References

Development of the faculty of intensive care medicine

P. Nightingale*
Royal College of Anaesthetists, UK
* E-mail: president@rcoa.ac.uk

On November 22, 2010, it was my great pleasure, in the presence of many of the Presidents from other contributing Colleges, to admit Professor Julian Bion as the first Dean of the new Faculty of Intensive Care Medicine (ICM) at its inaugural meeting. The journey to reach this moment bears reflecting upon as an example of how events develop over time based on the preceding efforts of others; as well recognized by Newton.1

The Intensive Care Society (ICS) was formed in 1971; the first such organization in the world. The Society continues to represent the interests of all those working in the specialty and remains committed to developing multidisciplinary input into training in ICM.

Although there are early references to discussions on developing a Faculty, it was not until the advent of the Joint Advisory Committee on Intensive Therapy (JACIT) that formal training posts were even established. In December 1992, the parent Royal Colleges of Anaesthetists, Physicians (England) and Surgeons (England) had agreed to develop a means of training doctors whose specialist skill was to be in ICM. The intercollegiate committee so formed eventually became the Intercollegiate Board for Training in Intensive Care Medicine (IBTICM) in September 1996 with a remit to take on the responsibility of regulating training in ICM. The first sitting of the Board’s Diploma in ICM was held in the summer of 1998.

After authorization by Frank Dobson, then Secretary of State for Health, changes were made to Part II of Schedule 2 of the European Specialist Medical Qualifications Order (the ‘Order’) on June 7, 1999, to include ICM as a specialty. This enabled the Specialist Training Authority (STA) to recognize ICM as a specialty that could develop a Certificate of Completion of Specialist Training (CCST) leading to entry to the Specialist Register of the General Medical
Council (GMC); this, however, would require a new training programme.

During this period of rapid change, there were undoubtedly tensions regarding the relationship of ICM with anaesthesia, and concern was raised within the College about the possibility of ICM developing autonomously or down a medical route. However, despite these difficulties, after a Herculean effort by Julian Bion, and others, a new competency-based curriculum was developed and approved in February 2001. On April 18, 2002, the STA approved the Board’s programme leading to a Joint CCST that could be obtained in addition to a CCST in a primary specialty. The Faculty continues to debate its strategy regarding the development of a Faculty; the decision was to watch and await developments. Towards the end of 2005, discussions took place more and more frequently within the Intercollegiate Board, with the ICS and the constituent Colleges of the Board, regarding the establishment of a Faculty. In May 2006, I spoke at the ICS Away Day to gauge opinion; it was agreed to continue dialogue. Following discussions on the development of faculties at the Academy of Medical Royal Colleges, the Intercollegiate Board was encouraged to detail its position. In December 2006, Charles Gilbe, the ICS President, writing in the Journal of the Intensive Care Society in September 2007, and the Regional Advisers in Anaesthesia at their meeting in November 2007.

In May 2008, Council of the Royal College of Anaesthetists (RCoA) debated the issue at great length and again at their Away Day and again at Council in June. It was reiterated frequently that all anaesthetists need critical care skills and this will always be so. Training in ICM is done over 9 months in a pattern of ‘spiral learning’ to a higher level than any other specialty. However, it is accepted that although anaesthetists may need critical care skills when caring for patients in the Operating Theatre and Emergency Department, not all will wish to deliver continuing care to critically ill patients within the intensive care unit (ICU). This ongoing responsibility is accepted by those consultants who wish to dedicate a significant part of their working week to the ICU, and requires a different training over and above that obtained by all anaesthetists.

At this time, the President of the RCoA, the accepted Lead College, was Judith Hulf who now engaged in direct conversation with the other six College Presidents constituting the Board (Royal College of Physicians of London, Royal College of Physicians of Edinburgh, Royal College of Physicians and Surgeons of Glasgow, Royal College of Surgeons of London, Royal College of Surgeons of Edinburgh, and the College of Emergency Medicine). At a meeting with College Presidents, the Chairman of the IBTICM and the President of the ICS on December 9, 2008, a full discussion took place. Although there were some points that would generate further debate through 2009, it was agreed in principle at that meeting that the Faculty would be supported.

Led by Judith Hulf, a Steering Group comprising Dr Alasdair Short (RCPEd), Professor Julian Bion (RCoA), Mr Kevin Storey (the RCoA’s Chief Executive), and Professor Tim Evans (RCPLond) was established to develop the way forward. The Faculty owes a huge debt of gratitude to Judith Hulf and her Group who developed the necessary Regulations and an implementation strategy that was acceptable to all Colleges. The parent Colleges finally gave their written approval for the establishment of the Faculty of ICM in July 2010.

The last meeting of the IBTICM was on November 25, 2010, at which stage it metamorphosed (though with a reduced and slightly different membership) into the Faculty’s Training and Assessment Committee. In the 14 years, it has been in place the Intercollegiate Board has exemplified the wish of intensivists to be part of a multidisciplinary training programme; that desire has seen it through a number of difficulties over the years. The Board has been hugely successful in bringing together those, from whatever background, who wish to raise the standard of training and practise within the specialty. The wisdom and foresight of those who saw that the specialty will essentially remain multidisciplinary are to be congratulated.

What of the immediate and short-term future? As alluded to in the opening paragraph, the Faculty will be 6 months old by the time this short history is published. Applications for Founding Fellowship have been open since January 1, 2011, and will close on December 31, 2011, by which stage the Faculty will have in place a number of different Fellowship and Membership categories so as to be inclusive to those with an interest in ICM; the future of the Faculty will depend on an adequate subscription income.

The first major challenge posed by the Regulator was their refusal, at the beginning of 2010, to allow the old Joint CCT programme to continue stating that, according to the Order, a single specialty CCT in ICM must be developed and only true Dual CCTs would be awarded in the future. The timeline given was, once again, ridiculously short but a team led by Dr Anna Batchelor and Mr James Goodwin, the Senior Administrator for the Intercollegiate Board at the College, produced a competency-based programme by reference to the work of the CoBatICE collaboration (Competency Based Training in ICM in Europe). The new programme was accepted, with some conditions, by the GMC in March of this year. This
means that trainees in ICM will be awarded true Dual CCTs with one of the primary specialties, or a single CCT in ICM for those choosing that programme, from August 2012. It is the general expectation that most contemplating a career in ICM will choose Dual CCTs, predominantly with anaesthesia.

As in many parts of the world, medical training and workforce development remains problematical. The current Coalition Government in England, in the face of a severe financial crisis, is consulting on how medical careers will be structured in the future. It is likely that consultants will be expected to deliver more service directly and, at the same time, be expected to work past the age of 65. Although ‘burnout’ is less of a problem than previously, it remains a worry for intensivists. Many consider that trainees should have skills in another specialty (e.g. anaesthesia) where their workload can be adjusted in later years.

Of course, with any training programme, there must be assessments and the Faculty, under the guidance of Professor Nigel Webster, is well on the way to producing a stand-alone examination for the ICM training programme. This must interdigitate with the examinations of the other specialties for those doing Dual CCTs to avoid assessment overload.

The Royal College of Anaesthetists can be proud of its vision and support of those who have laboured to improve the care that patients can expect when admitted to an ICU. By developing a career structure with a specific training and assessment programme, ICUs will more and more be staffed by consultants who want to be there. Most of them will be anaesthetists.

**Conflict of interest**

None declared.

**References**

1. Sir Isaac Newton. If I have seen further it is only by standing on the shoulders of giants. *Letter to Robert Hooke*, February 15, 1676