



TRAINEE EYE

10th Edition | September 2018

The Faculty of
Intensive Care Medicine

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NEWS & EVENTS

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WELCOME TO NEW TRAINEES!

Dr Richard Gould

Lead Trainee Representative

A warm welcome to all the new ICM trainees who took up their posts at the beginning of August! I'm sure all trainees are aware of the issue with the RCP ranking process, and the unfortunate confusion it resulted in, but we're sure that makes the final success that little bit sweeter!

We hope you've settled in and have had a chance to meet both trainees and consultants to help explain the process of ICM training (a brief run through below). You should have also registered with the Faculty by completing the ICM CCT registration form <https://bit.ly/2xsSHbH>, and have hopefully considered sending one or two WPBAs on the ICM ePortfolio to get the ball rolling! Advice for new trainees in ICM is attached (add in FICM Guidance Document)

As you have registered with the Faculty, you will need to liaise with your Regional Advisor. If you are not familiar with them already, they are all listed here: <https://bit.ly/2xxorZg>. If you do not have their contact details then please do let the Faculty know and they can provide them.

You should have also registered with the Faculty by completing the ICM CCT registration form <https://bit.ly/2xsSHbH>, and have hopefully considered sending one or two WPBAs on the ICM ePortfolio to get the ball rolling! Advice for new trainees in ICM is attached (add in FICM Guidance Document)

WHAT DOES THE TRAINING PROGRAMME INVOLVE?

A CCT in ICM can be achieved as a single CCT or as a Dual CCT with one of our partner specialties:

- Acute Medicine
- Anaesthesia
- Emergency Medicine
- Renal Medicine
- Respiratory Medicine

Entry to ICM training is through a competitive interview process at ST3 level. There are currently three core training programmes from which trainees can apply to ICM:

- Acute Care Common Stem (ACCS)
- Core Anaesthetic Training (CAT)
- Core Medical Training (CMT)

Upon completion of these programmes and attaining their equivalent exams- FRCA (primary), MRCP (full), FRCEM Primary (or MRCEM Part A after August 2012) and FRCEM Intermediate SAQ (or MRCEM Part B after August 2012) and FRCEM Intermediate SJP OR MRCEM (prior to August 2018) - it is then possible to apply to ICM training.

Training is divided into three stages:

Stage 1 (ST3-4): Designed to consolidate your ICM knowledge, and develop skills and competences not covered in the core training from which you applied. For example, those trainees from CAT will be required to undertake a period of medical training, whilst those from CMT will undergo basic anaesthetic training.

Stage 2 (ST5-6): Trainees rotate through sub-specialty intensive care units (Cardiothoracic, Neuroscience and Paediatric) to learn how to manage these patients. Whilst clearly essential for those that end up working in tertiary centres, all intensivists need this knowledge as we often provide the immediate management in smaller hospitals too. During this stage, trainees also undertake a 'special skills' year. For single ICM CCT trainees this may encompass echocardiography, teaching, research, management, etc. For those trainees on the Dual CCT programme, this specialist year will be spent in your partner specialty.

Stage 3 (ST7): The final, advanced, year of training is aimed to develop the skills necessary to become an Intensive Care Consultant.

THE INTERVIEW PROCESS

Dr Andrew Ratcliffe

FICM Trainee Representative

As I approached West Bromwich Albion football ground, memories of my previous visit came flooding back; my mouth became slightly drier, palms slightly sweatier and my heart rate definitely skipped a few beats. No, I wasn't there to stand on the terraces and support 'The Baggies', nor this time was my freshly organised portfolio tucked under my arm, but I had been invited by the Faculty to observe this year's interview process.

After convincing the welcome party at the main door that I really wasn't a candidate and that I really was here to observe, I was shown to the interviewer's holding pen. Just like the candidates, interviewers are led into an equally large waiting area, filled with caffeinated Consultants, bustling representatives from West Midland's Deanery and an air of anticipation for the day's events.

The degree of organisation and preparation that had gone into the day was nothing less than military in its precision and execution from the outset. As trainees, we spend hours printing, laminating, organising and filling our portfolios, ready to jump straight to our latest QIP or poster presentation; we peruse the FICM website hoping to demystify the training programme; we ask colleagues to quiz us on previous interview questions to stand us in the best stead to shine on the day of the interview. Yet we perhaps forget, or like me overlook, the amount of time and effort that the interviewers also surrender to ensure that they extract the best from each candidate as they tentatively take their seats in the executive boxes.

I was fortunate to observe all stations in the process. The marking process and score collection, like all other aspects of the day, is a seamless and highly scrutinised process with opportunity throughout to quality assure. Marks from each interviewer are entered in silence into the electronic system before any form of discussion takes place. These marks are sent in real time to the master spreadsheet back in the main control hub.

The candidates came from a range of clinical backgrounds and with varying degrees of experience. I have been asked on several occasions how, for example, an ST4 Anaesthetic Registrar can be compared to a CT2 medical SHO at interview. The simple answer to this is, they're not. The level expected in the clinical stations and elsewhere is that of a senior SHO. A logical, considered and above all, safe approach to patient care is key, not necessarily the detailed pathophysiology of serum rhubarb. Similarly, the ST4 may have had more time to produce an international poster presentation but the overall scores from the portfolio station are so similar that, in reality, an extra point scored here can easily be picked up elsewhere, and the discrimination factor is minimal. So, don't panic! A word of advice though, make sure you have dividers in your folder. There is nothing more embarrassing, for all parties, than to watch the candidate shuffle through paper, desperately looking for the MSF with 'excellent' remarks!

Reflection is a word that fills some of us with dread, but a word that, like the 'difficult cannula' request, will follow us throughout our careers. Just as the person specification/matrix is examined several times, in multiple different stations throughout the day, so is your ability to reflect and learn from your previous experiences. I cannot over emphasise not overlooking this in your preparation for the big day. I would encourage you to look though the AoMRC guidance on reflection. This provides a very good foundation on which to build your reflections and thought processes. The story is not important; it's what you learned from it and how you will act/behave/do differently next time that the interviewers are interested in.

Another piece of advice is to make sure your presentation is concise, with neat handwriting, and in more than one colour; the style of the presentation is taken into account. Those that performed better were not necessarily the ones with the most written on paper, but they were neat and had reflected on the task in hand!

It may sound obvious, but another recurring theme throughout the day appeared to be the inability of some candidates to read the question fully. This was not more evident than in the task prioritisation station. Like most scenarios in Critical Care, there is no right or wrong answer. We were presented with comprehensive arguments for most combinations of answers. Yet several candidates failed to use all the resources presented to them. Training in ICM is renowned for its supportive and collective approach to patient management. Consultants are contactable and amenable to offer help and advice 24/7, as they are in the scenarios you will face in the more fictitious environments at interview. Make sure you make use of all the resources presented to you; attempting to brave it alone and fight fires without support, will result in just as much difficulty in the interview as it will in real life.

I was pleasantly surprised at how rigorous the quality assurance process is. Everything from the phrasing of the questions to the layout of the room is scrutinised by multiple people on multiple occasions. This ensures standards are maintained and comparable from year to year and from day to day. At the beginning of the day we were shown videos of mock interview stations and asked to mark various candidates' performances to ensure the interviewers were all assessing candidates to the same standard; reassuringly the vast majority were. Discrepancies in the marking system are flagged almost in real time as the results come in. This allows prompt analysis of the performance of both the candidate and interviewer, again to maintain fairness across the board. As I alluded to earlier, the matrix is examined in several places throughout the day, so if you 'fluff' a question in one station, you can redeem yourself elsewhere.

Given the degree to which I have harped on about reflection, it would be slightly hypocritical not to end on a note on what I have taken away from this process. The view from the other side of the table is an interesting one, filled with similar amounts of angst; whether it be to phrase the questions appropriately, ensure fairness and equality across the board and, ultimately, to ensure we are recruiting the best candidates to become our colleagues of the future. Without doubt those applying are already highly talented individuals with much to offer the specialty. We are not looking for the finished article,

that's what the training programme is there for, but to select those who have the potential to train and become the next generation of Consultant Intensivists. Perhaps my next visit to West Brom will be to ask the questions rather than simply observe. Either way, it's clear that the future is bright for our new cohort of trainees. I look forward to working alongside some of you in the future and wish you all the very best for your future careers in this great specialty.

I would like to commend staff from the West Midlands Deanery for turning a logistically challenging process into an exercise in precision that the military would be proud of. My thanks to Drs Daniele Bryden, Jonathan Goodall and Mark Carpenter for inviting me and allowing me to observe the day's events.

Top 10 Take Home Tips

- 1. Organise your portfolio**
- 2. Prepare to reflect**
- 3. Improve your handwriting**
- 4. Read the question**
- 5. Use all the resources available**
- 6. Dress appropriately**
- 7. Don't argue with the interviewer(!)**
- 8. Practice, practice, practice**
- 9. Reflect a bit more**
- 10. Smile**

MY EXPERIENCE OF REVISING FOR THE FFICM & PUBLISHING A BOOK

Dr Kate Flavin

Consultant in ICM & Anaesthesia
East and North Herts NHS Trust

Given the wealth of revision resources and past questions that were at my disposal to help guide me when I was working towards all parts of my MRCP and FRCA, I found the Final FFICM a daunting exam to revise for. I sat the exam in January and April 2016, when it was still in its infancy. There was limited information and guidance available and revision materials were scarce.

For the written exam, there were a couple of MCQ books available and one SBA book. I know that there are now a number of others that have been published since I sat the exam, and all look relatively good. I found that I had to do a reasonable amount of bookwork, and this included re-familiarising myself with all the big ICM trials, and any relevant work that had been published recently. This onerous task was ultimately made incredibly easy by two superb resources that I was advised to use by consultant colleagues:

- Steve Mathieu's excellent website, [The Bottom Line](#), which provides neat summaries of all the important papers and is updated regularly so is very current.
- ICU Trials, an app available on iOS and Android, which summarises succinctly most of the important ICM trials you should be aware of. It's actually pretty useful to have on hand when you're at work too.

e-ICM is the latest e-Learning for Health (e-Lfh) programme and another useful tool. It is dedicated to ICM, is mapped to the syllabus and contains approximately 700 interactive e-learning sessions as well as review articles and links to relevant guidelines. It is free to access for anyone who works within the NHS.

The other resources that I found useful were the question bank on [Crit-IQ](#) and the [PACT modules](#) by

the ESICM. Both these sites require a subscription fee (although a fellow trainee and I decided to split the cost between us!) but they are pretty comprehensive and I found the different learning styles kept things a little more interesting.

When it comes to the SOE and OSCE, the single best piece of advice I can give is to get yourself a revision buddy. As you all know, revising for postgraduate exams is a rather isolating, lonely experience. Working with someone else who is in the same boat as you are, will help you to focus. Also, the opportunity to observe your friend's approach and to obtain real-time feedback about your performance will, in turn, enable you to hone your viva technique and presentation. My buddy and I would pre-plan topics to revise and then viva each other over multiple cups of tea and biscuits.

“ e-ICM is the latest e-Learning for Health (e-Lfh) programme, and is dedicated to icm. It is mapped to the syllabus and contains approximately 700 interactive e-learning sessions as well as review articles and links to relevant guidelines. It is free to access for anyone who works within the nhs.

At the time I sat the second part of the exam, the only materials I could find were a few mock questions on the FICM website and one OSCE book. There were certainly no SOE books, like there are for the FRCA vivas. I was fortunate to have a number of friends who had taken the exam in the preceding three years, and they were kind enough to provide me with the questions that they had been asked in both oral exams. This was very useful, as a number of the questions came up again in my sitting, and I would encourage trainees to speak to their senior colleagues

who have taken the exam for some support.

There are also many fantastic revision courses across the country, with more springing up all the time. They often have a ‘hot topics’ lecture where they detail topical themes that they suspect might feature. Most run both a mock SOE and OSCE and vary between one and two days in length. These are well worth the money in my opinion.

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I was rather frustrated with the lack of suitable material to assist and direct my revision, and I promised myself that, should I pass the FFICM on my first attempt, I would make it my mission to publish an SOE revision text book. I was incredibly naïve: I didn’t have any idea about the processes involved, or how long it would take, or how many different people I would have to engage in long email chains! I simply contacted a publishing house that I knew had published books for other parts of the FFICM exam and FRCA SOE books with my idea.

I asked my revision buddy, Clare, to help me write the content. I then began the search for someone I could invite to be our editor. Sarah came highly recommended, so I approached her and luckily for us she accepted my offer. Cambridge University Press (CUP) expressed an interest very quickly, so I filled out their book proposal form and it was vetted by a panel before we were given contracts to sign.

The next nine months involved a series of writing, re-writing and editing for myself, Clare and Sarah. It was a vast amount of work and I hadn’t realised

exactly how long it would take us and how much of my time I was going to spend working on it. I am a perfectionist, so I would re-read through things multiple times to make sure there were no typos and all the tables and diagrams were formatted correctly before submitting each batch of topics to the editor at CUP. We then had the rather laborious process of requesting permissions to reproduce original work, although the majority of this process could be done using an online automated system, which made things much quicker than we initially worried it would be. Several journals and publishing houses requested payment for their permissions, but once I explained that the money would have to come out of my own pocket they all were incredibly kind and allowed us to use their material free of charge.

We finally submitted the completed manuscript at the end of May 2017; however, the book was not published until the following February. The intervening period was filled with lots of emails back and forth between myself and the copywriters and editor at CUP, and multiple read-throughs, re-edits and re-submissions. I found the team at CUP to be very supportive and reassuring, and they answered my queries, no matter how small or seemingly daft, very quickly.

With the experience I have now, would I write another medical textbook? I highly doubt it! It took such a long time and was so much work. But the feeling of seeing your name and all your hard work in print is pretty great and I’m very proud of what we achieved.

“When it comes to the SOE and OSCE, the single best piece of advice I can give is to get yourself a revision buddy. As you all know, revising for postgraduate exams is a rather isolating, lonely experience. Working with someone else who is in the same boat as you are, will help you to focus.

PSYCHOLOGICAL SUPPORT

Dr Honor Hixman

ST6 Advanced ICM, Joint Trainee in Anaesthetics and Intensive Care Medicine

Working in the NHS provides us with fulfilling and interesting careers, packed with variety and challenges. One of the less well recognised challenges is the potential for exposure of staff to psychological trauma through our patient interactions.

Psychological trauma in this setting can largely be divided into two categories. The first, known as Type 1 trauma, is the unexpected tragedy where any member of staff involved has the potential to be emotionally affected. Type 1 trauma is more likely if the patient is at extremes of age or if the incident involves serious injury or death. Type 2 trauma is more difficult to recognise, and is related to the insidious pressures of the job. Both can be extremely damaging to an individual's professional and personal life and can ultimately lead to leaving clinical practice, burnout or more serious sequelae.

Our home lives have the potential to make even experienced members of staff vulnerable. We all have certain patients about whom we can remember every single detail because it resonated within us. None is immune to this and it can be surprising which cases can continue to trouble us. It is important that we have the chance to talk about these cases, and especially our reactions to them, outside the opportunity to analyse the management in a traditional debrief or M+M environment.

Invariably a member of the critical care team will be involved in unexpected deaths around the hospital; this has two consequences. The first is that we are more likely to develop resilience due to increased

experience. The second is that we are uniquely placed to recognise the signs that our colleagues, both within critical care, but also allied specialties, are struggling to cope with their exposure.

After a type 1 traumatic incident anyone has the potential to experience symptoms of an acute stress reaction. These may involve sleep disturbance, flashbacks and physical symptoms such as palpitations and anxiety that can last for several weeks. Talking about experiences will help to process what you have

seen. Avoidance of social isolation and avoiding reliance on alcohol, drugs or excessive exercise is very important. If symptoms are severe or not resolving with time, counselling may be helpful to assist with processing what you have been through.

Following training in psychological support, a group of colleagues and I have been responding to type 1 incidents around the trust. Over the past two years I have facilitated confidential sessions for doctors, nurses and acute critical care practitioners. We discuss emotionally challenging cases, our reactions to them and other problems related to our work. I have been humbled by the honesty and openness of those attending and the feedback has been overwhelmingly positive. Knowing that your reactions are normal and that others have had similar reactions is hugely reassuring.

The 'feel free to cope' attitude is going. It is essential that we are introspective and sometimes allow ourselves the opportunity to not be ok. We need to take the time to genuinely ask those around us "How are you?"

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APPLYING FOR LESS THAN FULL TIME TRAINING

Dr Helen Cole

WICM Representative

Application for Less Than Full Time (LTFT) training is available to all of us. Life has its various demands and training LTFT enables some of us to be able to continue with our careers without leading us to breaking point. Many of us consider applying and yet don't, for fear of the repercussions. I'm currently going through the process and hopefully these hard-won pointers can help you out if you're considering applying yourself.

- **Know what you need.** This might sound obvious, but if you are clear in your application then there are likely to be fewer complications. Eligibility for LTFT will be assessed and prioritised as follows: Category 1 covers disability/ill health, and caring commitments. Category 2 covers unique opportunities for personal and professional development, and provides huge scope for diversifying your work/life balance. Men have equal rights to apply for LTFT for childcare but this is used far less.
- **Start early.** The application process should be dealt with promptly. Three months is a rough guide, but this may vary hugely. Start the process as soon as you know this is what you want to do.
- **Know who to contact, and then contact them.** Talk to as many people as possible. LTFT colleagues, TPDs, RAs, and the Deanery LTFT teams are all obvious places to start. Lots of Deaneries have LTFT trainee groups so it would be worth getting in touch if you have one locally. Some even run child-friendly journal clubs for those with childcare commitments. If there isn't one for you, is there a local needs? You could always set one up!
- **Gather support.** Talk with your supervisor about your circumstances and make sure you have support on hand should you need it. Remember that you are as valuable as your full-time colleagues; your training is just taking a bit longer!
- **It doesn't need to be forever.** Circumstances change. Dependents become less dependent, and you might want to speed through the latter stages of training. Just keep your supervisors informed.

- **Understand the impact on your finances.** Your wages will obviously be affected, and you'll need to know just by how much. You'll earn pro-rata and will be on a trainee contract for longer. Work out your incomings/outgoings. The cost of outsourced carers may be reduced but not the mortgage unfortunately!
- **Understand the impact on your length in training.** The JRCPTB have a handy online calculator you can use to work out just how long your training will be extended by (see link in the resources section below).
- **Know what you're entitled to, and what you're not.** Fixed days or flexible? This will be determined by local need. If you have fixed days that you cannot be on the rota, you need to discuss this at the earliest opportunity with each new rota coordinator. Efforts should be made to accommodate you but are not guaranteed. Similarly, you are entitled to be considered for LTFT training, but you cannot demand a specific whole-time equivalent work rate.
- **Keep all documentation.** All the application forms, emails to Deaneries and Trusts, everything. If you have a meeting, follow it up with a summary email.

Each Deanery and Trust will have a slightly different process for application. Your local Deanery website should have the specifics as they apply to you.

Would you like to help the Faculty find out more about ICM LTFT trainees? Please get in touch with us as wicm@fcm.ac.uk to register your interest. In the next year, we'll be quizzing you about the impact of LTFT upon trainees. Keep an eye out and thank you in advance for completing yet another survey!

Resources:

FICM Website LTFT Guidance: <https://bit.ly/2NSQYGo>

A to Z Guide of LTFT Training: <https://bit.ly/2NSRGDa>

JRCPTB time left in training calculator: <https://bit.ly/2QG9KPN>

ICU LOGBOOKS: A BRIEF OVERVIEW

Dr Mark ZY Tan

Northwest ICU Logbook Developer

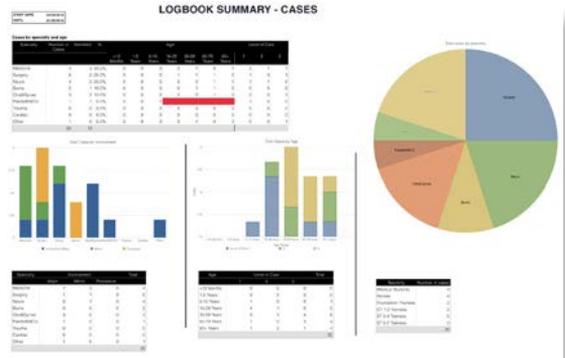
Logbooks are ubiquitous in medical training, serving purposes of standardising and structuring training, facilitating communication between trainee and trainer, identifying strength, weaknesses and assessing progression. Established medical colleges provide or recommend logbooks for their trainees. The Royal College of Surgeons endorse their intercollegiate eLogbook, while the Royal College of Anaesthetists' logbook has recently been superseded by their integrated Lifelong Learning Platform, demonstrating the ongoing value and investment into logbooks.

Logbooks can be either paper-based or electronic. However, this article will only look at electronic logbooks. Electronic logbooks can be either standalone apps/software, or spreadsheet-based.

Standalone apps are popular choices for doctors, and most specialties use these. They consist of a scaffold based on database software and a front-end user-display. These are often aesthetically pleasing and user-friendly. However, they are rigid in their data-collection fields and are often not modifiable. Moreover, problems may arise from software updates (e.g. iGasLog users lost their data when they stopped updating their software).

Spreadsheet-based logbooks are simple databases, usually built with Microsoft Excel or Mac Numbers type software. They may have formulae for auto-calculation and summaries. They are easy to use, often modifiable for one's own interests, and with Cloud technology, enable remote access and data entry. However, they might not be as aesthetically-pleasing as standalone apps.

The FICM recommends trainees keep a logbook, but do not specify nor endorse a specific logbook. New ICM trainees may be bewildered by the choice of logbooks available. Therefore, here is a short (but by no means exhaustive) list of some of the logbooks on the market.



Northwest ICU Logbook Summary Page

SPREADSHEET-BASED ICU LOGBOOKS

The Northwest ICU Logbook

<https://logbook.mmacc.uk/>

A personal, fully editable spreadsheet with summaries and graphs. Available in Microsoft Excel and Mac Numbers, with PDF instructions. This was designed by the author, Mark ZY Tan, an ICM trainee in the Northwest.

Pros

- Free, available for both Microsoft and Apple operating systems
- Easy to use, ARCP-compliant
- Able to be stored on a Cloud system (e.g. iCloud, Google drive, Dropbox)
- Mobile form input (Mac Numbers version) with offline capability
- Fully editable for individual interests, therefore can be used as a template
- Automatically generated summaries and colour graphs of data

Cons

- Still in its infancy
- May require basic spreadsheet manipulation knowledge for modifications or troubleshooting
- Excel version does not have mobile form input

Sunderland ICCU Medical Education ICU Logbook

<http://www.iccueducation.org.uk/>

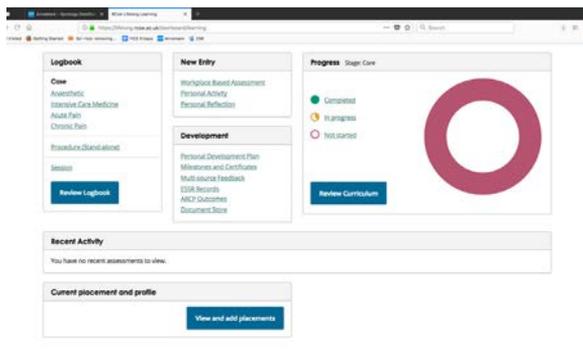
A Microsoft Excel spreadsheet with summaries. This spreadsheet has been around for some time and many trainees use it. It was designed by Peter Hersey, a consultant intensivist in Sunderland.

Pros

- Free
- Easy to use, ARCP-compliant
- Able to be stored on a Cloud system (e.g. iCloud, Google drive, Dropbox)
- Automatically generated summaries of data
- Offline capability

Cons

- No form function, therefore data-entry has to be via the entire spreadsheet
- Not as aesthetically pleasing as some standalone apps
- Password-protected therefore not modifiable



RCoA Lifelong Learning Platform

STANDALONE LOGBOOKS

MedELogbook

<http://medelogbook.com/>

An online logbook for doctors in ICU. Designed by Nish Arulkumaran, a research fellow in London.

Pros

- Free
- Easy to use, ARCP-compliant
- Simple and intuitive data input
- Generates Excel files for backup

Cons

- Requires internet connection
- No mobile input
- Not modifiable

LogICU

<https://m-pax.net/logicu.html>

An android-based logbook for ICM doctors.

Pros

- Offline data input
- Generates Excel files for backup
- Mobile input (Android)

Cons

- Cost (£11.99 on Google Play at time of writing)
- Not modifiable
- Last updated in 2014

Royal College of Anaesthetists' Lifelong Learning Platform

Integrated portfolio and logbook for anaesthesia, pain medicine and ICU

Pros

- Linked to RCoA portfolio and curriculum
- Beautiful user display and interface

Cons

- Only available to RCoA members
- ICU logbook is very basic and lacks detail
- Offline capabilities not set up yet (there are future plans for this)

In conclusion, logbooks are a valuable resource for trainees to record, reflect on and present their training progression. Different logbooks have their own advantages and disadvantages; there is no perfect logbook. FICM allows trainees to choose their own logbooks, as long as the ARCP requirements are met. This article has analysed several logbook options and will hopefully help trainees choose the most appropriate logbook for their own purposes.

Happy logging.

CURRICULUM UPDATE

The curriculum redesign continues apace. The primary focus has been on condensing our current domains into fewer 'Higher Level Outcomes'. It's a challenging process, particularly balancing the need to ensure the recognition of the competencies gained in a dual speciality. Once this work has been completed, and an accompanying 'purpose statement' written, the package will then be submitted to the GMC for initial approval. However, this will only be the beginning of the process. There will be a lot of further consultation, discussion and undoubtedly alterations before any new curriculum comes into action.

TRAINEE REPRESENTATIVE ELECTION

Notice is hereby given that an election for the FICM Trainee Representative Elect will be held on **23 October 2018**. This is a fantastic opportunity to develop your leadership skills and get more involved with the work of the Faculty.

Important dates

- Nominations closed on **21 September 2018**.
- A voting link will be sent out to all trainees on **Friday 28 September 2018**, which will include the nominee's statements.
- Votes must be cast by **5pm on Monday 22 October 2018**.
- The results will be published on the FICM website on **Friday 26 October 2018**.

For more information visit the FICM website: <https://bit.ly/2eUXqtz>

GROSS NEGLIGENCE MANSLAUGHTER

I'm sure you will all be aware of the outcome of Dr Bawa-Garba's appeal; the result means that she will be restored to the Medical Register. The case has highlighted many concerns from both the general public and the medical profession, particularly surrounding the law in this area.

The Williams review looked into this (<https://bit.ly/2sN7ADw>), and the Academy of Medical Royal Colleges will be central in developing guidelines from this. It will include recommendations about expert witnesses and also extensive advice on reflective practice. Interim guidance was released in March 2018: <https://bit.ly/2MLsry6>

FICM Trainee Representatives sit on the Academy's Trainee Doctors' Group, and so you can be sure that your issues are always highlighted.

ANIMATION ON ARCPs FROM HEE

This helpful video guide will take you on a journey on the ARCP process and provide useful tips. <https://bit.ly/2NOp1MD>

ICM e-PORTFOLIO UPDATES

Tickets should be sent under the Assessment menu on the ePortfolio and not from the curriculum pages. The curriculum pages work slightly differently. They are purely there as a prompt for you to use to contact your Educational Supervisor to say a competency is now adequately evidenced and ready to be signed off.

If your Educational Supervisor needs access to the ICM ePortfolio they can email us at contact@ficm.ac.uk. We will then assign them the role of ICM Educational Supervisor. You will then be able to link your ES to your admin post.

Although the Faculty has editing and admin control over the information added to the portfolio, we do not have any control over the back-end software that runs the system; this is entirely controlled by NES. If you contact the NES helpdesk please be aware that they refer *all* queries to the colleges/faculties as a matter of routine, even if the issue is a back-end one. Faculty staff will do our best to help you with any problem you are experiencing, but please be aware that if the issue is software related we will be unable to fix it and will have to raise a central helpdesk problem with the NES programmers to resolve the issue.

Once you have finished a training stage you will need to inform your ICM Regional Advisor or Training Programme Director. They will then go into your ePortfolio and complete the relevant Training Stage Certificate. The RA and TPD will then inform the Faculty whereby we will then open up your next training stage in your ePortfolio.

e-ICM

There is a new website containing all the key information (registration, module content, release dates) about this resource: <https://bit.ly/2cWvuSb>

FFICM EXAM INFORMATION

The next FFICM MCQ will take place at the RCoA on **8 January 2019**. The application window for this sitting opens on the **15 October 2018** and closes on the **22 November 2018**.

Details about the FFICM examination, including the regulations and fees can be found here: <https://bit.ly/2xwQtHg>

The Faculty has decided that it will, on a case-by-case basis, listen to requests from trainees who wish to sit the MCQ component of the FFICM in the very late phase of their Stage 1 training. This is on the proviso that the MCQ sitting in question, falls in the last few weeks of the trainee's Stage 1 training and that the trainee's Regional Advisor confirms that the trainee is on course to complete all of their required Stage 1 competencies.

e-PORTFOLIO USER GUIDANCE

The current guidance for trainees was recently updated. This is available on the FICM website: <https://bit.ly/2xkgElo>

It's also available in your ePortfolio under
-> Help
-> Information
-> User Guides

2019 FICM ANNUAL MEETING

The 2019 FICM Annual Meeting will be held on **Thursday 13 June** at the RCoA in London.

Next year, the event will be themed around end of life care and we are currently working on an exciting programme. The full programme will be available before the end of the year so keep an eye on our website and Twitter for more information.

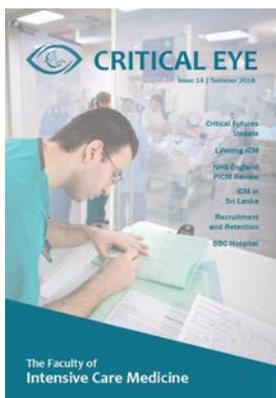
GPICS V2 CONSULTATION

The public consultation draft for GPICS V2 will be available in October. As the future of the specialty, we would really value your views. Full details and how to comment will be available on the FICM website.

CRITICAL EYE

The latest, Critical Eye is now available on the FICM website. This issue can be found here: <https://bit.ly/2mYgr1N>

If you would like to contribute to the next issue (due in January 2019) please get in touch at contact@ficm.ac.uk



CONSULTATIONS

The FICM keep abreast of relevant consultations from various organisations. Since the last Trainee Eye we have responded to:

- BMA, RCP & GMC - Clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent.
- AAGBI - Safe transfer of brain injured patients
- RCPCH - Care of children in emergency settings
- NICE - Emergency & Acute Medical Care
- NHS England - Do5 Service Specification

RECENT FACULTY PUBLICATIONS

Guidelines on the management of Acute Respiratory Distress Syndrome (ARDS)

An evidence based framework for the management of the adult patient with ARDS. Written in conjunction with the ICS and supported by the British Thoracic Society.

You can view the guidance here:

<https://bit.ly/2tZl1DG>

Care of the critically ill woman in childbirth; enhanced maternal care 2018

Recommendations relevant to the care of pregnant or recently pregnant, acutely or chronically unwell women, who require acute hospital maternity and critical care specialist services. Published jointly by the Royal College of Anaesthetists, Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Intensive Care Society, Faculty of Intensive Care Medicine and Obstetric Anaesthetists' Association.

You can view the guidance here:

<https://bit.ly/2OBT7Cy>



THE DECEASED DONATION COURSE
INTENSIVE CARE MEDICINE



Blood and Transplant

For More Details & Applications Contact:

ODTmedicaleducation@nhsbt.nhs.uk

0191 202 4515

Lectures & simulation training to gain knowledge and skills in:

Diagnosing death and organ donation.

Leading end of life discussions and approaching for organ donation

Withdrawal of life sustaining treatment and the safe diagnosis of death

Develop capacity to make informed ethical and legal choices in the context of organ donation.

Develop ability to work productively with others, particularly the Specialist Nurses in Organ Donation.



Free

2 day course

(includes accommodation)

ICM trainees

ST5 or above

**Consistently evaluated
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Domain 8: End of Life
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Course developed with
FICM and ICS
engagement

2018 FULL

Nottingham – September FULL
London -Oct FULL

2019 Available

Newcastle Jan 28th & 29th
Salford Feb 26th & 27th

More Dates will be released as
soon as available.

WOW

working
out
wellbeing

Wellbeing Day

A training day dedicated to the wellbeing of anaesthetic & critical care doctors & practitioners of all grades.

01.02.2019

Education Centre, RVI, Newcastle upon Tyne

AGEING & VITALITY / BURNOUT
BULLYING / YOGA / MINDFULNESS
COMPASSION / MEDITATION
WORK-LIFE BALANCE / FINANCE
MENTORING / BIKE MAINTENANCE
PHOTOGRAPHY COMPETITION
PARENT & BABY ROOM

*Fees: £35 for consultants, £25 for trainees/ACCPs
£10 for anaesthetic and critical care nurses, ODPs. Includes all talks, workshops,
refreshments and a healthy lunch.*

Limited tickets so get yours early!

*For more information and to register go to
www.workingoutwellbeing.co.uk*



MDU



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CO-NAVIGATE

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