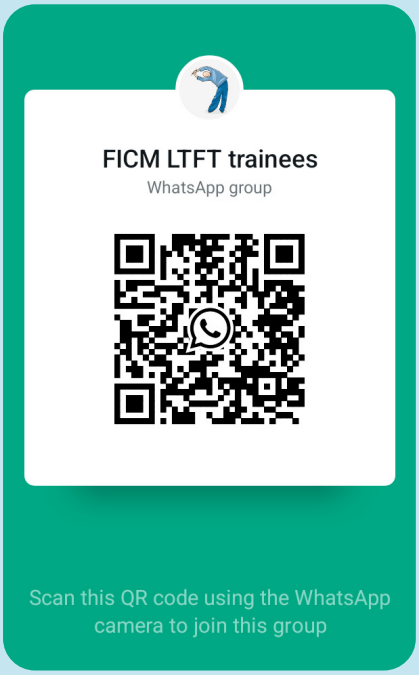
Dr Gemma Talling

Less Than Full Time (LTFT) Representative

I am a dual ICM and Anaesthesia trainee based in the West Midlands. I am representing the Less Than Full Time (LTFT) Intensivists in Training on the IiT Subcommittee. My aims are to promote LTFT working for current or prospective ICM LTFT residents and to assist residents in gaining clarification upon LTFT training issues. I also aim to assist trainees to maximise educational opportunities and improve training for current trainees.

This a new role and the first year FICM have had a LTFT representative on the IiT Subcommittee. I hope to be able to advocate for all individuals in the LTFT group so please do get in contact via the WhatsApp group or email if you have any ideas, queries or issues relating to LTFT training.

I have also been co-opted to the FICM Professional Affairs and Safety Committee where I will act as the Trainee Representative for Quality Improvement. Watch this space as we hope to highlight some of the wonderful QI work being undertaken by IiTs across the country.



Dr Chris Jacobs
LLP Representative

Work has been ongoing behind the scenes to improve the stability and productivity of the LLP including identifying areas for further development and improvements over the next few years. We have been working on improving the resources available to help IiTs and trainers make best use of LLP and there are numerous resources on the FICM website. We have also run some webinars with the RCoA, which may be particularly useful for new IiTs as we approach ARCP season.

As ever, the LLP team are open to feedback and suggestions for improvement. Often the best ideas come from IiTs navigating different portfolios so if you have any feedback, please do get in touch.

Dr Luke Flower
Academic Representative

We have been working hard to put together what we hope will be a fascinating programme for the 2025 FICM IiT Conference. In addition to the main programme, we have a schedule of interactive workshops, including one focused on ICM research, designed to give academic residents a chance to network and discuss their work.

The TRIC Network study on antimicrobial resistance, TRIC-MAN, has now concluded, involving 162 critical care units and over 2,500 patients across the UK — a huge thank you to everyone who contributed. The next TRIC Network national competition is already underway, with the winner to be announced at SOA25. Behind the scenes, we are continuing efforts to bring greater unity to the ICM academic community, so watch this space for more opportunities to get involved and help shape the future of our field. As always, I am here for any questions you might have, and if I do not know the answer, I will do my best to point you in the right direction!

For those dual training in both anaesthesia and Intensive Care Medicine. The juggling of two portfolios, added competencies, separate recruitment pathways, and the shaping of a career at the end of training are all known challenges. We are pleased to now have a recruitment pathway that now allows successful candidates to accept both anaesthesia and ICM NTNs without re-applyingin a subsequent year.

We understand the (sometimes significant) variation in experience of the medicine year for Stage 1 training. With the aim of optimising and narrowing this, we are working on a Best Practice Statement describing what we believe to be the optimum way this can be delivered to prioritise the training experience. We are also working on guidance for Keeping in Touch (KIT) days to ensure IiTs get sufficient days anaesthetising in theatre while on ICM rotations to ensure the maintenance of a balance of skillsets right up until CCT.

Dr Stuart Edwardson
Dual Anaesthesia/ICM Representative

Mayur Murali

DEI Representative

As FICM transitions to becoming a college, we are forming a new DEI Subcommittee to promote equity, diversity, and inclusion across the Faculty. This group will aim to guide FICM strategy, identifying barriers to equity and inclusion and developing targeted initiatives.

Differential attainment in exams and ARCPs among residents remains a concern. Despite efforts, we've been unable to access retrospective exam data to demonstrate the scale of the problem. We're also working to improve FFICM exam support, including an Exam Glossary and a document featuring reflections from examiner guidance interviews, identifying key themes for successful performance.

Dr Fraser Waterson

Dual EM/ICM Representative

Having just been appointed as a consultant in emergency medicine and critical care, my time as your EM/ICM IiT Representative is drawing to a close. But before I prepare to hand over the reins, I wanted to share a few exciting updates and reflections from the past few months.

First up: we're thrilled to have hosted our inaugural EM/ICM Careers Day on Tuesday 30 April at RCEM's Octavia House in London. The event was a sell out and is all about celebrating the breadth and potential of dual training; with sessions on onboarding, exam preparation, consultant career pathways, sustainable working, and academic opportunities. We were delighted to welcome Dr Danny Bryden, Dean of the Faculty, and Dr Ian Higginson, RCEM President Elect, as keynote speakers. It was an inspiring and energising day for all, whether early in their dual training journey or nearing the end.

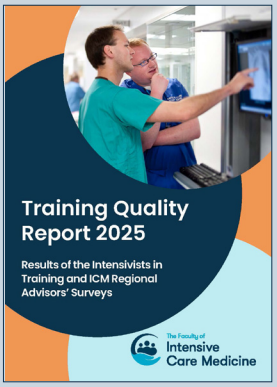
Alongside this, work continues on the creation of a best practice guide for dual training with emergency medicine. This document brings together examples of excellence from across the UK, shaped by input from IiTs, trainers, College Tutors, and Regional Advisors. Its aim is to offer practical, supportive advice to enhance the dual training experience — for both IiTs and trainers alike.

I'm also excited to announce the recently formed Intensive Care & Emergency Trainees Group (ICE-T), will be meeting in May. This group is designed to strengthen the link between the FICM IiT Subcommittee and EMTA, ensuring that our voice is heard within both FICM and RCEM. It's a brilliant opportunity to better share concerns, shape solutions, and build a stronger community across both specialties — so please keep an eye out for invites via the national WhatsApp group, agenda to follow soon!

Finally, I just want to say how much I've genuinely loved serving as your FICM EM/ICM Intensivist in Training Representative. It's been a privilege to work with such passionate, forward-thinking colleagues, and to play a small part in supporting dual IiTs across the UK. The role will be opening for applications soon, and I'd wholeheartedly encourage anyone interested to apply. If you've got questions or want to know more about what the role involves, I'm always happy to chat.

Thanks for all your support and engagement — here's to the next chapter!

FICM Training Quality Report Key Messages 2025



Positives!

- The ICM training programme continues to evolve with increasing representation of IiTs from diverse backgrounds, though this is not yet reflected in the current ICM consultant workforce.
- IiTs and trainers are highly engaged in training.
- IiTs appreciate and feel supported by their Trainers.
- The majority of IiTs are receiving programme inductions, regional teaching and some degree of EDT. There are improving reports of access to rest facilities, hot food and car parking arrangements.
- Support for the Faculty to progress toward becoming an independent College.

Training Challenges

- Stage 2 training continues to be challenging, with pressure of examinations, multiple placements and LLP requirements especially for those balancing dual and triple CCT commitments.
- Increasing numbers of IiTs are training Less Than Full Time
- Unacceptable episodes of bullying, discrimination and undermining are reported in both surveys
- Trainers reported ongoing struggles to be recognised at a management level for their roles. Greater institutional recognition for educational roles is necessary.

Job Planning

- Most IiTs plan to take up ICM consultant posts on achieving CCT, though remain concerned regarding job availability, particularly for Single CCT IiTs and those undertaking the dual/triple ICM CCTs with a medical specialty.
- A minority of regions reported difficulties appointing dual-trained IiTs in emergency medicine and medicine to consultant posts, due to traditional preferences and competition with anaesthesia/ ICM consultants.

OUT NOW!

[Click here for more detailed discussion and actions within the full report.]

MIDNIGHT LAWS

The Midnight Law series, from the Faculty's Legal & Ethical Policy Unit (LEPU), aims to cover thorny legal issues in a one-page summary that you can access whenever and wherever an issue may arise.

MIDNIGHT LAW

Managing adult patients who refuse life-saving treatment (England and Wales)

SITUATION

Managing patients who present to hospital with self-harm including overdose, who require life-saving medical treatment and who refuse treatment due to an underlying mental health condition.

SCOPE

This may cover patients with a formal diagnosis of personality disorder (ICD-10 code F60), but can also be used to guide the management of patients with PD traits and no formal diagnosis at time of intervention.

CONSIDERATIONS

1. Is there an immediate threat to life i.e. airway compromise, catastrophic bleeding, evidence of clinically significant overdose (as per Toxbase/ senior clinician opinion)? If yes, then treatment can be initiated alongside formal assessment of capacity.

2. Have you considered the patient's capacity to make decisions about the intervention required to meet the threat?

- Careful assessment of capacity applying the principles of the MCA 2005 will be required as in these situations presumption of capacity cannot be relied upon.
- Remember that a patient only has a right to make an unwise decision if they have capacity to do so.

3. If the patient lacks capacity, are you aware of an advance decision to refuse treatment?

- If a valid advance decision to refuse treatment (ADRT) exists which applies directly to the treatment in question, it must be followed.
- If medical treatment is withheld based on an ADRT, then it is paramount the requirements for validation of that ADRT are met in full, without doubt or contention.
- If in doubt, seek legal advice, and provide the necessary life-saving treatment in the interim.

4. Treatment can be provided under the MCA 2005 where you reasonably believe that the patient lacks capacity and the treatment is in their best interests.

- Remember to re-evaluate best interests as you get more information about the patient and their circumstances.

5. Will the patient need to be restrained to receive the treatment?

- It is possible to restrain someone to provide treatment where you reasonably believe that they lack capacity to consent to the restraint, it is in their best interests, and necessary and proportionate to the risk of harm they would be at otherwise: s.6 MCA 2005.
- Restraint lasting more than a short period is likely to give rise to deprivation of liberty, which will require authorisation either under the DoLS framework or by admission under the Mental Health Act 1983. Immediately necessary treatment should be provided whilst such authorisation is being sought.

6. Is detention under the Mental Health Act 1983 appropriate?

- Forced treatment under section 63 of the MHA can only be used for treatment of a mental health disorder.
- Careful consideration should be given before detaining a patient solely to rely upon section 63, but it may be appropriate where you properly consider that the patient has capacity to make decisions about medical treatment, but where their refusal is a manifestation of mental disorder.

7. What can be done clinically to de-escalate the situation?

- Continue to explore and alleviat potential factors which may be contributing to the patient's refu of treatment, e.g. fear, anxiety, environment, misinformation.

GUIDING PRINCIPLES

- Careful consideration of the patie capacity to make decisions abou necessary medical treatment is required, as the presumption of capacity cannot be relied upon i these situations.
- Life saving treatment can be prov using a 'best interests' approach i there is a reasonable belief the pa lacks capacity to make a relevant decision, unless there is a valid an applicable advance decision.
- If in doubt, seek legal advice, but provide life sustaining treatment in the interim under the least restric circumstances possible.

KNOW THE LAW

1. Mental Health Act 1983
2. Mental Capacity Act 2005

FURTHER READING

1. Re C (adult refusal of treatment) [1994] 1 All ER 819
2. P v an NHS Foundation Hospital [2 EWHC 1650 (Fam)
3. Kings College NHS Foundation Tru C and V (2015)

The Faculty of Intensive Care Medicine

Version 1.0/ Published Jun

V Godbole, A Ruck Keene, F Waterson on behalf of the Legal & Ethical Poli

This Quick Reference Guide is only intended as a helpful resource for n legal issues and does not constitute nor replace formal legal

MIDNIGHT LAW: Scotland

Approaching treatment plans for the person with a disability

SITUATION:

Clinical tools used to assess the benefits and outcomes of ICM treatment may not take specific account of the person with a disability. How can they be applied to treatment plans, in a way that is appropriate and consistent with the law?

CONSIDERATIONS:

Capacity and best interests

Although a patient with capacity may refuse treatment, they cannot demand that a doctor administers a treatment which the doctor considers is adverse to the patient's clinical needs. Where a patient is unable to consent to treatment, a doctor may lawfully give that patient treatment which is necessary in that patient's best interests.

Equalities Act 2010 and the European Convention on Human Rights (ECHR)

The definition of a disability is broad and treatment decisions will require consideration of **process** (e.g. communication support for the person) and **outcome** (what additional steps are needed to ensure, as far as possible, that the person with a disability can access critical care equitably?) Discrimination can arise not only where a person is treated differently because they have a disability, but also if policies that appear 'neutral' in fact affect disabled individuals as a group. A policy which may give rise to different outcomes for disabled people is only lawful if proportionate to the achievement of a legitimate aim.

What steps should I take?

- Ensure your decision making processes are consistent with the Equalities Act and the ECHR, to avoid discrimination.
- As with any patient with capacity, treatment decisions need, if possible, to be discussed with a patient with disability. Doctors must try to find out what matters to patients, so that they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action (GMC 2020 guidance on consent).
- Policies/guidance for clinical treatments that use screening tools validated for the non disabled patient population should carefully be scrutinised for unlawful discrimination against disabled individuals.
- Discrimination is more likely to arise where decisions are taken about access to treatments based on judgments about quality of life, as opposed to survivability.
- DNACPR decisions must involve an individual who has capacity, unless doing so would cause physical or psychological harm.

What particular steps should be taken if a patient lacks capacity?

- Treatment decisions must be of overall benefit for the patient and made in accordance with the requirements of Part 5, s47 of the Adults with Incapacity (Scotland) Act 2000.
- For DNACPR decisions relatives/relevant others must be informed without delay where practicable and appropriate. However, these individuals cannot insist upon or refuse treatment on behalf of the patient. CPR should only be offered if there is a clear expectation that its aim can be achieved.
- If the patient is a vulnerable adult, e.g. has mental illness, learning disabilities or dementia, the involvement of a medical practitioner appointed by the Mental Welfare Commission, may be required.
- Disabled persons at risk of losing mental capacity should be encouraged to develop advance care plans that make their wishes clear, to assist in future medical decisions. These plans must be informed, current, made without undue influence from others, and clearly apply to the current clinical circumstance. Although Advance Decisions for the Refusal of Treatment (ADRTs) do not hold formal statutory weight under the Adults with Incapacity Act, they are likely to be given at least some weight by the courts in Scotland.

GUIDING PRINCIPLES

- A person has a disability if there is mental or physical impairment (the cause of which does not need to be known) and the impairment has a substantial and long term effect on the person's ability to carry our normal day to day activities.
- Decision making is an ongoing process focused on "meaningful dialogue".
- Follow the 7 steps of the GMC guidance "Consent: patients and doctors making decisions together". Nov 2020

KNOW THE LAW

- Adults with Incapacity (Scotland) Act 2000
- Equalities Act 2010
- Human Rights Act 1998
- European Convention on Human Rights
- Scottish Commission for Human Rights Act 2006
- R (Tracey) v Cambridge University Hospitals NHS Foundation Trust & Ors [2014] EWCA Civ 822

FURTHER READING

1. DNACPR Integrated Adult Policy: Decision Making & Communication. The Scottish Government, August 2016.
2. UN Convention on the Rights of Persons with Disabilities
3. UK Equality and Human Rights Commission
4. Mental welfare commission

The Faculty of Intensive Care Medicine

August 2024/ Version 2.0

M Beatty, L Sutherland & N Mackenzie on behalf of the Legal & Ethical Policy Unit

This Quick Reference Guide is only intended as a helpful resource for medico legal issues and does not constitute nor replace formal legal advice.

Find out more at **www.ficm.ac.uk/midnightlaws**

FFICM Exam update

Dr Vickie Robson
Chair of Examiners

The FFICM examination started in 2013, with a final exam being designed as a summative assessment for the then new ICM, CCT programme. As the programme has no exclusive core training, a number of relevant core exams are accepted as the 'primary' ICM exam. There have been two sittings each year of the FFICM Final (except for one cancellation during the first Covid pandemic 'lockdown').

Candidate numbers have increased from approximately 100 per year attempting the oral components in 2013 to more than 400 across the two diets in 2024.

The Final exam is an important component of the ICM CCT training programme assessment strategy. It is the only summative assessment on topics that are not selected by the IiT, and it is assessed by a body of examiners who are not involved in the training of the individual, are trained in assessment delivery and audited on their practice. As such, it has an important patent safety role, ensuring the high standard of those who go onto become ICM consultants.

Recent changes

A number of regulation changes have occurred in recent years, mostly to increase the flexibility in eligibility for potential candidates. Those in the ICM training programme can now enter the multiple-choice question exam (MCQ) during ICM Stage 1 training if they feel adequately prepared (the OSCE SOE cannot be sat until an IiT is in Stage 2) and those who are not in the CCT training programme can enter after one year of UK ICM training, which may be in 6-month blocks. Those intending to enter the MCQ early should consider the three-year time limit of eligibility of an MCQ exam pass.

The expiration after 10 years of the primary qualification has also been removed and extensions of expiration dates of exam components for maternity/paternity/adoption leave or Less Than Full Time training have been added.

It is important to note that the standard of the exam has *not* changed. It is still set at the end of Stage 2 training, and all components of the training programme up to the end of Stage 2 (including anaesthesia, medicine, cardio-, neuro- and paediatric-ICM) will be tested in both the MCQ and OSCE SOE components. Candidates are encouraged to wait until they are fully prepared at this level before applying.

A number of changes have been made, some in response to recommendations in the Independent Review of all exams delivered by the RCoA published in February 2023.

- A comprehensive package of resources for candidates now exists on the FICM website containing videos showing good and borderline performances in OSCE and SOE stations, guidance on answering certain question types e.g. simulation, a greater number of sample exam questions than available previously, lists of topics which candidates did not perform

well on in previous exams, and lists of revision resources. A comprehensive FFICM examination syllabus has also been published.

- Pure knowledge components in oral questions (of which there were few) are in the process of being moved to the MCQ examination.
- Two new members of staff, a Faculties Examinations Manager and Coordinator dedicated to the management of the FICM and Faculty of Pain Medicine exams have been employed. The examinations continue to be overseen by the Head of Examinations, and supported by the Psychometric and Standard Setting Manager, and a new Quality and Standards Manager.
- The OSCE SOE question banks have been transferred to a purpose-built exams management system enabling electronic delivery and scoring of exams and replacing a paper-based scoring process.

All FFICM components have the pass mark set using criterion-referenced methods. Currently, the MCQ pass mark is set by an Angoff process with one standard error of measurement (SEM) subtracted to form the final pass mark. As recommended in the Independent Review, the subtraction of an SEM will cease from June 2025. In a review of the performance of candidates in their first attempt at the OSCE SOE, candidates who passed the MCQ because of the SEM subtraction, had a very low pass rate in the OSCE SOE compared to those whose score was above the Angoff-derived pass mark.

We are aware there is differential attainment in exam success by certain groups of doctors, including those from minority ethnic groups whose undergraduate qualification was obtained outside EEA and UK. Work is taking place within the Faculty and with the GMC to try to address this.

A group of candidates with a particularly low success rate in FFICM are those who are non-training posts. This is a heterogeneous group comprising candidates who have trained outside the UK and have not benefitted from the breadth of experience, teaching, training and supervision which the UK CCT training programme provides.

Candidates who fail an oral component on two occasions can request a guidance interview by emailing facultyexams@rcoa.ac.uk. This is an interview with an examiner who has reviewed the performance in all sittings undertaken and who can guide the candidate in how to prepare and perform differently next time.

Future of FFICM

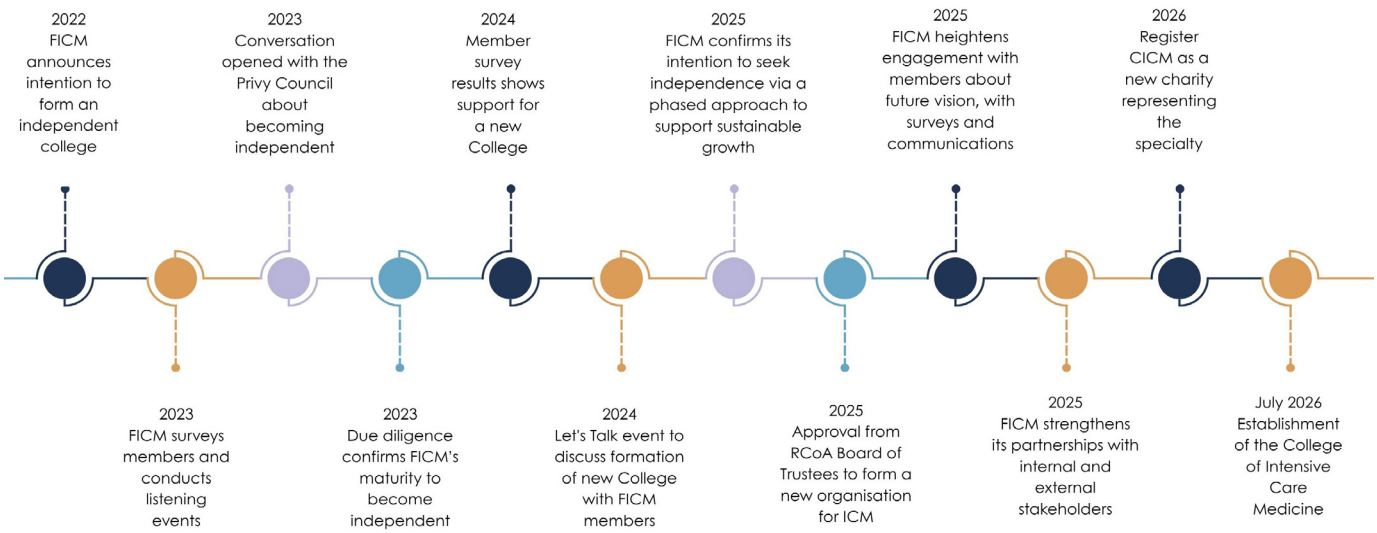
A review of the FFICM exam has been carried out in line with the Independent Review and a new oral performance examination to replace the current SOE and OSCE components is planned. The details have not been finalised, and will need GMC approval, but the current plan is for an exam called the Assessment of Clinical Reasoning Exam (ACRE). The FFICM ACRE will consist of a sequence of stations which reflect the clinical encounters an ICM doctor might expect in daily practice, such as a referral of a patient from Emergency Department, a ward round patient review, dealing with a clinical problem in critical care, a discussion with a patient, relative or health professional.

The exam standard will remain at the end of Stage 2 training. The current testing of higher order skills such as the formulation of differential diagnosis, balancing conflicting priorities, clinical reasoning, as well as aspects of professionalism will continue in the new oral performance exam. Understanding of the relevant applied basic sciences that underpin ICM practice will continue to be tested, as will both common critical care conditions and those rare conditions which it is important that an intensivist does not fail to consider.

Further information and sample resources will be available on the Faculty website from approximately June 2026, one year ahead of the anticipated launch of the new exam in academic year 2027-28.

Thank you

The development of the new FFICM ACRE is being undertaken by FFICM examiners and the Examinations Department. FFICM examiners are all volunteers and my thanks go to them for undertaking this time-consuming development work alongside examining candidates and writing and revising exam questions for the current format of the FFICM examination. My thanks also go to the staff of the Royal College of Anaesthetists' Examinations Department, who manage the development and delivery of this exam.



Becoming the College of Intensive Care Medicine:
Questions from Intensivists in Training

Mr Stephen Williams
Strategic Lead for FICM Independence

The FICM has announced that we will become the College of Intensive Care Medicine (CICM) on 1 July 2026. This is a huge milestone in our progress toward full independence. Forming the College of Intensive Care Medicine will reflect the identity of Intensive Care Medicine as a distinct and growing specialty. We are following the same journey as other faculties who similarly outgrew their parent colleges, with recent examples including both the RCoA and the Royal College of Emergency Medicine. We have added new resources and FAQs about our independence journey to the FICM website. Here, we answer questions submitted by your IiT Subcommittee representatives.

How is a Faculty different from a College and how do these differ from learned societies?

A Faculty is generally, but not always, a department within a larger organisation.

In our case, FICM is dependent on our host and lead College RCoA for its governance and ways of working. The RCoA Board of Trustees does not include members of the FICM Board but has responsibility for FICM's finances including setting FICM's membership fees.

This arrangement has supported FICM's establishment well, but it restricts the FICM Board's direct ability to make decisions for the benefit of the specialty and its members. Becoming a College of Intensive Care Medicine will ensure a future CICM Board of Trustees has full control over finances, governance and operations. This, in turn, will enable greater focus on the issues that matter to members, such as being able to better support career progression and lifelong careers in intensive care.

Faculties and Colleges both set curricula and training standards for medical, scientific and other healthcare professional trainees across medical specialties, and ensure these are approved by the appropriate regulator. They have a leading role in setting national guidelines and professional standards and provide a voice to service providers and commissioners to ensure the provision of high-quality services to patients and their families. Intensivists in training are required to register as a member of FICM.

Learned societies have no responsibilities for training or exams. They promote and support disciplines and tend to focus on aspects that touch on their members' interests. Membership may be open to anyone with a professional or personal interest, depending on the society. Membership of learned societies is not compulsory for Intensivists in Training.

What are the organisational benefits of FICM transitioning to CICM?

Our transition from FICM to CICM will follow the same natural evolution process experienced by other Faculties that have transitioned to become a College. We started small as a Faculty but remaining so will hamper ICM's ability to grow as a single unified specialty. As a College we will stand alongside peers in influence while standing as an independent body will support a future move to progress to our own Royal Charter.

We share our small secretariat team with the Faculty of Pain Medicine, and the team members will continue to be embedded within the RCoA structures and working relationships when CICM is launched on 1 July 2026. This will provide the stability we need for that team, our current IT and support systems, exams and training. As we evolve, our needs are likely to change too, but it's too soon to establish what we will need. We will engage with members and our staff as opportunities arise.

Organisational benefits will come from our ability to make decisions about the specialty, with direct control on our priorities, income and expenditure.

As a College, we will be optimally positioned to represent the voice of the specialty of ICM at the highest levels, which is more limited when we are seen as a subset of anaesthesia.

What are the benefits to intensivists in training and resident doctors of FICM transitioning to CICM? How will we be represented in CICM?

Establishing CICM will mean autonomy for the specialty, with a CICM Council representing ICM in external matters where the specialty needs an independent voice. This may range from campaigning on workforce issues to representing ICM in legal cases.

In addition, the CICM Board of Trustees will ensure the specialty can make decisions about its own governance, finances and operations. This will, in turn, support decision-making so that CICM is able to enhance member benefits.

Intensivists in training and resident doctors are currently represented on the FICM Board through an elected Lead and Deputy representative, while members of the IiT Subcommittee hold membership across its three core committees. We will retain and seek to strengthen our committees. The current FICM Board will transition to become the new CICM Council. No decisions have yet been made regarding its composition but representation from Intensivists in Training and resident doctors will be crucial. It is therefore important to share your views as part of our planned

> We want to hear the views of our Intensivists in Training and resident doctors. You are the future of the specialty.

engagement over the next few months. We want to hear from you.

Are there any disadvantages for Intensivists in Training and resident doctors if FICM becomes CICM?

We cannot see any disadvantages, but we want to keep talking with Intensivists in Training and resident doctors so that we can understand any impact we may not have foreseen and minimise any disruption.

CICM will not be able to do everything at once. We will need to build our resources and so we will initially remain within the RCoA infrastructure.

To ensure stability and fulfil a key guiding principle of providing value for money, we will actively engage with you as we determine how CICM will operate, including future fees, exams and membership categories. We want to develop the answers to these important questions with you as part of the transition process.

How can Intensivists in Training and resident doctors get involved and make sure our opinions are heard?

We want to hear the views of our Intensivists in Training and resident doctors. You are the future of the specialty and have a crucial role in shaping the design of the new College. We are launching an engagement plan that will provide opportunities for you to share your views. We want to create a space for conversation and engagement.

Members of the Faculty Board will be attending the forthcoming IiT Subcommittee meetings in June and September where there will be an opportunity for subcommittee members to share your views. We are also inviting Intensivists in Training and resident doctors to our 10 June online member engagement meeting so that we can talk about the plans and hear your views. We want to hold these regularly so that we can always stay focused on what matters to you.

Longer-term it is important to note that becoming a College is part of our, and your, journey but not the endpoint. There will continue to be opportunities for you to become involved with CICM throughout your career. This could include, for example, taking part in events, joining a committee, helping to develop educational content and generally being a proactive voice for the specialty within your unit, deanery and region.

Will there be changes to training/exams?

No. We are not planning any immediate changes to the delivery of training, the running of exams or the lifelong learning platform. Any changes over time will happen if in the best interests of members.

There is an already in-progress programme of work around updating all RCoA-delivered examinations as part of the independent review of exams conducted by Professor John McLachlan. Any changes affecting the standard or content of the examination, which would have an impact on candidate preparation, will be communicated with at least 12 months' notice.

Resources

- Becoming the College of Intensive Care Medicine
- The Story So Far
- Becoming a College FAQs
- We Want To Hear From You

CICM Connection

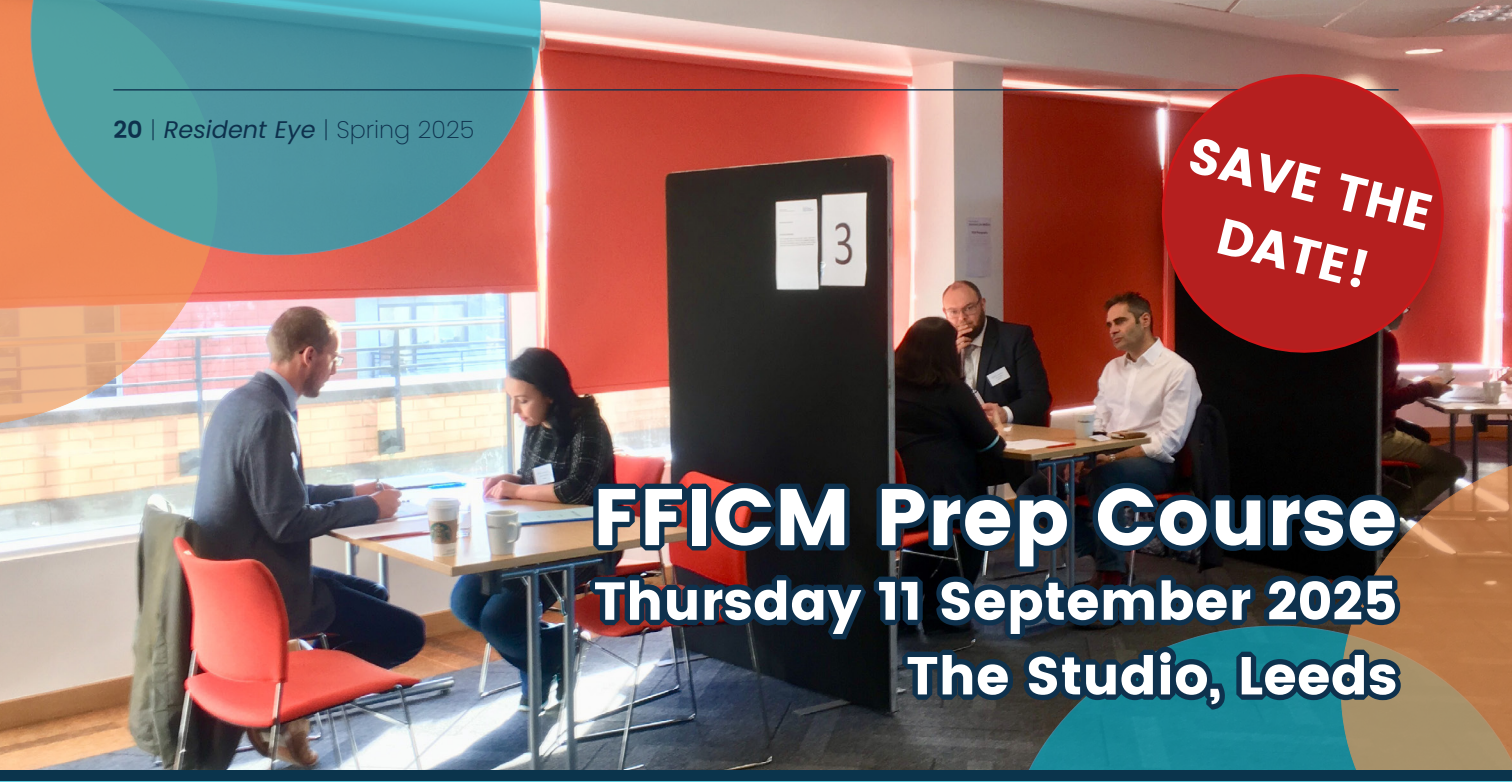
Your new College of Intensive Care Medicine

FREE Webinar
Tuesday 10 June 2025
Online 7:30pm

BOOKING OPEN NOW

The Faculty of Intensive Care Medicine

www.ficm.ac.uk/events



Bookings will open at the end of July 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

FFICM EXAMINATION CALENDAR

FFICM FINAL OCSE/SOE	
Exam applications open	23 June 2025
Exam applications close	4 August 2025
EXAM DATE	29 Sept - 3 Oct 2025
Fee	Both £735 OSCE £410 SOE £365
Results	28 October 2025

FFICM FINAL MCQ	
Exam applications open	10 March 2025
Exam applications close	24 April 2025
EXAM DATE	26 June 2025
Fee	£580
Results	15 July 2025

For full details please see the FFICM Examination Calendar.

SIGN UP TODAY!

FICM Thrive

FICM Thrive is a Career Mentoring and Personal Development Programme intended for consultants in their first five years post appointment. Thrive faciitates a strong productive mentoring relationship based on mutual, equal and collaborative development and learning between mentors and mentees.

Our mentors are ICM consultants from a broad range of backgrounds and are interested in providing support and guidance to colleagues. We welcome applications from consultants with two years or more experience from all ICM backgrounds, including both single specialty and dual trained. Find out more at:

www.ficm.ac.uk/careersworkforce/ficm-thrive

FICMLearning

@FICMNews

www.ficm.ac.uk/ficmlearning

FICMLearning is a free and open access educational material (#FOAMed) hub for FICM.

e-ICM

A joint venture between FICM and e-Learning for Healthcare. Nine modules of resources, free to all NHS staff members and students.

Case of the Month

Primarily written for IiTs preparing for the FFICM examination, these short articles can also be used as 'quick CPD' by anyone.

Simulation

Supporting development of basic or more advanced technical skills and capabilities at all levels of experience.

Podcasts

The FICM podcast is available on the FICM website as well as via Apple Podcasts (iTunes) and Spotify.

Blogs

Blogs are released every month in rotation with WICM and cover all apects of ICM. Blogs are written by subject matter experts.

Are you taking advantage of FICMLearning yet? Visit the website for regular updates.

Navigating the end of training

Dr Waqas Akhtar
Consultant in Intensive Care & Cardiology

Achieving the Certificate of Completion of Training (CCT) is a significant milestone, representing a journey of at least 14 years from the start of medical school. After a very clear structure throughout medical school and postgraduate training, life afterwards can be unsettlingly uncertain. In this article, I aim to share insights from my experience and our representative work to help guide you through this transition.

Stage 3

Over the duration of your training, you will have experienced a range of departments and potential consultant colleagues. Beyond the type of medicine or location I would say the most important factor is the culture of the department and the colleagues you may well spend a lifetime with. To that end it is important you have had the opportunity to work in places you wish to develop a long-term career.

Advice regarding Stage 3 training has been updated recently to give senior residents the opportunity to work in the unit they believe would be of most benefit to their future career aspirations, including general or specialist intensive care units. Have a conversation with your Training Programme Director early about where you would like to go.

There is of course opportunity for post-CCT fellowships. However, as a resident committee we pushed for these opportunities to be made available within training, which will be one of the central considerations for the national postgraduate medical training review underway. There is also opportunity for stepping up into a consultant role towards the end of training which can be a very valuable experience and discussed with your current unit.

Post-CCT

You can apply for a consultant role up to six months prior to obtaining your CCT. While securing a consultant position in advance provides stability, it is also one of the few opportunities in your career where you may have the flexibility to take a long break before retirement. I would strongly recommend taking time for yourself, your family and friends and things you enjoy.

However, it is important to consider the implications of gaps in continuous work, particularly for maternity leave. There is also the current workforce planning disaster unfolding in the NHS which may have implications for the availability of consultant roles in a certain specialty and location. If you accept a position, you can negotiate a delayed start date, with some departments offering several months before commencing work.

Application

There are several platforms where consultant vacancies are advertised, including NHS Jobs and Trac.jobs. Setting up alerts can help you stay informed about new opportunities. Additionally, engaging directly with clinical leads in units where you wish to work is key. Many trusts may create a new role for a valued candidate if there is sufficient workload.

Consultant positions can be offered as either locum or substantive roles. A locum post

typically lasts a maximum of two years, as after this period you would gain permanent contractual rights. Substantive roles are generally offered to doctors who have demonstrated their capability in a department through locum consultant roles. However, we have also advocated for resident doctors with positive experience in that trust to increasingly be considered for substantive positions directly.

If you want to pursue something unconventional, there will always be people who tell you it's impossible or not advisable. My advice is to ignore them and follow the path that brings you joy, whether it's a unique mix of medical or non-medical roles, or something entirely different. Stay true to your passion, and trust that you'll find others who will support and help you make it a reality.

Interview

The NHS consultant interview process is often perceived as daunting, similar to your previous applications for medical school, core training, and specialty training. However, it is just another interview. Be yourself, if a unit does not see you as the right fit it may not be the best place for you. Ultimately, they are looking for a colleague they will get along with and is a good doctor. Make it easy for them, read about the trust values, understand how the unit functions and the current issues and plans to address them. Engage with the multidisciplinary team, such as the nursing and management team, to understand their priorities and vision. These issues are important to understand but equally the impression you leave on them after your conversations may significantly influence your chances at interview.

Contract

Once you accept a role, follow up with the human resources department to obtain your contract. It is advisable to have the British Medical Association (BMA) review your contract to ensure that the terms and conditions are appropriate. If you have taken a longer training path, such as less-than-full-time training, you should be appropriately escalated on the consultant pay scale. Similarly, those who have extended training due to dual specialisation should receive recognition for their additional NHS service. However, due to outdated 2003 consultant contract guidance, trusts currently evaluate this on a case-by-case basis. Doctors' organisations are advocating for a contract amendment to address this inconsistency.

Job Plan

The day-to-day role will be discussed at an annual job planning meeting with your clinical lead. Consultant job planning consists of allocating typically 10 programmed activities (PAs) over a week. A PA represent four hours of work with various adjustments for out of hours. This can be extended to 12 PAs however beyond this many trusts are reluctant despite NHS England advice if work patterns are safe. Within these 10 PAs there will hopefully be 2.5 supported professional activities (SPA) for work such as educational supervision and attendance of department meetings with the remainder of your allocation termed direct clinical care.

The job plan is based on working 42 weeks of the year after accounting for your leave entitlement. Many units have annualised job plans which gives you the flexibility to do this work in any configuration over the course of year rather than a weekly template.

The first year will be a focus for transition to consultant life and providing good quality direct clinical care. When you feel ready there will likely be many extra roles the department will be keen for you to pursue, make sure you have the bandwidth and are allocated the PAs to complete this work. Job planning is a collaborative process, and you have a right to appeal a plan to make it workable for you and the trust.

Conclusion

I hope some of this will prove helpful and congratulations on the completion of your training. Surround yourself with a team that supports you, shares your values, fuels your passion and inspires you to grow. This is just another step in your journey — while it may feel daunting, life has so much more to offer, and everything will fall into place. Follow your dreams and enjoy the adventure!

What's It Like Being The Dean?

Dr Daniele Bryden
FICM Dean

There's no template for my role, but in my opinion it's definitely not one to do too early in your career. Working with the Faculty has been the most interesting and influential leadership role in my career so far, but actually being Dean carries enormous responsibility which has tested all my previous knowledge and experience. Let me explain.

There is no payment for the role (only the very largest organisations can 'backfill' i.e. pay your employer for your work). I've been lucky to have supportive medical and clinical directors who adjusted my job plan so I work clinically on ICU on Mondays and the rest of the week is free for Faculty work and other hospital activities. I'm also still doing the same out of hours work as colleagues — one weekend a month and resident nights.

The role is for three years so it's doable, but not one most people can take on without having an understanding family and few other external commitments. Many College Presidents take a pay cut by going part time to allow them to do the role.

Balancing

Being Dean is a tricky balancing act. The Faculty's main engines are the 3 big committees — Training, Assessment and Quality (TAQ), Careers, Recruitment and Workforce (CRW) and Professional Affairs and Safety (PAS) with all the other subcommittees feeding into them.

It's impossible to be on top of everything happening internally, so you can't be a control freak if the organisation is going to function effectively, but you must have an eye for detail when required, as ultimately the Dean is required to be the clinician sign-off on many of the outputs. The Dean is responsible for things they may have not been involved in so spotting potential issues is important. I'd done other roles on several committees before being elected to FICM Board and subsequently chairing CRW: that experience helps me now when committee chairs and Board members come to me for guidance.

I now chair Faculty Board which sets the strategic direction for the Faculty and monthly Executive meetings with the secretariat (the 'civil service' and corporate knowledge of the Faculty), Vice Dean and Chairs of TAQ, CRW and PAS.

The Dean needs to provide internal leadership, advice and support but actually much of my time is spent externally facing. There are an awful

lot of meetings and emails to respond to, in addition to a large reading list. As Dean I am co-opted onto RCoA Council and a full member of the Council of the Royal College of Physicians. FICM Dean is also one of the 25 voting members of the Academy of Medical Royal Colleges (the strategic umbrella organisations for all UK medical Royal Colleges and the larger Faculties) and I'm also an elected Trustee of the Academy Board of Trustees.

Monthly meetings take place with Chris Whitty as CMO for England, Stephen Powis as NHSE Medical Director and the GMC. I also meet regularly with the medical education leads of the four nations and touch base with the leadership of the UK intensive care societies. The Critical Care Leadership Forum which provides a space for all the professional organisations with an interest in ICM to come together is also part of my regular meetings list.

Advocacy

All of that doesn't include of course the meetings associated with whatever 'hot button' issues are happening within the world of medicine currently e.g. exams. Advocacy for ICM (currently making clear we need more NTNs and support for educators) takes place in all fora and also specifically in my meetings with politicians, civil servants and special advisors.

There are privileges, of which I consider attending Diplomates' Day the greatest. It's a genuine pleasure to welcome our new Diplomates in front of their loved ones, acknowledging the hard work and sacrifice that have got them so far. I know social media cynics suggest there are honours and financial rewards in College leadership roles, but for the vast majority of College/Faculty leaders that isn't true or a motivating factor. The real satisfaction has to come from thinking you've made a difference and been given an opportunity that very few get: it's the nature of volunteering.

The Dean should be a custodian, ideally helping the Faculty to develop and grow in its support of the specialty, members and patients. I personally will always be proud that as Dean I've been able to move us from the dream to the reality of the new College of ICM. However it shouldn't ever be about the person who is the Dean but what they've been able to do in the role. Most importantly you should accept that when you leave, the door to the Faculty closes behind you to allow others to take over and lead in your place.

Spotlight on: The Special Skills Year

One of my aims in coming to this role was to raise awareness of how LTFT residents can maximise the educational opportunities available to them during their training. On reflection this goal is applicable to all IiTs no matter what their current or future work pattern might be.

Dr Gemma Tallling
Less Than Full Time (LTFT) Representative

I wanted to highlight the Special Skills Year, when I started out as a Single CCT Intensivist in Training it was a great unknown, an entire year of training of your choosing with so many potential opportunities. How do you choose what to do? Read on and I will discuss what the year involves and share case studies from IiTs in my region who are currently undertaking or have completed their special skills year.

What is the Special Skills Year?

The Special Skills Year (SSY) is 12 months of training during which you either further your experience in a sub-specialty within ICM, develop another clinical skill or develop a non-clinical competency relevant to practice as an ICM consultant. The intention is the expertise you develop will benefit both patient care and service alike.

What can I do in the Special Skills Year?

There are a huge range of options (see below). Not all SSYs are available in all regions. Where a particular SSY module is not available in your training region, it is possible to apply to undertake the module in another region as a year of Out of Programme Training (OOPT). This would then count towards your ICM CCT. For further information, speak to your TPD.

What should I do now?

Find the ST6/7 Single Specialty IiTs in your own region and ask about their experiences. I would suggest you start thinking about your Special Skills Year (SSY) early and meet with your ES / TPD to discuss your options. Your TPD / RA will be able to help guide you to options currently available in your deanery or elsewhere and help you to arrange the SSY.

I contacted some of the West Midlands IiTs to ask their experiences during their SSY year in Echocardiography — see over for their views. If you have recently undertaken an SSY and would like to share your experiences please do make contact.

Further information

1. FICM Special Skills Year Handbook
2. FICM Website Special Skills Year
3. Read Dr Samantha Gaw's Blog on her Special Skills year in Education

Current SSY Modules:

Academic Research

Cardiothoracic Intensive Care Medicine

Critical Care Echo

Education

Extra-Corporeal Membrane Oxygenation (ECMO)

Home Ventilation

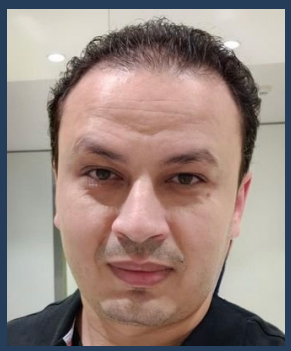
Neuro Intensive Care Medicine

Paediatric Intensive Care Medicine

PHEM Pre-Hospital Emergency Medicine

Quality Improvement in Healthcare

Transfer Medicine



Dr Ahmad Gamal

Currently undertaking Echocardiography SSY at University Hospitals of North Midlands

Why did you choose your SSY?

I chose echocardiography for my Special Skills Year because it's a growing area of critical care training. I believe that having the clinical ability to perform echocardiography will become a standard part of training in the future. It's a valuable clinical tool that can be used with many intensive care patients.

How did you arrange your SSY?

I contacted my TPD as soon as I thought it would be possible — probably about a year ahead of time, or at least six months before —so I could arrange a suitable place to do my SSY and get the most benefit from it.

What do you hope to achieve during your SSY?

The minimum goal I hope to achieve during my SSY is BSE-1 accreditation. I am also planning to add FUSIC HD accreditation and, in the future, potentially add more accreditations, but these are my immediate goals for the SSY year.

What do you perceive to be the benefits of your SSY?

I believe the main benefit of my SSY is that it allows me to develop a particular area of interest that enhances my clinical practice. It adds to my expertise and proficiency. Additionally, it will help me with my future planning after training; for example, set up specialised clinics, training courses, or establish a new practice in my workplace.

What are the negatives of your SSY?

One downside of my SSY is that it coincides with a year that includes exams. Exams require a significant amount of time and effort, which can dilute the experience of having the SSY year. This can also make it difficult to focus fully on my goals and achieve them in a timely manner.

What advice would you give to IiTs considering an SSY such as yours?

I would advise all IiTs to start thinking about their SSY year as soon as they begin their training. If they decide they have a particular area of interest, they should start reading about it and preparing themselves theoretically before beginning clinical practice. This will help them achieve more and hit the ground running when they start their SSY.

Dr Ebrahim Ahmad

Completed his SSY in Echocardiography at The Royal Shrewsbury Hospital

Why did you choose your SSY?

I have always had a passion for echocardiography and ultrasound. Echocardiography specifically and ultrasound generally are an essential part of evaluating any critically ill patient and I cannot imagine their absence from the field having experienced the level of information they can provide. The SSY year gave me dedicated time to learn more expertise in this area.

How did you arrange your SSY?

I discussed my plans with my TPD and we decided on a trust and supervisor for my SSY. Prior to starting the post, I contacted my educational supervisor and the rota coordinators and arranged to have one day per week dedicated to echocardiography as per the SSY guidance from FICM. Once in post I linked in with the echocardiography department in Shrewsbury.

What do you hope to achieve during your SSY?

My initial plan was to get at least one accreditation within the year; either BSE L1, fTOE and/or FUSIC HD. Eventually I managed to get all three logbooks done within the year. Remember for ARCP, evidence of progression is enough. You cannot change exam times.

What do you perceive to be the benefits of your SSY?

It was a very enjoyable learning opportunity. If the clinical workload wasn't too heavy, then I could scan on my clinical days as well as my echo days. I enjoyed extending ties between departments including critical care, anaesthetics, echocardiography and cardiology. Being in an SSY also gave me chance to participate in national audit as site lead for NEAT-ECHO.

What are the negatives of your SSY?

The only downside is that more time is needed. Personally, I think at least 40% of the clinical time should be dedicated to the SSY, especially if seeking an advanced accreditation.

What advice would you give to IiTs considering an SSY such as yours?

Finding mentors can be difficult. BSE Level 1 was easy — there were plenty of mentors in the echo department. For FUSIC HD (including VEXUS) there was only one supervisor, so I needed to stagger the supervised scans for when he was available.

Spend lots of time learning with sonographers — it helped a lot. Being with a sonographer helped with obtaining views and seeing things from their angle and how they can adapt or add more measures as the scan evolve if they suspect certain pathologies.

Consider left hand scanning as you undertake longer scans. It takes a bit of practice — but it was worth it, you scan for the rest of your career so is important to adopt a position that is comfortable.

Applying for consultant jobs

Dr Anandh Balu

Consultant in Anaesthesia and Critical Care, Manchester Royal Infirmary

I am a consultant in Intensive Care and Anaesthesia at Manchester Royal Infirmary. I started in post in August 2024 a week after completing training in the West Midlands Deanery. I was the exception in my cohort of IiTs in moving region for consultant jobs. It was something we had discussed as a family for a long time that made sense for several reasons like being closer to my brother and our friends and for our children to grow up close to their cousins.

Unfortunately, clarity on where we wanted to settle did not help with the stress of the process. Applying as an external candidate felt like being in an uphill battle as I was conscious that I was going to have to prove myself against well-liked, internal candidates. During the process, I arranged site visits, observer shifts and spoke to friends who trained in the region as well as IiTs and consultants in the department.

Speaking to advanced IiTs in the region at a teaching day recently, I was reminded how stressful the process can be (I ended up getting shingles prior to my interview!) so thought I would try and compile some of the lessons I learned along my application process. The Centre for Workforce Intelligence (CfWI) modelling suggests that demand for ICM CCT holders/consultants will continue to outstrip supply rising to a potential 30% deficit by 2033[1]. This modelling from 2015 is slightly outdated and the landscape has since shifted seismically from a socio-economic perspective as well as a political one. Word of mouth reports of hiring freezes due to budgetary issues are likely true but ultimately can only be transient as the pressure on consultant bodies everywhere increases without fresh reinforcements.

My point is if you persist with your training, you will always be wanted somewhere. It may be that it might not be your first-choice job and it may be that you have to jump through additional hurdles like fellowships or locum consultant jobs prior to substantive appointment. There are opportunities aplenty, but there is also an element of being in the right place at the right time and figuring out where that place is for your individual situation.

My advice

1. Speak to the clinical director early of the department that you are interested in. If you are an external candidate, this should be 18 months to two years ahead of CCT. It's good to keep an open line of communication and check in to demonstrate your interest.

2. Don't compare yourself to your peers or recent appointments. We can't all summit Everest, represent our countries, publish in *Nature* or set up a randomised control trial from scratch (most of us don't!) Work on your CV and develop clarity about the kind of consultant and the kind of colleague you want to be and where your strengths lie.

3. When considering moving out of region, speak to senior IiTs and consultants in the region that you are interested in.

4. Courses aren't necessary but if it helps you feel you've done everything in your power to help the situation then do it.

5. When it comes to interviews, practice, practice, practice! The best people to practice with are experienced consultants who have previously been clinical directors or on interview panels or those that have been recently appointed.

6. Have a structure and approach it like a viva if it helps but don't be afraid to express your honest opinion when asked.

References

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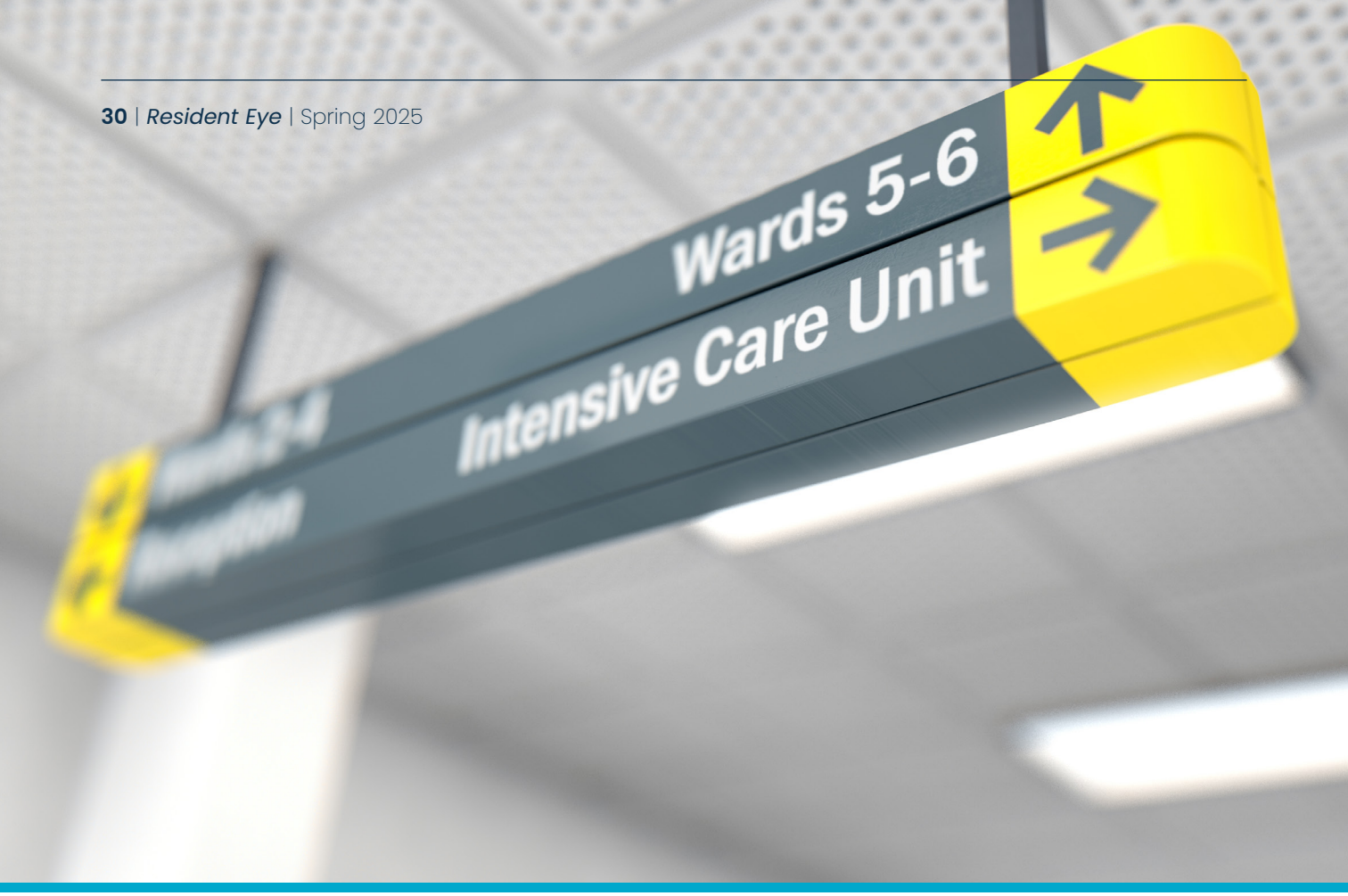


Career planning for single specialty training

Dr Hannah Richards
Consultant in Intensive Care Medicine with a special interest in palliative care

"What actually is the point of you then?" This question, asked after discussing how I did not have a second specialty, epitomised all the fears I had training as a single specialty intensivist. Would I ever get a job, would I ever be accepted in a department, would my career choices always be restricted? Thankfully, several years on, as the number of single specialty intensivists in training rises, I can confirm that none of these fears came to pass. I now work as a consultant in Intensive Care Medicine with a special interest in palliative medicine and am lucky to have a job that I love!

Single specialty ICM is a rapidly evolving training programme. One of the most exciting aspects of the programme is the opportunity to develop a special interest during the Special Skills Year. For a single specialty IiT, this year is a key part of planning for consultant life.

Passion

I knew from the outset of training that my passion lay in developing palliative care within ICUs and so I explored this as part of a QI SSY. With support from my TPD and RA, and lots of advanced planning, I spent the year working between the ICU and the hospital palliative

> I spend one day a week working as part of the hospital specialist palliative care team and the rest of my clinical sessions in critical care.

care team gaining skills in QI as well as palliative medicine.

I knew that when applying for consultant jobs having another 'string to my bow' would be valuable and so spent time gaining as much skill and competence in my chosen specialist interest as possible. I also used this time to demonstrate the positives for patient care that having strong links with another specialty can give. This became invaluable as I discussed options for consultant roles as I could demonstrate a need for improved cross-specialty working.

Dream job

I always knew my 'dream job' would be to work between ICU and palliative medicine but was never sure that it would be possible. As I neared the end of my training I knew that a job with sessions in palliative medicine would take time to organise (if indeed it was possible). I therefore began to explore with local hospitals whether there was any interest in such a role. Establishing consultant jobs takes time and energy and so starting early and being clear with trusts was vital. Some trusts will be able to offer a full-time critical care role to a single specialty intensivist, but many will ask that you can provide sessions in another specialty. Knowing what the potential options are is important for you and the trust when you are thinking about applying.

Those years of planning have paid off and now I have a job plan that suits me well. I spend one day a week working as part of the hospital specialist palliative care team and the rest of my clinical sessions in critical care. My palliative care days are spent seeing patients across the hospital, although I tend to gravitate to the acute wards, A&E and critical care. I have tried to bring some of what I've learnt to our critical care unit and work alongside the rest of our team to improve the palliative and holistic care we offer to our patients.

Having an interest outside of critical care has given me opportunities to learn new skills, work alongside a really varied MDT and bring those teams together as much as possible. I love to see our palliative care and critical care teams working together both inside and outside the critical care unit to improve the end of life care we give our patients.

But how do you get here? If you are a single specialty intensivist in training my advice to you would be this:

- Start thinking about your SSY year early. Find something that you're passionate about and see it as an opportunity to develop not only your interests but your career pathway too.
- Speak to your training leads and trusts about SSYs and consultant jobs early, explore what your options might be and be honest about what is important to you.
- Trust the process. I do not regret my single specialty training pathway, and you will finish training a skilled intensivist with consultant job options!

Develop

So what is the point of single specialty intensivists? Well, apart from being highly trained specialists in looking after critically ill patients, we have the opportunity to develop skills and interests outside of the traditional skills of an intensivist. We can bring a breadth of knowledge to a department and become invaluable members of ICU teams that are growing in diversity along with our patient groups.

NHS Fellowship in Clinical Artificial Intelligence

Dr Robert Crichton
ST8 in Anaesthesia and Intensive Care Medicine

Artificial Intelligence (AI) has been a growing presence in healthcare for several years, with the potential to streamline administrative tasks, support complex diagnostic processes, and even personalise patient management.

However, the practical aspects of governance, feasibility, validation, and ongoing impact of these systems are often overlooked. The NHS Fellowship in Clinical AI offers healthcare professionals from clinical backgrounds the opportunity to gain hands-on experience in the development, deployment, and ongoing management of AI systems.

Why AI in Intensive Care Medicine?

ICM is a high-stakes, data-rich environment where advancements are driven by expert teams leveraging collective experience, knowledge, and cutting-edge technology to optimise patient outcomes. With increasing demands on existing resources, AI has the potential to enhance efficiency and innovation in ICM.

My experience with the Fellowship

I first learned about the NHS Fellowship in Clinical AI in 2022 when the programme was still in its early stages. Throughout my training I have developed a belief that clinicians have a responsibility to improve patient care through safe innovation, AI presents a myriad of opportunities to achieve this. To build my understanding I undertook digital transformation Quality Improvement Projects (QIPs) and completed several free AI courses, such as those offered by King's Innovation Scholars.

In August 2024, I was fortunate to be accepted into the fellowship and assigned to an AI project in cardiac imaging in my training region. Although this was outside my primary specialties, I found that many of the skills and experiences are highly transferable. Throughout the year, I have also engaged in additional educational, research, and managerial projects, significantly deepening my understanding of AI applications within the NHS and allowing me to contribute meaningfully to various initiatives. My project work has been supported by educational content from funded access to DataCamp including e-learning modules in programming and the opportunity to earn recognised certifications in AI and data science.

One of the most valuable aspects of the programme has been the opportunity to network and collaborate with other enthusiastic clinicians and those who are shaping the future of AI in the NHS. The fellowship fosters this through an intensive residential bootcamp, followed by monthly workshop days hosted at locations across the country, led by national thought leaders in the field.

Overall, the fellowship has massively broadened my perspective and prepared me to navigate some of the challenges and opportunities that AI faces within the NHS. I now feel far better equipped to practically drive improvements in ICM, anaesthesia and beyond!

Fellowship details

The NHS Fellowship in Clinical AI provides fellows 40% FTE protected time over one year (August–August). Applications for Cohort 5 open November 2025, with an initial shortlisting process followed by online interviews. Successful candidates will be matched with AI projects under expert supervision for their fellowship year. Funded posts and projects are available across most UK deaneries, though applicants are advised to check the fellowship website at gstt-csc.github.io/fellowship.html for specific details.

Press Pause to Progress: A guide to time spent Out of Programme

Dr Sophie Hayhoe
ST5 Dual ICM and Anaesthetics

The path to a CCT in Intensive Care Medicine is demanding, requiring years of dedication and training. However there are times when stepping away from formal training can be beneficial both personally and professionally. Out of Programme (OOP) periods provide residents with this opportunity.

Having recently taken an Out of Programme Career Break (OOPC) myself, I want to share insights into the different types of OOPs available, key considerations when planning one and how to ensure a smooth transition back into training.

Types of OOPs

There are several types of OOPs available:

- Out of Programme Training (OOPT): Time spent in a post that contributes to training, such as an overseas fellowship.
- Out of Programme Research (OOPR): Time dedicated to research, such as a PhD or MD.
- Out of Programme Experience (OOPE): experience such as global health work or leadership roles.
- Out of Programme Career Break (OOPC): A break for personal reasons such as family commitments
- Out of Programme Pause (OOPP): An opportunity to undertake work in the UK and in non-UK placements. You may accrue capabilities which could count towards training.

Benefits of taking an OOP

The advantages are numerous, including:

- Pursuing a special interest (e.g. research, global health, education).
- Developing personal and professional growth
- Preventing burnout and enhancing well-being
- Broadening perspectives by experiencing different healthcare systems.

When to consider OOP

Deciding when to take an OOP depends on personal and professional circumstances. Bear in mind that OOPs will not normally be agreed until you have been in training for at least one year. Key questions to ask yourself include:

- Will this enhance my training or career development?
- Do I need time away for personal reasons?
- Have I considered the financial and logistical implications?

> An OOP can be a valuable and enriching experience, and although it requires careful thought and preparation.

Planning and organising an OOP

Each deanery will have a named lead for OOPs who can provide guidance throughout the application process. Organising an OOP requires careful planning. The steps include:

1. **Discussing with Supervisors, Regional Adviser and Training Programme Directors**
   Early discussions are crucial as formal approval is required. Some types may also require GMC and FICM approval.
2. **Gaining approval from the Postgraduate Dean**
   This must be done prospectively and recorded in the designated Health Education England form.
3. **Clarifying employment and contractual agreements**
   It is vital to understand whether you will remain under any form of contractual agreement with your NHS Trust. If not under a formal contract you may not be entitled to NHS employment benefits.
4. **Seeking advice from the British Medical Association**
   The BMA can provide clarification on your rights, preventing unexpected complications.

Important considerations before starting an OOP

- **Financial planning:** Especially important if taking an unpaid OOPC.
- **Duration and impact on training**
  OOPs typically last 6–12 months but can sometimes be extended up to two years, with OOPRs potentially extending to three. Prolonged periods away may necessitate additional training time.
- **Visa and relocation issues**
  If working or living abroad ensure visa and licensing requirements are met.

Returning to your training post

Returning after an OOP can be challenging and the Supported Return to Training (SuppoRTT) programme aims to facilitate a smooth transition. Your deanery will have a lead for SuppoRTT who can advise you with regard to benefits such as an initial period of enhanced supervision and access to additional training and refresher courses.

My personal experience with an OOPC

I took a 12 month OOPC to accompany my husband on a military deployment to the US. This break allowed me to nurture my family life, strengthen my relationship with my husband and gain fresh insight into my clinical role and healthcare delivery, both through having the time for personal reflection and through experiencing a vastly different healthcare system in the US. It provided me with personal growth that I may not have achieved within the rigid structure of training.

An OOP can be a valuable and enriching experience, and although it requires careful thought and preparation, the personal and professional benefits are significant. If you are considering an OOP seek advice early, plan thoroughly and embrace the opportunity to shape your career in a way that aligns with your aspirations and circumstances.

Useful Resources

- FICM Guidance on OOPs
- GMC Guidelines on OOP Approval
- Gold Guide: A Reference Guide for Training — see section 3.143
- BMA Employment Advice
- SuppoRTT Programme

Life as a Military Intensivist in Training

Squadron Leader Andrew McCafferty
ST8 in Anaesthesia and Intensive Care Medicine

Life as a military intensive care trainee is, in large parts, identical to life as a civilian trainee, with regular and reserve trainees embedded among the many deaneries around the UK. We are grilled in the same interviews, sweat in the same exams, judged by the same ARCP panels and spend our time in the same NHS hospitals.

We are largely protected from prolonged deployments in order not to disrupt training. However, ultimately, we are employed by the Defence Medical Services (DMS), which brings demands and rewards. Alongside our NHS training, military Intensivists in Training (IiTs) learn skills ranging from weapons handling and survival to managing the unique challenges of conflict medicine, including chemical, biological, radiological, and nuclear threats and mass casualty incidents. These skills are acquired through courses, mandatory theory and practical training, exercises and (with

> Military intensivists are now grappling with the challenge of how to provide prolonged care near the point of injury in contested environments.

any luck) some live operational experience, all alongside our NHS commitments.

Deployment

As a consultant, job plans follow a similar pattern of blended NHS and military work across the year. Military consultants may have planned periods of deployment away from the NHS or remain on standby for operational deployment whilst continuing work within their trusts. This provides an exceptional and enjoyable variety of work but navigating both NHS and military organisations requires a deep understanding of both NHS and military hierarchies and culture.

One's parent service strongly influences the nature of the military work but all roles support the 'operational patient care pathway', a framework describing a service person's pathway from the point of injury or illness back to definitive care in the UK. This may be on a floating ICU as part of a carrier group, in a 'Role 2' forward surgical facility providing damage control resuscitation or on an aircraft transferring critically injured service personnel away from the theatre of operations.

Challenges

The specialty as a whole faces new challenges. The traditional model of military critical care is based on the principle of freedom of manoeuvre — rapidly transporting casualties through escalating echelons of care back to the UK. However, with evolving geopolitical threats, this may not always be possible. Military intensivists are now grappling with the challenge of how to provide prolonged care near the point of injury in contested environments with potentially limited resources. With potential solutions coming from remote monitoring and review technology, non-physician critical care providers and lessons from resource-limited civilian environments.

For military IiTs this geopolitical instability is not abstract and academic. Whilst the routine of ward rounds and WPBAs continues, there remains the understanding that should the worst happen, we may be called away from our families and friends to care for our service personnel in austere and dangerous environments.

Ultimately, the additional pressures of a multi-organisational working are worth the rub. With a long history of collaboration, cross-pollination and solidarity that benefits intensivists, the NHS and Defence. Most importantly, it ensures that our patients both civilian and military, receive exceptional standards of critical care, wherever they may be.

Percutaneous Tracheostomy:

A trainee initiative to fill a training gap

Dr Sofia Hanger

ST8 Respiratory and Intensive Care Medicine, St George's University Hospitals NHS Foundation Trust

Dr Giada Azzopardi

Intensive Care and Renal Registrar, Royal London Hospital

Percutaneous tracheostomy is a skill which Intensivists in Training (IiTs) are expected to have gained exposure and competence in by the end of training, however it can be hard to come by opportunities for training. Approximately two-thirds of tracheostomies are inserted in intensive care units, highlighting the increasing need for training.

Furthermore, percutaneous tracheostomy is a high-risk procedure with significant complications related to insertion, hence the need for formalised and structured training. The inaugural FICM IiT national conference presented an opportunity for us to partially address this with the inclusion of a set of workshops, one of which focused on percutaneous tracheostomy insertion.

Hands-on

We planned four 90-minute sessions, with an interactive theory session followed by ample time for hands-on practice with a range of insertion kits. We approached experienced consultants from a range of hospitals to be involved in developing the workshop content and lead the sessions. The equipment required was largely supplied by company representatives, who provided manikins for front of neck, bronchoscopes and percutaneous tracheostomy insertion kits. Participants were given ample time to practice the technique on manikins in a simulated environment, with a second person managing the airway and handling the bronchoscope. Live feedback was provided to the participants throughout the workshop. The session also included flexible bronchoscopy theory and opportunity to practice scope handling as an essential part of the procedure. Workshops were run in parallel to the conference sessions; 39 attendees signed up to the workshops across the 4 sessions.

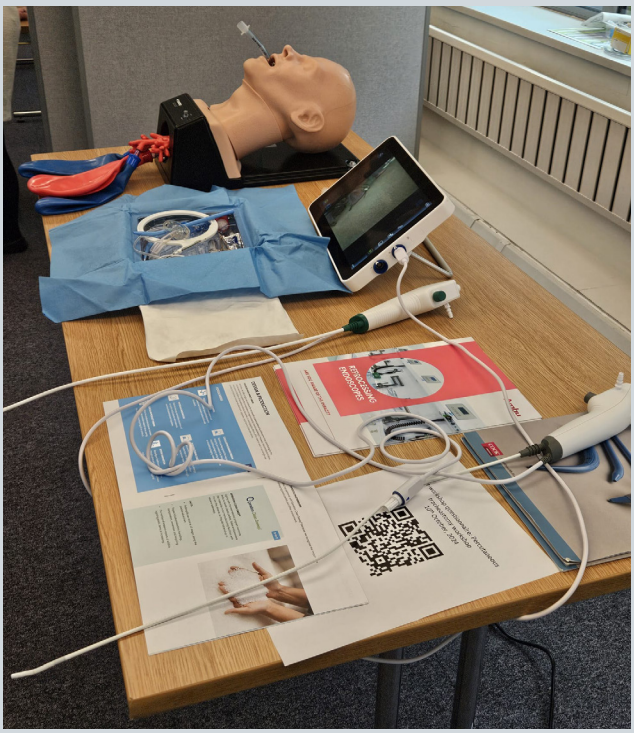
Prior to the session, 70% of participants reported no formal training in percutaneous tracheostomy insertion. The majority of participants reported inserting 0-2 percutaneous tracheostomies prior to attendance. Only 10.5% of attendees rated themselves 4-5/5 on the confidence scale (5 being very confident) prior to attending. This increased to 64.1% after the course. IiTs reported they found the session useful because of the range of equipment, opportunity for hands-on practice and the presence of experienced faculty.

Toolkit

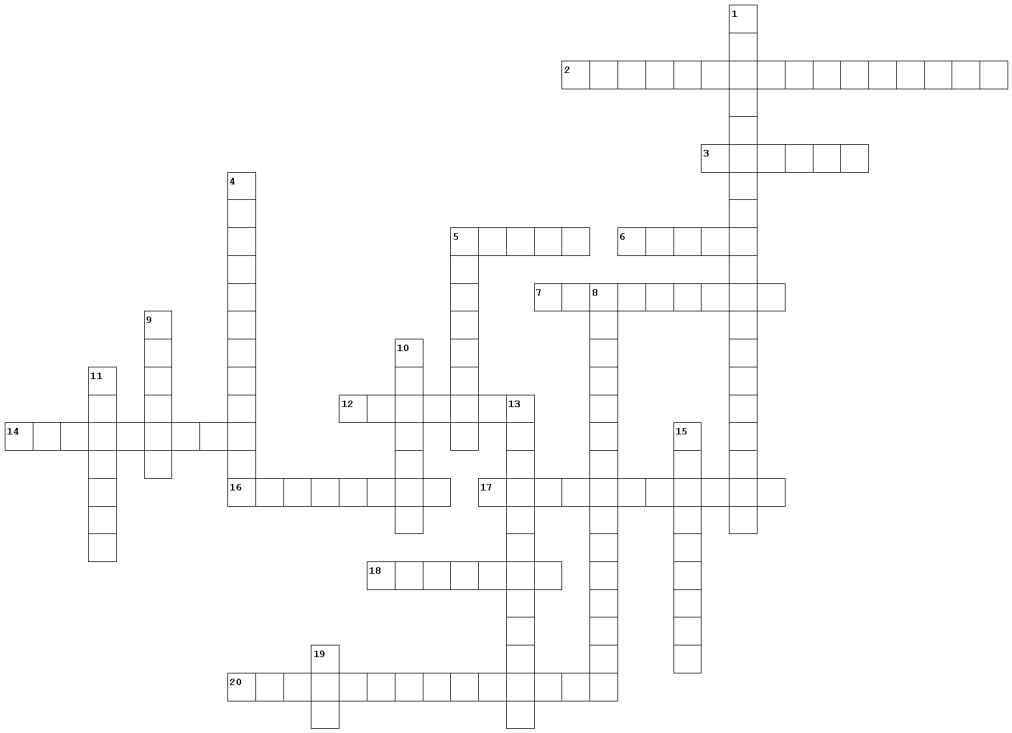
Following the successful pilot of these workshops we have developed a workshop toolkit, aimed at enabling trainers and IiTs to develop their own regional percutaneous tracheostomy insertion workshops.

Our work has highlighted a gap in IiT training nationally, which can be addressed by the simple intervention of simulation workshops. We hope to continue to run this workshop at future IiT conferences with the overall aim to encourage safe practice in percutaneous tracheostomy insertion nationwide.

Our thanks to Dr Tom Williams, Dr Linsey Christie and Dr Stephen Shepherd, who supported development and delivery of the workshop.



ACCU Endocrinology Crossword



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

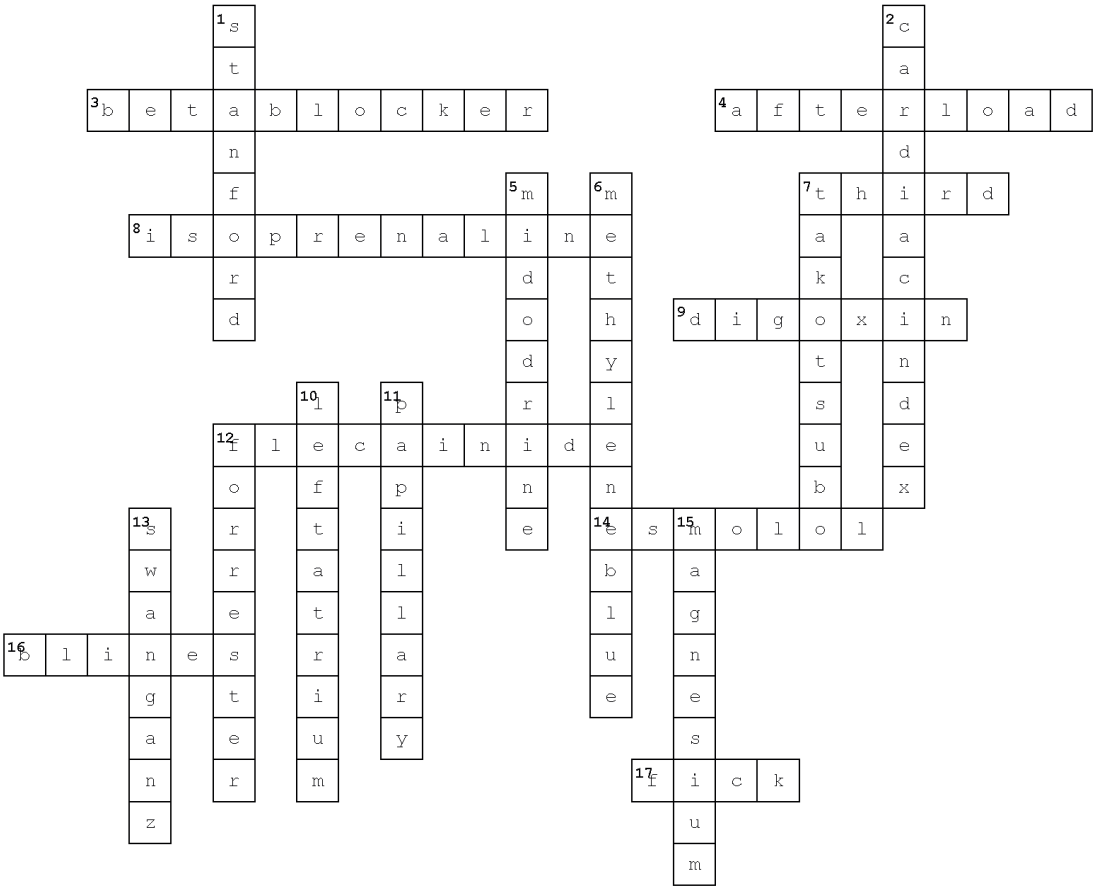
11. Mood stabiliser which can cause a nephrogenic Diabetes Insipidus

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)

ACCU Cardiac Crossword: Answers



Across

3. Drug class good in chronic but poor in acute heart failure
4. Positive intrathoracic pressure reduces LV...
7. Degree of heart block with P waves bearing no relation to QRS
8. Pure beta agonist chronotrope used in bradycardia
9. AF rate controlling drug with positive inotropy
12. AF chemical cardioversion. Avoid in structural heart disease.
14. Short acting beta blocker used in shock refractory VF
16. Evidence of pulmonary oedema on thoracic ultrasound
17. Gold standard CO equation (CO = VO2/Ca-Cv)

Down

1. Classification of aortic dissections (A and B)
2. ? = Cardiac output x body surface area (2.6-4.2 l/min/m2)
5. Oral alpha 1 agonist vasopressor
6. Vasopressor which works by reducing cGMP
7. Octopus pot cardiomyopathy
10. Pulmonary Wedge Pressure estimates pressure where in the heart?
11. Post MI muscle rupture causing pulmonary oedema, shock and pansystolic murmur
12. Four level classification of shock (cold, warm, wet, dry)
13. Invasive cardiac monitoring catheter used to assess left atrial pressure
15. Shown to improve rate control in fast AF in the LOWMAGHI trial

Crosswords created by Dr Harry Yong

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