Intensive Care Medicine: Organization, Education and Politics

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I would like to begin with compliments to the article Ball et al. (1). The article mainly concentrates on the education and training aspects. The title gives hope. And there are many issues that I agree on. However, the authors are sometimes quite fixed in their statements due to their background and yet may have omitted important matters, which are crucial for quality of care. I shall try to discuss some of these issues.

I am strongly convinced that the organization aspects form the fundaments of Intensive Care Medicine. A clear place in the organogram of the hospital and an independent department with 24/7 dedicated personnel and budget are the essentials. Whatever their backgrounds are, the presence of intensivists for patient care is mandatory (2). As mentioned in my previous article, these aspects improve patient care (3). Moreover, the issues mentioned in the article of Ball such as, the difficulties encountered in the management of intensive care units, in terms of quality of care, training, internal leadership and coordination with other divisions within the hospital will be solved mainly with the well established Intensive Care organization. In other words, "it is the organization which saves the lives of the patients". Whether Intensive Care Medicine should be a primary specialty is not a discussion to begin with, but the result of the whole evolution. The building cannot stand without the fundaments.

Ball et al. (1) express their feelings as anesthesiology being the base specialty most frequently linked to Intensive Care Medicine. I understand their points. I have the same feelings, not only as an anesthetist from origin, but also looking in the history and seeing the great contribution of anesthesiology in the development of Intensive Care Medicine in many countries. However, practical skills often mentioned are not the only components of Intensive Care Medicine. During polio epidemics, airways and respiration were the main problems. When the respiration was treated and people did not die immediately, circulation failed and infection became a problem. We treated respiration and circulation and the kidneys failed. Multi organ failure followed eventually. Today, the competencies of a trained intensivist have a huge diversity. In fact too big to be owned by a classical specialty, whichever it may be. I certainly do not deny the importance of high standard skills and competencies that an intensivist should have. However, the days are long gone that a good intubation skill would be seen to be equivalent to a good intensivist. In a multidisciplinary setting, we learn daily from each other's competencies and teach accordingly to the next generation. To refer to Khanna and Kaplan (4), a good intensivist must have:

- The keen observation of a pediatrician (ventilated ICU patients cannot talk),
- The patience of an obstetrician (watchful waiting is a part of beneficial therapy),

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- The thoughtfulness of a physician (multiple complex problems need sorting),
- The rapid reflexes of an anesthesiologist (quick thinking and action as needed),
- The aggressiveness of a surgeon (definitive invasive intervention when needed),
- The communication skills of a psychiatrist (families and friends need counseling).

Last issue is on the free movement of intensivists across European countries. An anesthetist from a European country can move to another, his diploma being automatically accepted. Today, the inhomogeneity of training and education to become an intensivist prevents this movement. An intensivist from Spain cannot get a job in the Netherlands because he does not have a primary specialty in order to be registered in the Dutch medical association. An intensivist from one European country often needs to have extra training to be registered in another, due to different training requirements. European Diploma in Intensive Care (EDIC) and the European Diploma in Anesthesiology and Intensive Care (EDAIC) did not solve this problem so far. The European Union of Medical Specialists (UEMS) is the place where this issue of uniformity in training should be addressed. Anesthesiology can have an important contribution within UEMS for this achievement.

Ball et al. (1) conclude with the sentence: "More importantly, we believe that, any medical-surgical profession, independently from the type of individual specialty, should include high level of clinical, educational and research skills finalized to optimize the diagnostic and therapeutic approach as well as to improve patients outcome and their quality of life after hospital discharge". To be honest, I could not agree more. Let's walk it like we talk it.

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