Speciality status for intensive care medicine?

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Intensive care medicine (ICM) originates in response to the polio epidemic in Copenhagen in 1952. Long-term mechanical ventilation was then introduced as a treatment, and a broad spectrum of additional intensive care became necessary. This successful experience stimulated others in various countries and specialities. Many pioneers in this early period were anaesthesiologists (such as Lassen and Ibsen in Denmark, Holmdahl in Sweden and Safar in the USA), but specialists in internal medicine and neurology were also involved (such as Mollaret in France and Dönhardt in Germany).

Today, ICM has a multidisciplinary approach in many countries. A survey of the European Society of Intensive Care Medicine (ESICM) [1] showed that in 10 out of 19 European countries there is a multidisciplinary approach to intensive care training with a common core curriculum. Only in eight countries is training in ICM available solely through anaesthesia (ie as a subspeciality of anaesthesia). Seventeen countries out of the 19 offer an official registration (accreditation) for special competence in ICM, and in 16 countries out of these 17 this accreditation is combined with a base or major speciality, such as anaesthesia, internal medicine, surgery and paediatrics; in these countries ICM can be described as a 'supraspeciality'. Only in Spain is ICM considered a speciality in its own right (monospeciality) without a second or a base speciality; however, even in Spain the national society of Intensive Care Medicine (SEMICYUC) recommends open, multidisciplinary access.

Outside Europe, the multidisciplinary access has also been established in the USA where ICM training programmes are available through the common major specialities.

Considering its multidisciplinary appearance, ICM seems vague to many professionals. ICM even seems to be subject to professional covetousness sometimes, in that some societies claim sole representation of ICM.

In view of this, I can well understand those intensivists who long for ICM to become a speciality in its own right; in my view, though, this is not a desirable objective at present. My vision for ICM is that of the 'supraspeciality' with a multidisciplinary access.

My reasoning for this is that ICM provides a multidisciplinary spectrum of actions that cannot be compared to most of the other specialities. ICM obviously represents a cross-section of medicine for acute situations. Thus, ICM has to unite various influences and experiences from many different specialities. It represents a highly active synapsis in clinical medicine where the influences of many specialities meet, to the benefit of the patients.

On the other hand, the capacity of ICM itself depends on its influence through the various base specialities as intensivists are a small group of specialized physicians. Being part of large 'mother' specialities, ICM often profits from the professional influence and power of these large base specialities. It may also profit from the large financial basis of these specialities. Thus, the close connection to the 'mother' specialities offers ICM a greater political power on the professional playing field.

Furthermore, from a 'marketing' perspective, intensivists should be domiciled in a base speciality in order to remain flexible and, if necessary, to be able to return back to their origins. Such a return to a base speciality offers an intensivist a safer professional perspective in case of any change of employment or even closure of departments or hospitals. In a system where such a switch between the main speciality and a sub/supraspeciality is impossible, the use of human resources is inefficient and uneconomic. Furthermore, in any country there are many more anaesthesiologists needed than intensivists and thus the 'market' must produce more anaesthesiologists than intensivists. In smaller hospitals, the conditions for practising full-time ICM will always be limited. Here, special training and education for ICM will not be possible, but anaesthesiologists can still be trained. Thus, I am fully convinced that ICM still need the connection to base or 'mother' specialities.

However, the status of ICM within the medical community must definitely be improved, for example by recognition of special ICM competence (by defining quality standards as well as by creating professional structures which offer acceptable job prospects).

A highly progressive and innovative area of medicine such as ICM requires tight control of professional quality and continuous quality improvement. Education and training

ICM = intensive care medicine; ESICM = European Society of Intensive Care Medicine; SEMICYUC - Spanish National Society of Intensive Care Medicine; UEMS = European Union of Medical Specialists; ESPNIC = European Society of Paediatric and Neonatal Intensive Care.

in ICM needs high standards and continuous upgrading; training programmes must be well defined and approved by official institutions (governmental or through the medical associations), hospitals offering training programmes must be officially certified (accreditation) which also has to take into account the spectrum of services within the hospital. High-quality continuous medical education must be ensured even for physicians already specialised in ICM. The ESICM has defined recommendations and guidelines for education and training programmes [2].

Moreover, to offer effective and successful conditions for research, ICM needs to be professionally accepted. For this, ICM must get some degree of independence and some defined status, either as a supra- or subspeciality or another certification of special competence. Only then will physicians devote themselves to ICM in the long term and plan a long-term 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 (and there are huge variations within Europe). The quality of education and accreditation of units amd hospitals must meet high standards that must be harmonized and equalized across Europe. This must be well controlled by official independent bodies and cannot be left at the discretion and for the self-interest of some single professional societies or to some competing societies that define different standards. This can only be achieved by universal European regulations as it is virtually too late for sole national solutions. Today, we need a common concept for structures and standards of ICM 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 advantage of the multidisciplinary approach for ICM, and recently a promising starting point has been realized. The official body within the European Union responsible for harmonization and improvement of the quality of medical specialist practice is the European Union of Medical Specialists (UEMS). All main specialities are represented in the UEMS by delegates of the national medical societies of the European countries. However, as ICM has not been recognised as a main speciality, it is not yet represented in this structure.

Now, the UEMS has made a large step forward. Recently, a "Multidisciplinary Joint Commission for Intensive Care Medicine" has been created within the UEMS. This Multidisciplinary Joint Commission is now open to all specialities involved in ICM. To date, delegates from the UEMS sections of anaesthesiology, internal medicine, neurosurgery, paediatrics and surgery are members of this Commission. ESICM has been invited to participate officially with delegates on a Standing Advisory Board, together with a delegate from the European Society of Paediatric and Neonatal Intensive Care (ESPNIC). This step can indeed be regarded as the formal recognition of ESICM/ESPNIC as the true European representation of ICM.

The aim of this Multidisciplinary Joint Commission is to define the rules and regulations for harmonizing professional structures of ICM in Europe, such as rules for accreditation of intensive care units for professional training, recommendations for training programmes and the minimal requirements of personnel, equipment etc. Furthermore, concepts for continuous medical education in ICM will be defined.

Certainly, this promising development is not a substitute for a speciality status for ICM; however, it is an important step for the adequate recognition of ICM within the European community of medicine.

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