

## *Clinical Focus: Intensive Care*

# **THE BIRTH OF A NEW SPECIALITY: THE GROWTH AND GROWTH OF INTENSIVE CARE MEDICINE**

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The Royal College of Anaesthetists (RCA) has been safely delivered of a child. After much pushing and straining, and possibly rather more shouting than was strictly necessary, the infant was delivered on 7th June 1999. Not yet christened, the child is known only as Intensive Care Medicine, and seems to be sound of heart, lung and limb. Unfortunately, there remains some doubt about parentage, as an absentee father, said to be the Royal College of Physicians, has claimed parental rights over and above those of the natural mother. Chromosomal analysis cannot clearly differentiate between the two parties, but the infant, surprisingly outspoken for one so young, has expressed a clear wish to remain with its mother. For the while.

The first steps in the development of intensive care medicine (ICM) in the UK were taken back in the 1950s when one of the first general Intensive Care Units (ICUs) grew out of the chance combination of interested clinicians, an innovative anaesthetist of private means, a local engineering company and a busy road. Prior to this, dedicated wards existed for managing patients with burns, chronic respiratory failure and particular surgical problems, but there was little for patients who needed intensive nursing and medical support for other conditions or complications of treatment.

Times have changed. The ICU now forms the essential hub around which a hospital's surgical services collect, and the daily availability, or otherwise, of beds directly influences the nature of the surgery that can be performed. Vast sums of money are spent on small numbers of patients and individual clinicians become ever more skilled at spending it. But which clinicians?

Within the UK, most medical staff running ICUs are anaesthetists. Within London, most are physicians; worldwide, there is an even mix. Less commonly, consultants in A&E or surgery also run general ICUs and, as far as anyone can tell, no one group is noticeably worse at it than any other. What does differ, however, is how much training in intensive care medicine is available to junior doctors before they assume the role of consultant responsible for intensive care. As is so often the case, in the UK we started off with a good idea and then left others to get on with the wearisome process of developing it. As a consequence, unlike many younger and wiser countries, we have not developed a coherent training programme in intensive care medicine.

Over the past few years determined efforts have been made to redress this error. Initially, training was directed at

junior anaesthetists with the introduction of specific ICU training modules and the inclusion of critical care in the post-graduate college exam. More recently, some ICUs have offered ICU places as part of a surgical rotation and, less frequently, trainee physicians have also had ICU attachments, though difficulty in filling the consequent gaps in the native speciality have sometimes hindered uptake of these posts. More definitively, in 1993 the Royal Colleges of Physicians, Surgeons and Anaesthetists jointly established an intercollegiate body to make recommendations about how training in adult intensive care medicine should develop in the future (a separate body for paediatric intensive care medicine being established in 1995).

This process has not been without difficulty. Withstanding the clamour of the unbelievers, the Intercollegiate Board for Training in Intensive Care Medicine (IBTICM) has slowly developed a training programme that will lead, in due course, to the first awards of a CCST in ICM in the United Kingdom (a CCST, or Certificate of Completion of Specialist Training, issued by the Specialist Training Authority (STA), being the prerequisite for appointment to a hospital consultant post). Uniquely, would-be trainees can only apply for a Specialist Registrar (SpR) post in ICM once they have already been appointed to an SpR programme in some other base speciality: a CCST in ICM can only be awarded as part of a dual award, and even then both the SpR post in the base speciality and that in ICM have to be awarded after competitive interview. Uniquely also, no-one has yet been appointed to such a post. This is because the peculiar conditions of entry into ICM training have been seen by some to be inequitable, leading to the need to establish legal reinforcement of the current arrangements before they are put into effect.

Quite apart from the intricacies of entering into an ICM SpR programme, the exit from it is also somewhat unusual. At present there are neither exit exams from the programme nor other exams to be passed on the trainee's way through it. Training is 'competency-based', according to criteria issued by the IBTICM, and under the immediate supervision of the educational supervisor appointed in each training ICU. Fortunately, this is in keeping with current training in anaesthesia, and is therefore less of a shock for most educational supervisors in ICM than it might be for trainers originating from other specialities. Unfortunately, the lack of exam validation, and the brevity of the training has made the IBTICM fairly rigid about the amount of time and workload it requires of ICM trainees to achieve their CCST, which has on occasion been misunderstood as bloody-mindedness.

Necessary training for a CCST in ICM currently consists of three months in a recognised ICU at SHO level, followed by at least six months as an SpR, usually in two three-month blocks. In addition, trainees with a base speciality in medicine would be expected to complete six months in anaesthesia as a 'complementary module' and those with anaesthesia as a base speciality complete six months in general medicine. Those with a base speciality in surgery will have to do both. Satisfactory completion of the nine months training in ICM would enable trainees to apply for consultant posts with sessions in intensive care, although applicants for posts with two or more sessions in intensive care per week will have to have their training in ICM approved by the IBTICM prior to appointment.

For those with a more extensive interest in ICM, or who aim to become the director of their ICU, a further 'advanced' period of training in ICM beckons. This additional year of training, bringing the total to 18 months training as an SpR and three months as an SHO, will entitle the trainee to the holy grail of a CCST in ICM (once the lawyers have sorted the whole thing out). For the real enthusiast, the new UK Diploma in Intensive Care Medicine provides the entirely optional opportunity to achieve a postgraduate qualification in ICM but neither it, the longer-standing European equivalent nor a CCST in ICM are currently pre-requisites to a consultant post in intensive care. Rather, for the immediate future, applicants for consultant posts with a significant responsibility for the ICU will be appointed on the basis of their CVs, and the IBTICM's assessment of their training. In due course this will change and, as for other specialities, a CCST in ICM will be required prior to appointment, although it is hard to see this happening for some years. Furthermore, the IBTICM has decided, after considerable discussion, that CCSTs will not be awarded retrospectively - that is, neither consultant intensivists currently in post nor SpRs gaining experience in ICM at the moment will be eligible for CCSTs in ICM. Whether this will hinder the ability of current ICU consultants to move jobs in the coming years, should they wish to do so, remains to be seen. For many people with an interest in intensive care medicine these efforts to improve training in ICM will be seen as long overdue, although admittedly introduced with something less than finesse. The role of intensive care has grown enormously over the past few decades, and the collection of skills and knowledge

required has unquestionably developed its own separate identity. Some might think it surprising that these changes will require, at most, only 21 months of dedicated training to obtain a CCST in ICM, and compare that with the years of training required for other specialities. Some might wonder at the absence of an exam to validate the training, and whether competence-based training is a suitably rigorous alternative. Others may question how long the Royal College of Anaesthetists will retain its designation as 'lead college for ICM' from the STA, and welcome the recognition that, however firm the grip of the RCA on the IBTICM (to which it presently contributes almost 50% of the members), intensive care is in reality a multi-disciplinary endeavour.



'Excuse me, son - just what sort of bird ringing did you do on your youth training scheme?'

These uncertainties keep many of us awake at night, but I think we can be sure that, in time, there will be further changes to come. A new speciality may have been born, and may even have already reached a troublesome adolescence, but it has yet to mature fully. For the present we are happy to be recognised as a training Intensive Care Unit, and to be able to offer SHO placements to surgical trainees who want to broaden their understanding of the nature and management of critical illness.