

## Speciality status for Intensive Care Medicine?

Intensive Care Medicine takes its origin from the epidemic of poliomyelitis in Copenhagen in 1952, when long-term mechanical ventilation was introduced into the treatment of these patients. These patients also required general and additional care of a more intensive nature. This successful experience stimulated others in many different countries. Many pioneers in this early period came from anaesthesiology, such as Lassen and Ibsen in Denmark, Holmdahl in Sweden and Safar in the USA. Specialists from other medical disciplines, in particular internal medicine and neurology, also became involved and included such individuals as Mollaret in France and Dönhardt in Germany.

Today, Intensive Care Medicine embraces a multidisciplinary approach in many countries. A survey undertaken by the European Society of Intensive Care Medicine showed that in 10 of 19 European countries there is multidisciplinary access to intensive care training with a common core curriculum [1] (data updated). Only in eight countries is training in Intensive Care Medicine available solely through the discipline of anaesthesia (i.e. as a subspecialty of anaesthesia). Seventeen countries offer an official registration (accreditation) for special competence in Intensive Care Medicine; in 16 countries this accreditation is combined with a basic or major speciality such as anaesthesia, internal medicine, surgery or paediatrics. In this case, Intensive Care Medicine can be described as a 'supra-speciality'. Only in Spain is Intensive Care Medicine a recognized separate speciality, but within this completely government-controlled system no second, sub-, or basic specialities are possible at all. Remarkably, the Spanish national society of Intensive Care Medicine has recently recommended the creation of multidisciplinary access.

Looking outside Europe, multidisciplinary access has, for instance, also been established in the USA where Intensive Care Medicine training programmes are available through the common major specialities. However, in the USA there are two main societies competing for Intensive Care Medicine – the *Society of Critical Care Medicine* (SCCM), which is a multidisciplinary society (with moderate participation by anesthesiologists), and

the *American Thoracic Society* (ATS), which is a society consisting mainly of pulmonary physicians in which Intensive Care Medicine is represented by a *Critical Care Assembly*. Apparently, in the past, many of the American anesthesiologists have lost interest in Intensive Care Medicine and this has now turned out to be a disadvantage when claiming a dominant position for anesthesiologists for Intensive Care Medicine in the USA.

Considering its multidisciplinary appearance, Intensive Care Medicine may seem for many professionals to be somewhat vague. In view of this, I can well understand those intensivists who long for Intensive Care Medicine to become a speciality in its own right. I do not personally regard this as a desirable objective at the present, however. My personal vision for Intensive Care Medicine is as a 'supra-speciality' with multidisciplinary access. My reasoning for this view is that Intensive Care Medicine provides a multidisciplinary spectrum of activity, which cannot be compared with most other specialities. Intensive Care Medicine clearly represents a cross-section of the entire sector of acute medicine. Thus, Intensive Care Medicine has to embrace many different influences and experiences from many different specialities. It represents a highly active sphere of clinical medicine where the influences of many specialities meet – to the benefit of the patients.

On the other hand, intensivists are very likely to remain a rather small group of highly specialized physicians. Thus, the power of Intensive Care Medicine will predominantly depend on its influence through the various base specialities. Being part of large 'mother' specialities, Intensive Care Medicine profits from the professional influence and power of these large base specialities. It may also profit from their large financial basis. Thus, the close connection to the 'mother' specialities offers Intensive Care Medicine a greater political power on the professional playing field.

Also, from a 'marketing' perspective, intensivists should be closely aligned to a base speciality in order to remain flexible and, if necessary, to be able to return to their origin. This is wise in the possible event of a change of employment or even closure of a department or a hospital when a switch back to the base speciality offers

a safe professional perspective for these intensivists. In a system in which such a switch between the main speciality and a sub/supra-speciality is impossible, the use of human resources is inefficient and uneconomic. Therefore, I am fully convinced that Intensive Care Medicine still needs tangible connections to base or 'mother' specialities.

Furthermore, in any country, there are many more anaesthesiologists needed than intensivists. Thus, the 'market' must produce more anaesthesiologists than intensivists. In smaller hospitals, the conditions for practising full-time Intensive Care Medicine will always be limited. There, special training and education in Intensive Care Medicine will not be possible, but anaesthesiologists can still be trained. An 'automatic link' between anaesthesiology and Intensive Care Medicine (i.e. every anaesthesiologist is 'automatically' or 'by definition' also an intensivist) is far from being a good solution. Particularly in the future, when continuing medical education becomes obligatory, any anaesthesiologists who during their original training may have been well-educated in Intensive Care Medicine, but have lost practical experience, will no longer be able to be certified for Intensive Care Medicine. This may still be far from being realized, but it will and must happen.

Nevertheless, the status of Intensive Care Medicine within the community of medicine must definitely be improved, e.g. by recognition of the special Intensive Care Medicine competence and by defining quality standards as well as by creating professional structures, which offer acceptable job perspectives.

A highly progressive and innovative area of medicine such as Intensive Care Medicine requires a tight control of professional quality and continuous quality improvement. Education and training in Intensive Care Medicine need high standards and continuous upgrading. Training programmes for Intensive Care Medicine must be well-defined and approved by official institutions (governmental or through the medical associations). Hospitals applying for official certification (accreditation) must offer the broad spectrum of services suitable to provide the necessary knowledge and experience. Even for physicians already specialized in Intensive Care Medicine, a high-quality continuing medical education programme must be ensured. The *European Society of Intensive Care Medicine* has defined recommendations and guidelines for such education and training programmes [2]. For this purpose, it has also initiated PACT, a multimedia distance-learning programme, which will cover the entire spectrum of Multidisciplinary Intensive Care Medicine.

Moreover, to offer effective and successful conditions for research, Intensive Care Medicine needs to be professionally accepted. For this to happen, Intensive Care Medicine must obtain some degree of independence, some defined status, either as a supra- or sub-speciality or through the medium of a certification of special competence. Only then will physicians devote themselves to Intensive Care Medicine in the long term, planning a long-range career in this area of their interest and be accepted as physicians with special competence.

Speciality status and structures are determined at the national level and depend to a large extent on national politics of which there are huge variations within Europe. The quality of education and accreditation of units and hospitals must comply with high standards that need to be harmonized and equivalent all over Europe. This must be well-controlled by official independent bodies and cannot be left to the discretion and self-interest of some single professional societies, or to some competing societies defining different standards. This can only be achieved by universal European regulations. It is too late for sole national solutions. Today we need a common concept for structures and standards of Intensive Care Medicine that are accepted all over the European Community.

The common European denominator is the multidisciplinary access. There are now an increasing number of professionals in many countries who understand the potential advantages of the multidisciplinary approach to Intensive Care Medicine. A promising starting-point has been reached.

The official body within the European Union responsible for harmonization of structures and improvement of quality of medical specialists is the *European Union of Medical Specialists* (UEMS). All main specialities are represented in the different UEMS sections by delegates from the individual national medical societies. However, as Intensive Care Medicine has not been recognized as a main speciality, it is not yet represented in this structure.

However, UEMS has recently taken a large step forward. A '*Multidisciplinary Joint Committee for Intensive Care Medicine*' has been created within the UEMS and is now open to delegates of all specialities involved in Intensive Care Medicine. To date, delegates from the UEMS Sections of Anaesthesiology, Internal Medicine, Neurosurgery, Paediatrics and Surgery are members of this Committee. The *European Society of Intensive Care Medicine* has been invited to participate officially with delegates in a Standing Advisory Board together with a

delegate from the *European Society of Paediatric and Neonatal Intensive Care*. This step can indeed be regarded as the formal recognition of these two bodies as being the true European representation of Intensive Care Medicine.

The aim of this Multidisciplinary Joint Committee is to define rules and regulations for harmonizing professional structures of Intensive Care Medicine in Europe, such as rules for accreditation of Intensive Care Units for professional training, recommendations for training programmes and for minimal requirements of personnel, equipment, etc. Also, concepts for continuing medical education in Intensive Care Medicine will be defined. Some important recommendations have already been released (see: <http://www.uems.be/mjicm.htm>).

In summary, the recent development is promising. It is an important step for the adequate acknowledgement of

Intensive Care Medicine within the European community of medicine.

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## References

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