TRAINING UPDATE

Royal College of Anaesthetists

The Faculty of Intensive Care Medicine

Best practice for management of Dual/Triple/Single CCT ICM trainees

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Introduction

Many critical care units now comprise doctors with varied backgrounds and training from acute, respiratory and renal physicians, emergency department physicians and anaesthetists. The landscape of intensive care medicine is changing with an increasing number of doctors in training from differing backgrounds, who are pursuing either a dual programme with emergency medicine (EM) or anaesthesia, or a triple programme with their medicine specialty, or indeed a Single CCT in ICM. All of these doctors have individual needs in order for them to meet their training requirements. The training needs and contributions of all members of the team are, and should continue to be, valued and harnessed to deliver good patient care.

The RCoA and FICM Training Committees felt it was important to outline the general principles on how these doctors should be supported by a good anaesthetic and critical care department. A recent ICM StR survey has highlighted issues and concerns regarding variability in the experiences of trainees from medical and emergency medicine backgrounds compared to those from an anaesthetic background in terms of received behaviours, rota management and provision of educational opportunities. We would like to take this opportunity to emphasise that the differential treatment of these trainees is not acceptable.

For context, an overview of the training and experience that doctors in ICM training require at each stage is below. There are 14 Higher Level Learning Outcomes (HiLLOs) that form the basis of the ICM curriculum. HiLLOs 12, 13 and 14 cover the sub-specialty elements. See page 7 of the ICM curriculum.

Stage 1 ICM training (ST3–4)

Doctors recruited into ICM training are from the base specialties of core anaesthesia, medicine, ACCS EM or ACCS Anaesthesia. The purpose of stage 1 is to consolidate and unify their training and they will each have to complete 12 months of anaesthesia, 12 months ICM and 12 months medicine including any training prior to ST3 recruitment.

Stage 2 ICM training (ST5–6)

This stage covers subspecialty paediatric, neuro and cardiac ICM (and may include some sessions in anaesthetics) and a-separate special interest year (which is in their dual specialty if dual training).

Stage 3 ICM training ST7

This includes 12 months of ICM, with consolidation of HiLLO capability levels and preparation for taking up a consultant post. This can include some time spent in anaesthetic theatres and activities, to maintain skill levels as per HiLLO 10.

Principles

- ICM trainees from a medical and emergency medicine background should neither be disadvantaged from access to training, clinical or rota opportunities, nor be subject to disparaging opinion on their chosen career path. They should be given equity of opportunity in line with other doctors in the similar training programme.
- In Stage 1 ICM, once these doctors have completed six months of anaesthesia and are on the theatre on-call rota they should continue to enhance their anaesthetic skills and can be included as airway trained for the purpose of ICM on-call rotas.

- Access to local and regional anaesthetist in training teaching should be provided.
- In ICM stage 2 (with neuro, cardiac and paediatric placements), access to teaching should be equitable where it is suitable for the trainee's learning requirements. Access to deanery based (School/Regional) teaching should be explored and promoted as both candidate and faculty.
- Doctors in Stage 2 ICM training will have anaesthetic skills to develop beyond their stage 1 capability level. It must be remembered that they have already done at least one year of anaesthetics and additional years on Intensive Care Units and so must be treated as such, and be capable of participating on an appropriate airway rota.
- All trainees should have a nominated educational supervisor ideally with a similar background. However, if this is not the case, the same quality, opportunity and provision of supervision should apply.
- All intensive care units have a FICM-appointed Faculty tutor. They should be consulted when rotas are compiled regarding airway competence and curriculum requirements.
- Intensivists in training from medical and emergency medicine backgrounds should participate on emergency bleep rotas and have regular suitable anaesthetic lists with consultants to enable them to collect supervised learning events and other evidence as required for their development and achievement of Learning Outcomes.
- They should be offered the educational opportunities they require to develop capabilities such as pre-assessment, cardiopulmonary exercise testing and pain clinics, sedation lists etc. This should be discussed at the initial educational supervisor meeting.
- Support should be provided to pass the FICM exams in the form of study leave, local viva practice and access to regional exam courses.
- Ideally peer support mentors should be provided to give more general wellbeing support.
- The 2021 FICM Curriculum requires completion of the 14 HiLLOs for each stage of training. In addition to the clinical HiLLOs, there are others which require professional behaviours to be assessed, and opportunities to complete quality improvement, business cases, teaching, mortality reviews and serious untoward incidents should be encouraged whilst in anaesthetic placements.

Both training committees would like to thank all the Faculty and College tutors for their hard work and dedication in supporting trainees from such diverse backgrounds. We understand the complexity that providing such bespoke training requires. If you are having any difficulties, please contact any of the authors who will do their best to help you. Our email addresses are available on the RCoA website.

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