

UK Intercollegiate Diploma in Intensive Care Medicine

Report by Chairman of Examiners, June 2008

Introduction

An initial application in the form of an outline, was received from 57 candidates. Forty-one dissertations were submitted; there were three candidates with higher degrees. Thirty-five candidates were finally listed for the oral examination, including two candidates with higher degrees who were exempt from the dissertation. The total number of candidates examined now stands at 135, and the number of diplomates in the United Kingdom is 114.

The examination consisted of five oral examinations as detailed below. For those who had submitted a dissertation, there was a dissertation oral. There was then a clinical and data analysis examination, which consisted of a long case, where a written clinical scenario was available to the candidate for 10 minutes prior to the oral examination, which was then explored by the examiners. There then followed three short cases. These were based on and around an investigation result such as an ECG, X-ray or on blood tests that might be seen in the clinical environment, leading into a discussion of the case and its management. In a further oral examination, the candidates were examined on the 10 selected cases they had submitted. A minimum of two cases in each part of the oral examination were discussed, but often more. Finally, there were two oral examinations, both based on two structured questions.

Dissertation summaries

Far more candidates are now adhering to the format required for the dissertation summary (details available in the online guidance at www.ibticm.org) and almost all were on intensive care-related topics. Feedback from the examiners, where indicated, was provided in the form of a synopsis of remarks made by them. As the examiners only see the summary, these comments reflect their anxieties or thoughts from reading the summary, and are intended to be helpful remarks for consideration if relevant. It may well be that the matters are already dealt with in the dissertation being prepared, but it is worthwhile for candidates to discuss these points with their supervisor.

From August 2008 onwards, the dissertation summary can be sent in at any time and will be reviewed promptly by the examiners – actual application for the examination is now when the dissertation is submitted, but this requires the summary to have been approved. The closing dates for the exam will be in April and September each year, and the examinations will be held in June and November.

Dissertation

A total of 41 dissertations were examined of which seven failed. Three higher degrees were also submitted.

Many of the dissertations were very impressive. The range of topics was wide, and while several are clearly favourites that recur annually, the clear intention is that the dissertation is on a subject of specific interest to the candidate and this appears to be the case. It is important that the candidate chooses a subject that is of particular interest to them, but that the subject matter is broad enough to justify exploration and yet not so broad as to be self-defeating. Some of the topics were a little narrow and hence clearly provided difficulty due to the limited scope, while others suffered from trying to encompass too much material. If the candidate has a research project on which the dissertation can be based this is very acceptable, but if it is only a small or narrow project then a full review of pertinent literature would be helpful. It is important that candidates producing such dissertations should be knowledgeable about the methods and in particular should be able to critically appraise what they have done and what they might have done differently. This is inherent in any research project and it is surprising when candidates fail to have any idea of potential limitations in the work they have used for the dissertation. Again, reference to the supervisor is helpful.

In producing reviews, either systematic review or narratives are perfectly acceptable, but the candidate should state which it is and then adhere to the rules governing systematic review if that is their choice. In planning the dissertation it is important to look at the guidelines and what is being sought, which includes a search strategy, assimilation of relevant material, a critical review of what is and is not available and the formulation of opinion that can be defended at oral examination. The guidelines are quite clear on how the dissertation is marked and what is sought and it is sensible to be guided by them. The examiners will be marking against the six domains. Defining the question will give the dissertation direction and purpose. A key recurrent issue this year was the failure to clearly explain search criteria, even when it was clear that searches had been thorough. Some candidates found vast quantities of literature which was then discarded. This may have been appropriate but with no explanation it is hard to assess. Providing facts and lists of facts may be relevant but the examiners are also looking for personal interpretation and argument, not simple regurgitation of others' conclusions. The argument for a point of view must be cogent. The examiners are looking for critique. An example might be acknowledging

that the information or evidence may appear strong, such as being a randomised-controlled trial, but by virtue of its method or numbers is actually weaker than it looks.

There are acknowledged methods of assessing the value of a paper which are well worth reading; one such guide, used by JAMA, can be found at: <http://pubs.ama-assn.org/misc/usersguides.dtl> or <http://www.cche.net/userguides/main.asp>.

Impression is sought even if a definitive conclusion is impossible. There should be some form of answer to the question being asked by the dissertation. The general standard of writing was good.

Please note that if literature is to be used and quoted it is important to acknowledge the source, especially if 'quotes' are used verbatim. It is all too easy in writing reviews, to extract whole sentences from the literature and assemble an article. This is usually readily apparent to examiners because of the changes in writing style that are easily observed running through the dissertation. This approach is to be discouraged as it produces a dissertation that reads more like a collection of apparently unlinked sentences, rather than a coherent discussion of the objectives outlined at the beginning of the dissertation.

Once again it is clear that some candidates have not sought advice from their supervisors or if they have, may not have followed it. We would urge candidates to use such resources.

Clinical scenario and data interpretation

This section comprised a long case and several short cases. The long case requires the candidate to review a written clinical case history for ten minutes prior to the oral examination. The case is then explored with the examiners. As the discussion progresses the candidate may be given further information as the clinical case evolves. This section was generally well managed by the candidates. It is similar to discussing a case on a ward round, or at least that is the intention. A differential diagnosis is important and the examiners are looking for method and approach rather than specific diagnosis. Management of a patient with myasthenia gravis posed a few problems for some but this is a case of obvious weakness in a young patient and other diagnoses such as Guillain-Barré are also important considerations. Discussion of areas of management has clear parallels with what happens on day-to-day ward rounds. Renal failure and the management of pancreatitis were also discussed.

The short cases comprised data such as an X-ray, ECG or blood gases or other commonly available information leading to diagnosis of the problem and its management from actual clinical cases. The specific diagnosis was difficult in a couple of these cases, but it was the technique by which the data was interpreted, the differential diagnosis and the discussion of management that was of greater importance. This was generally well-handled by the candidates.

It is clear that many candidates would benefit in having some specific revision in simply relating a problem-specific history and examination, prior to the examination.

It is important to have a methodical approach to reading and interpreting an ECG or chest X-ray; likewise with blood gas and electrolyte results. The examiners were looking for

a methodical approach rather than an immediate spot diagnosis. In each case, a method of describing the data, its abnormalities, and then giving a differential diagnosis, was what was expected.

Cases included an X-ray of a collapsed lung, blood gases from a severe metabolic acidosis, a CT scan of pancreatitis and an ECG with heart block. The blood gases required a sensible approach to interpretation, not the final diagnosis, which was considered difficult by some of the examiners. Identifying and working through a severe metabolic acidosis should be routine in intensive care practice. The ECG also posed problems and was mistaken for atrial fibrillation. This in itself was not disastrous, as it was the discussions leading on from that which were more important. Again, interpreting ECG in intensive care is routine. It did seem that some benefit could have been gained by more time spent looking at X-rays with radiologists, ECGs with cardiologists and blood gases with colleagues in the ICU, and by revisiting basic methods of reviewing these tests.

Selected case summaries

This was a strong section; the cases were presented as might be seen in a journal. The relevant details in a case presentation leading into a focused discussion and review, often with a limited number of appropriate references, were helpful. The candidates select the cases they submit for the examination so it is wise to know the details of the case and to have a reasonable depth of knowledge of the material covered in the review. It may be sensible to ask colleagues to examine on these cases so that the kinds of questions leading from the cases can be anticipated.

Structured oral examinations

These covered two main topics in both of two oral examinations. The topics were diverse and covered several aspects of intensive care, all listed in the syllabus. Acute lung injury featured and the examiners explored strategies for ventilation; ARDSNet amongst others. Blood transfusion in the critically ill is, and has been, a major topic over the last few years and was usually well-handled by the candidates. Acute liver failure was also discussed. There was some biochemistry, with a discussion of lactate and its production that led directly to clinical aspects of lactate of which there are several. Again most candidates did well. Acid-base also was explored and most candidates seemed to have a good level of knowledge of the Stewart hypothesis which came up in discussion. This was a section looking at major topics in ICM. It was expected that candidates have a thorough working knowledge of these areas. Where there is contention, this was often discussed. It is important to have views and opinions and to be able to defend those opinions.

A new type of question was also used on this occasion. Much of intensive care practice is about difficult management issues which lead often from fairly simple clinical matters. Whether admission is appropriate and can achieve anything, what the ICU can genuinely offer, how to determine a sensible line of management in a difficult situation and, in fact, the sort of issues to which there may not be a right answer. What is more important is to define the issues and show how they

could be addressed, who should or must be involved and how to seek resolution. These are the problems that arise every day and are difficult. It is intended to incorporate more of these questions in the future.

Conclusion

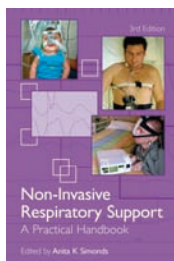
Overall, the examiners were impressed by the performance of the candidates, who were well versed in current intensive care practice and easily capable of demonstrating not only

knowledge but also opinion. The standards achieved by the candidates reflect well on the UK training programmes, and bode well for the future.

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Book review



Non-Invasive Respiratory Support, A Practical Handbook. Third edition

Edited by Anita Simonds

368 pages

London, Hodder Arnold. 2007

£34.99

ISBN 978-0340925607

This book is a comprehensive treatise on all forms of non-invasive ventilation (NIV). The book is edited by Dr Simonds and 16 of the 25 chapters have in fact been written by the editor, with 11 other authors contributing chapters. This does mean that the majority of the chapters follow a consistent style.

Early chapters cover a brief overview of the indications for non-invasive respiratory support, which is expanded in later chapters, and the equipment used, which is a relatively short section considering the complexity of the equipment described. The author concentrates on the interface with the patient more than ventilator type and terminology. There is also a guide to setting up an NIV service.

Chapters four through nine cover acute indications for NIV including COPD, hypoxaemic respiratory failure and others, and then describes practical aspects of the technique, including trouble-shooting. Chapter 10 addresses the use of NIV in post-extubation respiratory failure and chapter 11 follows with the use of NIV in weaning. Chapter 12 then covers other uses of NIV in acute situations, such as in the emergency room, for acute asthma and during procedures.

The remainder of the book deals more with the use of NIV and CPAP in chronic conditions, including domiciliary ventilation and the treatment of obstructive sleep apnoea. The final chapter covers the ethical and legal issues

surrounding NIV.

The sections of the book that will be of most immediate relevance to critical care practitioners are those dealing with the acute indications, particularly Mark Elliott's chapter on NIV in COPD and Bernd Shoehofer's chapter on the use of NIV in weaning, because they explore the common nature of the problems presenting. The chapter on initiation of NIV gives useful guidance on how to set it up and how to recognise failure, and the trouble-shooting guide is a valuable aide memoire.

For most critical care practitioners, the remainder of the book is likely to be of most use as a reference when faced with a patient established on domiciliary ventilation during an acute deterioration or intercurrent illness or who is undergoing surgery. There is also useful guidance for those patients who might benefit from referral to a domiciliary programme once recovered from an acute illness.

All in all, this book might find a place on the shelf of any unit wishing to use NIV, or interface with an NIV service, and should be available to anyone who might wish to have a practical guide to setting up NIV.

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