TRAINEE EYE

THE TRAINEE MAGAZINE FOR THE FACULTY OF INTENSIVE CARE MEDICINE

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Observing ICU: From Croatia to Nottingham

The Faculty of Intensive Care Medicine

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Your Lead Trainee Representative

Dr Matt Rowe
FICM Lead Trainee Representative

As my term as Lead Trainee Representative draws to a close, I have no doubt that I am leaving the role in good hands. Waqas has already been an outstanding advocate for trainees during his time as deputy and I'm excited to see what he and the newly elected Deputy Trainee Representative will be doing over the next year.

The past two years have been an enormously rewarding challenge and I have felt privileged to be able to represent the interests of the trainee body on a national level.

Flow of information

I'm delighted to say the StR Subcommittee continues to go from strength to strength and there are plans to improve the flow of information between this group, the elected regional representatives and the FICM leadership. I'd like to thank each of the doctors I've worked with in this group for their ongoing hard work towards ensuring that training in ICM is to the benefit of all its trainees.

There is however, still work to be done. With the, as yet unpublished, StR-led trainee survey results demonstrating a need for improvements on a range of issues. The StR Sub-Committee and I are, at the time of writing, working on analysing these survey results and preparing them for publication, so we hope this will be with you soon. I will be staying on in some capacity, continuing to work with the StR Subcommittee, to ensure that any action points generated from this work are carried forward in a way that delivers meaningful change for trainees in ICM.

Additionally, I'm proud to say that the first iteration of the FICM Reverse Mentoring project is approaching its conclusion and is already starting to generate some meaningful action points that I believe can make a real difference to reducing the impact of the challenges faced by this group of colleagues. I hope to be able to expand the project out to include the wider ICM educational leadership community over the next year or so.

Thank you

Finally, I'd like to end by saying thank you to the wider trainee cohort for giving me the opportunity to represent your interests. I can only hope I've done you justice. It has been an immensely rewarding process and I'd encourage any trainee reading this to put their names forward in the future.

Your Deputy Trainee Representative

Dr Waqas Akhtar
FICM Deputy Trainee Representative

I would like to start by thanking Matt Rowe for his excellent leadership of the STR Subcommittee and trainee representation across FICM Board and committees over the past two years. Only being recently formed the StR Subcommittee is growing in strength each year to bring trainee representation to the forefront of policy at FICM.

Matt has also created and led the FICM Board reverse mentorship project which will have significant impact on the direction the Faculty with our diverse membership. I wish him all the best for the future and am sure he will continue to have a big impact on the future of intensive care in the UK.

Tumultuous times

The past few months have been tumultuous time for training in the UK, notably with the Royal College of Anaesthetists' EGM. I believe what this and the wider discussion in the medical field orients around is what it means to be a doctor in the UK and importantly the training it takes to achieve this. Intensive Care Medicine has made big strides over the past decades in the formation the Faculty and development of single and dual programmes, and as it looks to become its own college we cannot loose focus on the state of training in ICM.

The national StR Survey results will soon be released and really highlight a number issues that most trainees will be well aware of. This coming year as I take over the Lead Trainee Representative role it will be my focus to ensure FICM delivers actionable outcomes from this to make the lives of trainees better and address difficulties in training and subsequent careers.

Career planning

Some issues the Faculty is currently addressing include development of career planning support for single and dual medical trainees in trusts which may not historically have this role. There is also work on adjustment of exam eligibility at an earlier stage in training and the content of these exams considering the independent investigation earlier this year. There is also scoping work with MDRS around dual specialty application timeframes to increase flexibility and opportunities to apply for dual programmes.

We need to ensure that trainees voices are heard strongly at the FICM Board which is why it essential we provide channels for you to report issues directly to us. If you are unable to resolve training issues locally then we need to know about it. The regional trainee representatives are an excellent channel to raise this regionally and we are establishing a direct link to the FICM StR Subcommittee so we can centralise information on issues and deal with them from the top. I am also more than happy for you to contact me directly at waqas.akhtar@nhs.net.

Having spent a year on the Board at FICM I have no doubt of the intentions and incredible hard work the members of the Faculty give to improving the quality of training with the limited resources provided. With your feedback and FICM's engagement I am certain we can continue to improve with the aim to make ICM training the best of any specialty in the NHS.

Top ICM Podcasts

Dr. Jonathan La-crette
Respiratory and ICM Dual Trainee
Luton and Dunstable Hospital

With the average Brit commuting an hour to work, each day, this article will direct you towards my favourite intensive care podcasts.

Because of the unfortunate nature of rotational training, many of us commute large distances. I work in the East of England, the geographically largest deanery in England, and after a stressful day at work, made more stressful by a sizeable commute, I often lack the energy to crack open a book. Even the thought of spending the few remaining waking hours on medicine instead of with loved ones seems like a fast-track to burnout. The remote working revolution that has saved Brits 73 minutes a day (and probably a few marriages) will pass us by. Unlike some colleagues intensive care doctors do not have the option to work from home, but we can make that 'wasted time' work for us. Listening to these podcasts won't save your life but could save your work/life balance.

EmCrit

The EmCrit podcast headed by New York intensivist Dr Scott Weingart, is my favourite ICM podcast. These are weekly podcasts ranging from journal clubs, one-on-one interviews, clinical scenarios, interesting cases and literature updates. Recent shows have centred on APRV, crashing anaphylaxis and asthma, reduced dose peripheral systemic peripheral fibrinolysis in massive PE and massive haemorrhage protocol. Episodes range from 30-90 minutes. The website www.Emcrit.org includes the show notes and a comment section, where the global critical care community can discuss an episode. Scott is an ED physician, so his shows naturally have a resus slant, but he balances it out with shows focusing on wellbeing topics like avoiding burnout or financial literacy for doctors.

Resus Room

If you're looking for a homegrown, British-based podcast, look no further than the Resus Room. The show is led by prehospital Emergency Medicine consultant, Dr Simon Laing and paramedic James Yates. Shows are presented as 'Papers of the month', where three recently published papers are critically appraised; or as 'Roadside to Resus', where the management of conditions, such as Pnemothoraces and Traumatic Brain injury, are discussed, from pre-hospital to the emergency department. Shows are released fortnightly and the website www.resusroom.co.uk has quizzes where CBD points can be earned.

Pulm-Peeps

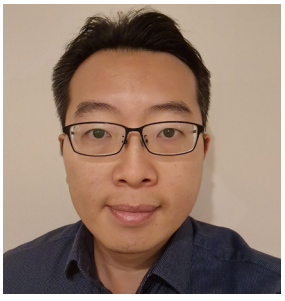
Honourable mentions to the Pulm-Peeps, an American podcast focusing on respiratory and critical care. As the podcast is hosted by Pulm-Crit residents, the American way of saying dual training respiratory and critical care registrars, this is a podcast by trainees for trainees.

FICMLearning

The FICM have a bi-monthly podcast on the FICMLearning webpages; the latest being on 'Research in ICM'. Not to forget our anaesthetic colleagues, the RCoA has 'Anaesthesia on Air', a podcast aimed at UK Anaesthetists. They've recently released a 12-part series for novice anaesthetists covering the airway, anaesthetic drugs, anaesthetic emergencies and inducing, maintaining and emerging from anaesthesia.

There's an intensive care podcast for all critical care trainees, regardless of partner specialty, so download now!

International Critical Care Fellowship in Toronto



Dr Jun Jack Wong
Consultant in Critical Care and Acute Medicine Unit, Aintree Hospital, Liverpool

Having triple accredited in Intensive Care Medicine, Respiratory Medicine, and General Internal Medicine, I have a cross-trust post that enables split working between intensive care and lung transplant medicine. Cross-trust working is not everyone's cup of tea. From the perplexed looks I occasionally get when describing my working life, some clearly prefer the familiarity and routine that comes with traditional single-site working. For me, variety is important and change (of working pattern, specialty, *and* hospital) is as good as a break.

After spending most of my training in Intensive Care Medicine and Acute Medicine in the North West (Mersey) deanery, I often wondered whether the skills and knowledge obtained was transferable across health systems and countries. My interest in exploring this was further piqued following some experience in a ESICM NEXT fellowship in several critical care units in Europe in countries such as the Netherlands, Germany and Spain, where I witnessed a wide variety of approaches to treat the same conditions we see in Liverpool.

Personal challenge

I decided to go to Canada as it was completely unknown to me as a personal challenge. One of the senior consultants I worked with had been before and had kindly put me in touch with the Critical Care Fellowship Program Director in Sunnybrook Health Science center, the largest trauma center in Canada. The University of Toronto otherwise runs a well-established international critical care fellowship programme, where it provides exceptional clinical, educational and research experience in various hospitals in Toronto. I had a phone interview and I applied before completion of my CCT and FFICM exam, hence I used MRCP (UK) as my qualification which was accepted. The process went smoothly and soon I received a contract and a proposed start date. I did the fellowship as post-CCT credentialing which in hindsight was the right decision for me as it took away any stress from UK portfolio and urgency to return to UK for subsequent placement especially during the pandemic. I have met two other UK trainees from London and Manchester in the same department who did it as OOPT (Out Of Programme Training) which counts towards their ICM training.

The work permit and medical license application stage was essential but arduous. It involves submitting biometrics information in person (in London), health screening, criminal background check, submission of all paperwork relevant to medical qualifications and more which cost around £1,500. Thankfully, the University of Toronto has a comprehensive induction booklet and a well-supported Facebook group that guided me through the process. The alumni in the group were also extremely helpful and patient in answering queries.

Eventually, I started my fellowship in Sunnybrook Health Science center in July 2019. It was an 80 bedded critical care unit scattered across various Level 2 and Level 3 units in the hospital with Trauma, Neurosurgery, Cardiothoracic, Burns, Plastic surgery, Stroke, General surgery and General Medicine. I worked with fellows from all over world including Argentina, Brazil, United States, Singapore, India, Egypt, Israel, Belgium, Turkey, Switzerland, Sweden and of course Canada. Despite the vastly diverse background and origin we quickly worked as a well knitted team as the clinical job itself is fast paced and challenging.

The consultants (called 'Staff') who I worked with were mostly well known for their research effort globally yet they were extremely down to earth. The junior doctors (called 'Residents') we worked with came from various specialties including Family Medicine and Obstetric and Gynaecology yet they were hardworking and receptive to learning in critical care placement. The critical care nurses were highly skilled and friendly, not to forget that they were also a diverse group from all walks of life which enriched the working environment and interactions. The respiratory therapists are a godsend amidst the busy clinical job as they help with intubation, ventilation, transfers (independently without clinician presence most of the time), spontaneous breathing trial, weaning and extubation. They are equivalent to the UK ODP, respiratory physiotherapist combined and more.

Eye-opening

It was an eye-opening experience to witness the discrepancy in practices and culture as well. There was no four hour wait target in emergency departments, therefore it is quite often that we have a handful of patients receiving critical care treatment in a busy ED as outliers. The concept of goal of care was also different to the UK such that there is a lower threshold in admitting patients with multiple co-morbidities and limited function to critical care. The governance process is also slightly more lenient comparatively which enables rapid deployment of new ideas and innovation especially during the pandemic.

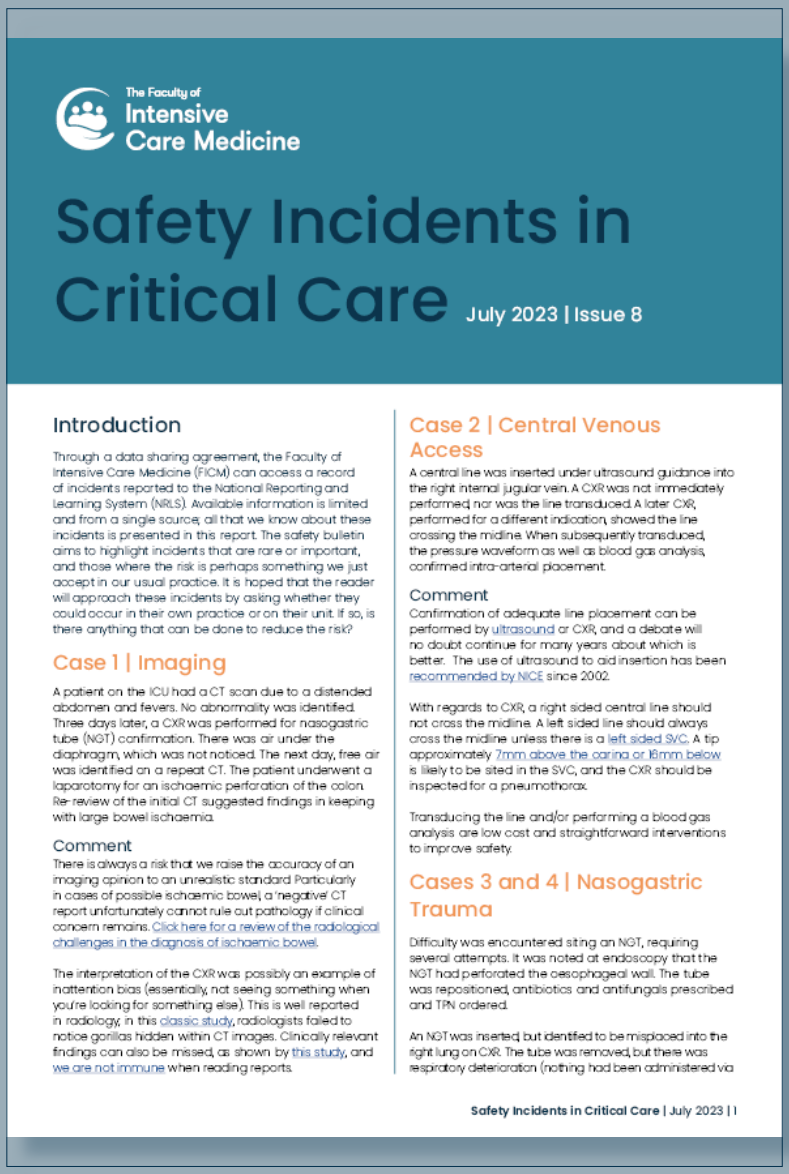
The pay is variable depending on which trust you work with. My salary as an international fellow was similar to the salary of a senior registrar in the UK but the work hour was up to 50 to 60 hours per week in average due to the 24-hour on-call shifts. Despite that, due to the clear delegation of responsibilities within the multi-disciplinary team

I found the relative long hours very manageable as I was mostly called to make medical decisions, troubleshoot, perform advanced clinical skills such as intubation or line insertion and prescribe (which was often acceptable verbally over the phone) while most of the other tasks were delegated to nurses or respiratory therapist. This system enabled clinicians to look after a larger group of patients.

There was a high quality weekly regional teaching programme for international and local fellows and there were also opportunities to do elective placements of up to one in every 12 months which was not limited to critical care. There were a lot of research opportunities and the weekly journal club was chaired by research-experienced consultants.

Toronto is vibrant and lively. There are always some activities and events around the city that suits everyone. The landscape for such a modern city is particularly impressive with cyclist friendly route, islands, green belt and beaches within reach of public transport. What's more important is that the city is bustling with amazing food scene where most of the international food is authentic and has been the sole culprit for my rising cholesterol after two years of fellowship.

It was an extremely invaluable experience and I had not regretted the decision at all looking back. Not only had I gained more confidence and experience but more importantly I had also gained a group of friends that I would otherwise never meet if I decided to choose the advised 'safer path' of getting a consultant job in the UK straight after CCT.


The Faculty of Intensive Care Medicine

Safety Incidents in Critical Care

July 2023 | Issue 8

Introduction

Through a data sharing agreement, the Faculty of Intensive Care Medicine (FICM) can access a record of incidents reported to the National Reporting and Learning System (NRLS). Available information is limited and from a single source, all that we know about these incidents is presented in this report. The safety bulletin aims to highlight incidents that are rare or important, and those where the risk is perhaps something we just accept in our usual practice. It is hoped that the reader will approach these incidents by asking whether they could occur in their own practice or on their unit. If so, is there anything that can be done to reduce the risk?

Case 1 | Imaging

A patient on the ICU had a CT scan due to a distended abdomen and fevers. No abnormality was identified. Three days later, a CXR was performed for nasogastric tube (NGT) confirmation. There was air under the diaphragm, which was not noticed. The next day, free air was identified on a repeat CT. The patient underwent a laparotomy for an ischaemic perforation of the colon. Re-review of the initial CT suggested findings in keeping with large bowel ischaemia.

Comment

There is always a risk that we raise the accuracy of an imaging opinion to an unrealistic standard. Particularly in cases of possible ischaemic bowel, a 'negative' CT report unfortunately cannot rule out pathology if clinical concern remains. Click here for a review of the radiological challenges in the diagnosis of ischaemic bowel.

The interpretation of the CXR was possibly an example of inattention bias (essentially, not seeing something when you're looking for something else). This is well reported in radiology, in this classic study, radiologists failed to notice gorillas hidden within CT images. Clinically relevant findings can also be missed, as shown by this study, and we are not immune when reading reports.

Case 2 | Central Venous Access

A central line was inserted under ultrasound guidance into the right internal jugular vein. A CXR was not immediately performed, nor was the line transduced. A later CXR, performed for a different indication, showed the line crossing the midline. When subsequently transduced, the pressure waveform as well as blood gas analysis, confirmed intra-arterial placement.

Comment

Confirmation of adequate line placement can be performed by ultrasound or CXR, and a debate will no doubt continue for many years about which is better. The use of ultrasound to aid insertion has been recommended by NICE since 2002.

With regards to CXR, a right sided central line should not cross the midline. A left sided line should always cross the midline unless there is a left sided SVC. A tip approximately 7mm above the carina or 18mm below is likely to be sited in the SVC, and the CXR should be inspected for a pneumothorax.

Transducing the line and/or performing a blood gas analysis are low cost and straightforward interventions to improve safety.

Cases 3 and 4 | Nasogastric Trauma

Difficulty was encountered siting an NGT, requiring several attempts. It was noted at endoscopy that the NGT had perforated the oesophageal wall. The tube was repositioned, antibiotics and antifungals prescribed and TPN ordered.

An NGT was inserted, but identified to be misplaced into the right lung on CXR. The tube was removed, but there was respiratory deterioration (nothing had been administered via

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The eighth issue of the *Safety Incidents in Critical Care* Bulletin is now available. The Safety Bulletin covers safety-related issues in critical care and specific topics.

NEW SAFETY BULLETIN OUT NOW!

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ICU observership at Nottingham University Hospitals NHS Trust

Dr Vjeran Leventic

Anaesthesiology and Intensive Care Trainee

University Hospital Centre Osijek, Croatia

Having the opportunity to work in two healthcare systems in parallel, as a Resident Medical Officer in the UK since 2017 and an anaesthesiology trainee in Croatia since 2018, I have always appreciated the insight I gained into how different systems handle the same problems.

However, since I exclusively worked in private hospitals in the UK, I was shielded from the realities of end-of-life decisions and their implications. In Croatia, I was often exposed to death and human suffering, especially during COVID. Unfortunately, due to the lack of staff and resources, it was difficult to provide the standard of care that we would have wished, despite the efforts made. Motivated by a deep curiosity about NHS practices, I pursued an ICU observership at Nottingham University Hospitals NHS Trust (NUH). Little did I know that my experience there would profoundly impact the way I practice Intensive Care Medicine.

Openness and transparency

Soon after arriving at the NUH ICU, I was struck by the remarkable openness and transparency with which end-of-life decisions were approached. Decisions to withdraw or withhold life-sustaining therapy (LST) were made daily, and patients would often arrive in ICU having already had conversations regarding DNAR and escalation of therapy. From the moment a patient entered the hospital, families were actively involved in healthcare decisions. In Croatia, such decisions were seldom openly discussed or extensively communicated with families, with most discussions occurring between physicians. A lack of legal framework and guidelines in Croatia leaves healthcare professionals without clear directives and means that decisions to withdraw or withhold LST are much less common.

Frameworks

Two frameworks I've seen used in the UK deeply resonated with me. The first is a structured approach to breaking bad news, known as 'Breaking Bad News as a Shakespearean Tragedy'. This method provides a framework for delivering sensitive information with empathy and professionalism. I found this approach enlightening and appreciated the emphasis on compassion and telling a coherent story understandable to families. The second is 'MORAL Balance', a framework for ethical decision-making based on Beauchamp and Childress's four principles of medical ethics[4]. Together, these methods become a powerful tool for making and effectively communicating difficult decisions at the bedside.

Advocate for change

My time as an observer at NUH has given me the tools to advocate for change in how we approach end of life discussions in Croatia. This transformative experience serves as a testament to the power of cross-cultural experiences.

Reflection on the experience from Dr Dale Gardiner (NUH ICU Consultant) "Having an international observer like VJ gave NUH the opportunity to appreciate that our normal may not be the world normal. Additionally, you can never truly understand a topic until you can teach it. Demonstrating and explaining our approach to end-of-life care and decision making was educational for us in NUH".

Working in a dual consultant post in Emergency Medicine and ICM

Dr Craig Walker
Consultant in Critical Care, St John's Hospital, Livingston

I'm a Dual Emergency Medicine and Intensive Care Consultant in NHS Lothian. I graduated University in 2003 and started my consultant post a decade later, working between the Royal Infirmary of Edinburgh (EM) and St John's Hospital in Livingston (ICM).

I think it's important to emphasise early on that my experience will be different to your experience — a lot of changes happen in training, curricula and exams over the course of two decades. Challenges I've faced may be very different to challenges you will face; my Job Plan will likely be different to your Job Plan. Don't let my article sway you one way or another. I can only tell you how things have been for me, not how things will be for you. Sermon over, here are some specifics.

What was the biggest challenge in securing an EM/ICM dual consultant post?

Aside from jumping through the formal examination hoops, CV-building and trying to tick the "good guy" box so that people would actually want to work with me, the biggest challenge came down to two things: (1) few people in Scotland had done it before, and (2) out-of-hours working. The second issue was the most challenging. In the far more established anaesthesia/ICM training pathway, many consultants end up doing daytime anaesthesia sessions and doing all their out-of-hours commitment in ICM. This can work well given that a large bulk of anaesthesia workload centres around managing elective cases done during daylight hours so there is more need for daytime cover and comparatively less need for out-of-hours consultant cover. Anaesthesia and critical care are usually part of the same directorate and that can also make job negotiations easier: you are still providing out-of-hours cover for the same overall directorate/department.

In EM, however, there is a definite need for evening and weekend consultant cover. The result is that

> **It's great to see things from different perspectives and gain insights into the inner working of different specialties and departments. It's interesting to go from referring patients in EM and then to be the one receiving referral calls from the ED or inpatient specialties in ICM.**

you end up approaching two different departments belonging to different directorates and both may want you to do full out-of-hours work for them. I think that for the vast majority of people, that is unreasonable to expect and not sustainable — and therein lies the difficulty and the start of negotiations.

Was there a clear path for me to follow or was my dual consultant post an 'in-house' negotiation?

It was very much the latter. There had only ever been one previous consultant in my region who worked in a combined EM and ICM post (doing full out-of-hours work in ICM and in-hours work in EM). He later changed to sole ICM.

I needed to be proactive. Well before my last 12 months as a trainee, I had worked out what my first to fifth preferences for consultant posts and Job Plans would look like and had communicated my first and second choices to the relevant Clinical Leads (being clear that this was a Wish List, not an expectation!). I had also visited the EM and ICM directorates of the other hospitals lower down my list to see what potentials there were for combined posts either contained within one NHS Board or across Boards. Although departments were open to the idea, there had never been dual ICM/EM Consultants in the other hospitals and the logistics would have been more difficult.

When I became eligible to apply, there had already been two consultants appointed to the largest of the critical care units in the region over the preceding 12 months. Thankfully, the ICU in St John's Hospital in Livingston had a potential post available and they were also the regional Maxillofacial, ENT, Plastic Surgery and Major Burns Centres. I thought that setup may also help provide additional opportunities for advanced airway skill maintenance and practice in a Centre of Excellence. Out-of-hours, critical care was covered by a mix of anaesthetists and intensivists who also covered Obstetrics, so there was no requirement for me to do out-of-hours work for ICM.

Most importantly, I had done previous anaesthesia and ICM attachments in the same hospital and absolutely loved the mix of consultant and other senior staff personalities in the departments: so many were fun, supportive, exceptionally talented, actively encouraged discussions around potentially challenging decisions and opinions, and absolutely hilarious. I was keen to be a part of the department, particularly with the strong interworking relationships between the anaesthetists and the intensivists.

I also wanted to be part of the excellent Emergency Medicine team in the Royal Infirmary of Edinburgh, the busiest ED in Scotland and soon-to-be Major Trauma Centre; it my first choice for EM posts. Consultant posts were advertised for there and, following successful interview, they were keen that I stayed, offering to fund not only my EM post but also the first year of an ICM consultant post in Livingston. If everything went well in that trial and all sides were happy, critical care in St John's would take over the ICM funding thereafter. Thankfully, we were and they did.

What does my Job Plan look like?

In terms of EM and ICM split, this has changed very little over the past nine years as a consultant. I work full-time (currently 10 PAs). 70% of my time is contracted to EM with 30% in ICM. I do all my out-of-hours work for EM. This amounts to a weekend frequency of 1 in 6 and other weekday evenings (17:00–23:00)

and nightshifts (covering until 02:00 then on-call until 07:30). My total out-of-hours PAs is 3.25. It is worth noting that the consultant contract for Scotland states that no more than 3 PAs per week should be out of hours other than in exceptional circumstances [1] — that is partly why I believe that doing full out-of-hours for two different specialties is unlikely to be sustainable or desirable for most people.

I work a block of one week in ICM every 8 weeks. This allows for better continuity of care for patients and also makes rota planning much easier for both departments as I can block out my ICM weeks well in advance. Up until this year, I also did an Extra PA (EPA; an additional 4 hours per week) in daytime EM. I requested it after my first year given that working in two specialties meant I ostensibly had two part-time jobs with a significant proportion of out-of-hours work. I therefore thought it might be a good idea to optionally increase my daytime EM sessions. I'm not sure if this was needed clinically. It also translates into very little take-home pay due to tax thresholds so, both in terms of work/life balance and finance, I've dropped the extra PA for this year and I'll see how it goes.

Separately, I'm a Simulation Lead for Emergency Medicine and now receive Job-Planned time for that. I'm an EM Clinical and Educational Supervisor and the Morbidity & Mortality Lead for critical care in St John's Hospital.

How do I feel about it now and would I change anything?

I'm very happy with my combined EM and ICM role. Although they can both be high-intensity, high-pressure environments, they complement each other. I get to help manage some of the sickest (and for me, the most interesting) patients in the hospital right from the time they arrive and are brought in to Resus and then later in ICU and thereafter. I get to help coordinate large teams in the ED and then smaller teams in the ICU. I get to work closely with some of the most exceptionally talented nurses and allied specialists in the hospital across both specialties, each bringing their own unique knowledge and skills sets, and together we provide truly team-based care.

Every specialty has its 'heart-sink' issues. Switching from one to the other and back itself often helps provide some respite: When I get disheartened by managing a massively overcrowded ED at >120 patients and at >400% capacity due to a total lack of inpatient beds, I often get to switch and manage less than 10 patients to a far more detailed degree. When I get disheartened by the slow decline of longer-stay ICU patients or the drip-drip emotional impact of having

repeated conversations with families whose relatives continue to deteriorate despite escalating therapies and all interventions, I sometimes get to switch to the ED, relocating joints, managing fractures, cardioverting arrhythmias, coordinating medical teams and helping to relieve distress in other ways.

It's great to see things from different perspectives and gain insights into the inner working of different specialties and departments. It's interesting to go from calling inpatient specialties predominantly to refer patients in EM and then to be the one receiving referral calls from the ED or inpatient specialties in ICM. [That actually serves as a constant reminder to try and remain grounded and friendly when receiving referral calls; it will surprise no-one that some people sound very polite and lovely when referring a patient to another specialty but go right to the opposite side of the incivility spectrum when receiving a referral themselves].

Are there any downsides?

There are downsides: keeping up-to-date in two high-intensity, acute specialties can be tricky. Working in two departments in different hospitals means that I see staff in both less frequently. I had to accept early on that I needed to give up seeing Paediatric EM patients: I work in an adult ED and an adult ICU; continuing to see paediatric presentations would have meant working across three departments and essentially having three part-time jobs. I thought that would have been ill-advised, giving me too little time in each area. Similarly, being an Emergency Medicine and ICM during a respiratory pandemic was not the most fun experience ever…

Many of my colleagues in anaesthesia had their lists cancelled or changed to local anaesthesia lists and had issues for a time of having too many staff with too little active operating theatres. I instead flipped back and forth between the carnage of an overcapacity, under-resourced and expanding ICU to the carnage of an overcapacity, under-resourced and overcrowded ED, with deluges of policy, procedure, kit changes and miscellaneous updates flooding in everywhere at all times of day and night from both specialties. It would be very nice not to repeat that.

Overall, though, despite the pressures that result from our under-resourced health system, I'm very happy in my current roles and grateful for the opportunities and experiences they provide. My take home message is this: it's been worth it; it remains worth it.

I'm happy to be contacted by medical staff considering Dual ICM and EM careers and who have further questions: Craig.A.Walker@nhslothian.scot.nhs.uk.

Reference

1. BMA Scotland. The Consultant Handbook for Scotland 2022 [website], 2022., Accessed 24 November 2022.

Moving from Australia to the UK for a Post-CCT Fellowship

Dr Tamishta Hensman

ECLS fellow at St Bartholomew's Hospital, London

I completed 12 months as a severe respiratory failure/ ECMO fellow at St Thomas' and am finishing a 6-month role as the ECLS fellow at St Bartholomew's. I'll be going back to Australia as a consultant in a tertiary centre in Melbourne. The last 18 months have been incredibly informative for me, not only clinically, but also in helping me distil what values, priorities and practices I want to take (or leave) in my future consultant life. I am an unashamed advocate for international fellowships and moving to London has been one of best career and life decisions I've made.

As a background, I'm a post-fellowship/CCT trainee from Australia and have long wanted to work overseas. Initially it seemed daunting — the choice was huge, but two factors helped to narrow my options. The first was that I had no interest in sitting further exams. This limited both the countries I could go to as well as the specific hospitals I could work in. The second was speaking to prospective future employers and consultants who had completed overseas fellowships. The general consensus was that it was a great idea and that I should consider finding a job that would expose me to ECMO.

Generosity

I asked for a lot of advice and help, and found unreserved generosity from a number of people who offered to introduce me to their previous places of fellowship. St Thomas' has a history of accepting post-fellowship Australian trainees and it was a natural place to start. There was always another Australian trainee or observer around which helped me to navigate the culture shock of a new system. I got in contact with the recruiting consultants early — the paperwork involved in moving from overseas is painful.

The recruitment process in Australia is longer and finding out if I had a chance of getting the job was helpful in alleviating anxiety around ending up unemployed. I contacted previous Australian trainees (some I knew well, others I didn't) who had come to Tommies to get their advice around how to make the most of the fellowship, and took all of it! It resulted in a few publications and presentations, but not at the expense of making the most of London-life and travelling a nauseating amount within the UK and Europe. St Bart's has been a different but complementary experience- I'm now the only ECLS fellow rather than one of nine, but it has similarly been an amazing opportunity to learn from some insightful clinicians.

Experience

The timing of my fellow experience has worked well for me. It was not difficult to navigate consultant applications from London and I ended up being approached to apply for additional jobs.

Having plenty of experience, including in different health networks helped me to navigate the cultural and practical differences of working overseas. It also allowed me to focus on a narrow area as I could be intentional about what knowledge, skills and programmes to take back with me.

FFICM Prep Course

SAVE THE DATE

In-person mock OSCE/SOE

Tuesday 27 February 2024

Look out for details on our website and Twitter/X @FICMNews

www.ficm.ac.uk/events

FFICM EXAMINATION CALENDAR

FFICM FINAL OCSE/SOE	
Exam applications open	11 December 2023
Exam applications close	2 February 2024
EXAM DATE	18-21 March 2024
Fee	Both £695 OSCE £385 SOE £350
Results	31 October 2023

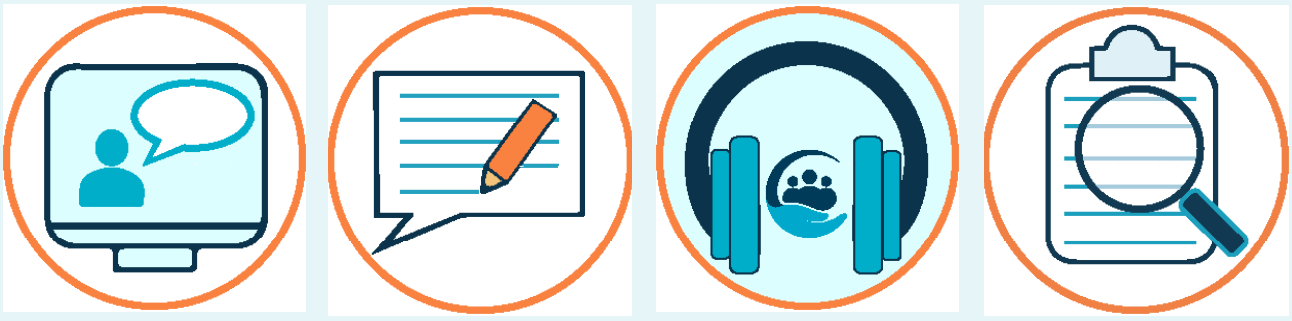
FFICM FINAL MCQ	
Exam applications open	11 March 2024
Exam applications close	25 April 2024
EXAM DATE	27 June 2024
Fee	TBC
Results	31 January 2023

FICM Learning

Visit the FICMLearning website for some fantastic podcasts, blog posts and cases of the month. Our most recent content includes:

- Case of the Month #45 Major Obstetric Haemorrhage - Part 1
- Case of the Month #45 Major Obstetric Haemorrhage - Part 2
- Blog: Maternal Critical Care: The Role of Critical Care Outreach Teams in Improving Care
- Case of the Month #44 High Anion Gap Metabolic Acidosis
- Striking the Balance Meeting – Diversity and Inclusion
- Simulation Scenario: Maternal cardiac arrest
- Case of the Month #43 Refeeding Syndrome

www.ficm.ac.uk/ficmlearning



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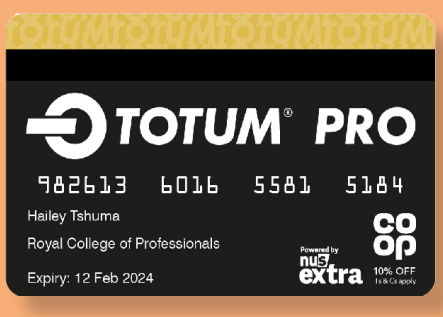
Become part of FICM Thrive

Are you interested in helping someone develop their career, find their perfect work/life balance, or do you need that extra something to help you achieve your goals?

Visit www.ficm.ac.uk/careersworkforce/ficm-thrive for more.

The latest *Critical Eye* is now available on the FICM website. Click here to read the full issue.

If you would like to contribute to future issues, please get in touch at contact@ficm.ac.uk.



TOTUM PRO is the only discount card available for professional learners to purchase giving discounts from a wide range of high street and online retailers. Discounts range from travel and eating out, to health, technology and fashion.

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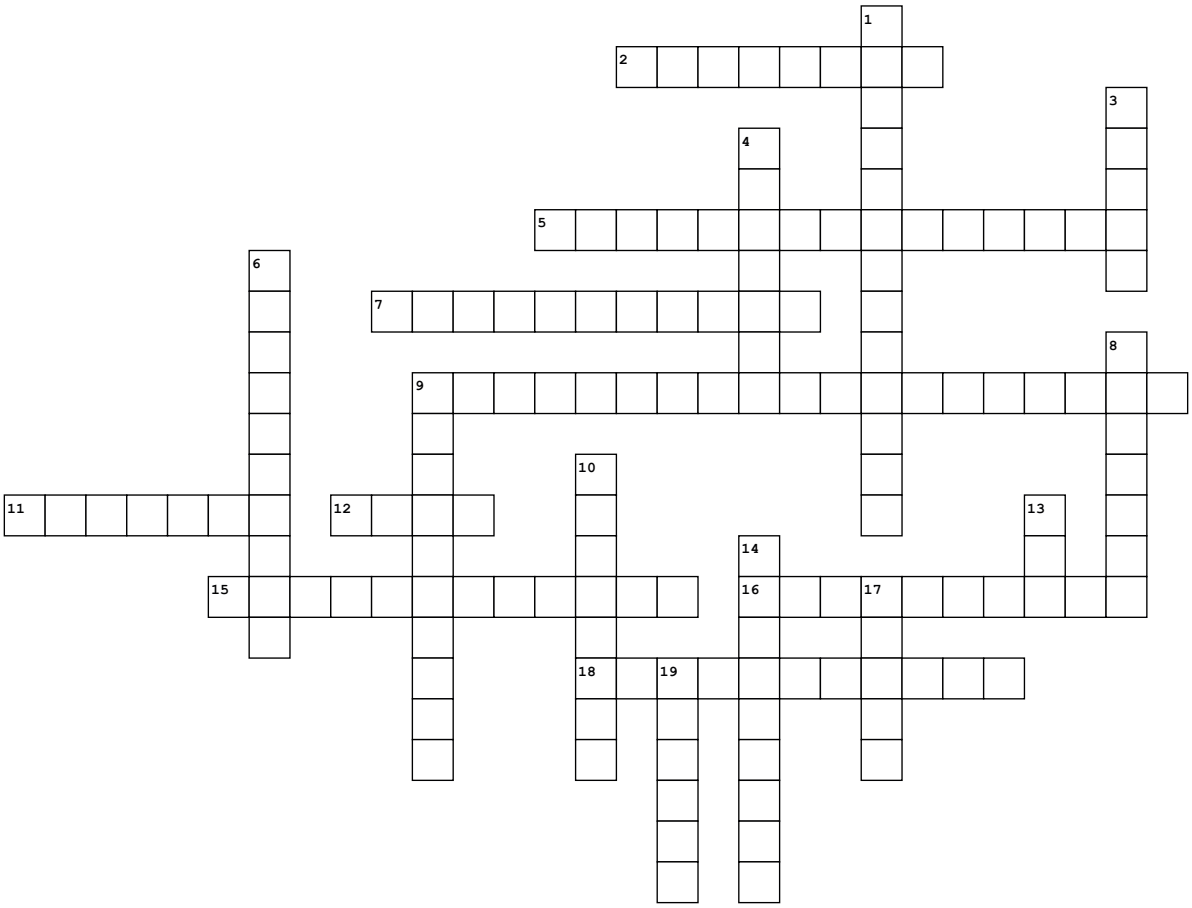
ACCU Shock Crossword



Across

2. Inotrope in beta blocker poisoning, increasing cAMP without the beta receptor

5. Systolic BP variation on respiration occuring in tamponade

7. Second line vasopressor to be avoided in known GI ischaemia

9. Tube used in management of acute variceal haemorrhage

11. Causes shock through inhibition of the electron transport chain with hyperlactataemia

12. Triad of shock, raised JVP and muffled heart sounds in tamponade

15. Class of shock, i.e. anaphylactic, septic, neurogenic

Down

1. First line vasopressor in shock

3. African trial suggesting harm from large volume fluid resuscitation

4. A PE with haemodynamic compromise

6. Hypotension and bradycardia due to loss of sympathetic outflow.

8. Element of stroke volume affected by fluid resuscitation

9. Heart Rate/Systolic BP

10. Shock with hyperkalaemic hyponatraemic metabolic acidosis

13. Systolic BP + (2 x Diastolic BP)/3

14. Renally excreted inodilator with a long half life

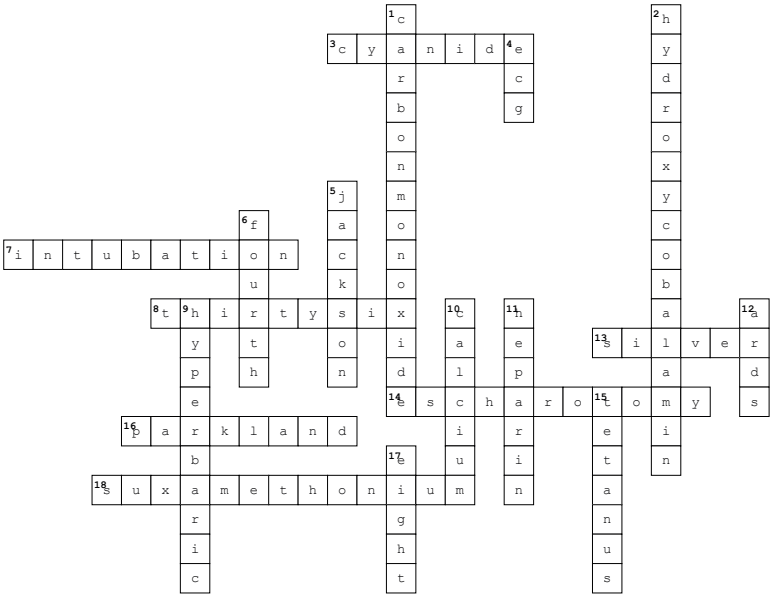
16. Antidote for haemodynamic collapse secondary to local anaesthetic toxicity

18. Class of shock, i.e. tamponade, tension pneumothorax, massive PE

17. Haemostatic test used to guide blood product resuscitation in haemorrhage

19. Form of shock that is not true shock. Presents with flaccid areflexia.

ACCU Burns Crossword: Answers



Across

3. Toxic exposure which can occur with burning upholstery, leading to shock with a raised lactate

7. What procedure is indicated by a burned moustache, soot in the nares and a hoarse voice?

8. Based on the rule of nines, what is the burned surface area in a man with burns across the front and back of his chest?

13. Metal ion which is used in burns dressings for antimicrobial properties

14. Surgical procedure performed in circumferential burns

16. Formula used for calculating fluid replacement in burns (3ml/kg/% burned surface area)

18. Induction agent to avoid due to risk of hyperkalaemia in burns

Down

1. O2 saturations are over-read in what form of toxicity associated with burns?

2. Chelating agent administered in a 5g dose to severe burns patients which leads to chromaturia

4. Mandatory investigation in all electrical burns

5. Zones of injury in burns (coagulation, stasis, hyperaemia)

6. Degree of burn which extends into muscle tissue and bone

9. Oxygen therapy which can be considered in patients with CO toxicity

10. Serum electrolyte which can become dangerously low in Hydrofluoric Acid burns

11. Inhalational burn fibrin cast formation can be reduced by nebulised Acetylcysteine and...

12. Smoke inhalation can lead to what syndrome, defined by the Berlin criteria?

15. Vaccination which should be given in all serious burns cases

17. When fluid resuscitation has been calculated in a burns patient, the first half is given over how many hours?

The Faculty of
Intensive
Care Medicine

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