

# Training in intensive care medicine: an accident and emergency trainee's perspective

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*Emerg Med J* 2002;19:106–108

There are a number of compelling reasons why some accident and emergency (A&E) doctors may also wish to train in intensive care medicine (ICM). This article reviews and discusses the benefits and practicalities of dual A&E/ICM training from a trainee's perspective. It should be read in conjunction with: Shelly MP. A&E/ICU interface: training in intensive care medicine.<sup>9</sup>

being initiated for some patients, for example, continuous positive airway pressure. As a consequence of this, and difficulties with access to critical care beds (particularly medical high dependency beds), these patients are often in A&E resuscitation rooms for longer periods of time.

- The principle of continuity of care is well established. The Department of Health review of adult critical care services has emphasised the importance of an integrated "hospital wide approach" to critical care services.<sup>8</sup>

The Intercollegiate Board for Training in Intensive Care Medicine (IBTICM) and the Royal Colleges have issued a joint statement supporting the development of the specialty of intensive care medicine (ICM) to allow dual accreditation with anaesthesia, medicine, surgery or accident and emergency (A&E) medicine.<sup>1</sup>

The aims of this article are to review the benefits and current practicalities of dual A&E/ICM training from a trainee's perspective and to discuss future developments.

## WHY INTENSIVE CARE?

Appropriately, A&E is developing much closer links with those specialties with which it has continual interaction, for example, paediatrics, acute medicine, and intensive care. As a natural progression, some A&E doctors are electing to complete further training in these disciplines. There are a number of compelling reasons for this.

- Intensive care and A&E have much in common. Both are relatively young, rapidly developing specialties that are promoting the importance of acquiring the skills and establishing the systems necessary to manage patients with life threatening illness or injury. Intensive care has been described as a horizontal specialty cutting across the traditional vertical specialties of medicine, surgery, paediatrics, etc.<sup>2</sup> This description could equally be applied to A&E.
- Up to 20% of patients on a general adult intensive care unit are admitted directly from A&E.<sup>3–5</sup> In addition, some patients who initially go to a general ward are subsequently admitted to either high dependency or intensive care facilities, often because the severity of their illness was originally underestimated. The importance of the early recognition, referral and appropriate management of patients who might benefit from critical care is increasingly being recognised.<sup>6,7</sup>
- Sick medical patients constitute a significant proportion of the A&E resuscitation room workload. Increasingly complex treatments are

## INITIAL CONSIDERATIONS

The present training requirements for ICM are discussed in an accompanying article, which also outlines the difference between intermediate and advanced level training.<sup>9</sup> New training guidelines (for CCST in ICM) are being introduced. These are available from the Intensive Care Society (ICS) web site ([www.ics.ac.uk](http://www.ics.ac.uk)). The proposed changes and their implications for A&E trainees are discussed in subsequent paragraphs (*The future and Personal view*).

A&E specialist registrars (SpRs) who wish to complete either intermediate or advanced level training (usually towards the end of A&E training) will need to get a training post with the flexibility to provide them with all the experience they need to meet these requirements. Presently not all SpR posts in ICM have this degree of flexibility.

You should not assume that A&E training secondments to anaesthetics/ICU or medicine will always count towards ICM training. The length of these secondments, your clinical exposure and/or level of responsibility may be judged to be inappropriate or inadequate, especially if you have been supernumerary.

If you have not yet completed your secondments you could consider negotiating six months in an SHO training post. However, such jobs may be difficult to find, especially in anaesthetics and you need to confirm in advance that the job will be recognised for ICM training. Although this approach could save some time in the long term you will lose the flexibility and freedom offered by an A&E secondment, which permits you to address your specific A&E learning objectives. These will not be identical to your ICM learning objectives. Attempts to save time could mean that

**Abbreviations:** ICM, intensive care medicine; NTN, national training number; ETR, educational training record

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Accepted for publication  
12 December 2001

you do not satisfy the JCHTA&E requirements—that is, a minimum of three years A&E as an SpR and all essential secondments. There are also good clinical reasons not to try to complete dual training as fast as possible but instead to acquire comprehensive experience.

A number of clinical fellow in intensive care posts and critical care rotations (at SHO level) have recently been advertised. Some of these jobs offer experience in acute medicine as well as intensive care and may be suitable for certain trainees. However, you should check very carefully that such posts meet your requirements and are accredited for ICM training, as many are not.

All these issues should be discussed with your A&E educational supervisor and regional ICM advisor as early as possible. In effect you need two mentors, one from each specialty. Your plans will subsequently need to be discussed with your postgraduate dean because under the current system you need agreement to take your national training number (NTN) with you. Further advice can also be found in the handbook of the Trainees Division of the Intensive Care Society (ICS).<sup>10</sup>

### FINDING A SPECIALIST REGISTRAR POST

There is now an *Intensive care* section in the *BMJ Classified*. At the moment not all SpR posts are necessarily advertised there and you should continue to look under *Anaesthetics and Medicine* as well.

Particular questions to ask yourself and others about any post include:

- Will this job meet my training requirements?
- Will I get a breadth of intensive care experience? It may be necessary or beneficial to rotate between hospitals/units.
- Is there an active teaching/research/audit programme?
- Will I be able to continue my A&E professional development?

For posts offering anaesthetic experience you should also ask:

- Will I do anaesthetics first? This is usually logical.
- How will my anaesthetics be structured? You will need a lot of emergency work (rapid sequence intubation), paediatrics and, ideally, some experience of specialist lists, for example, neurosurgical, cardiothoracic, maxillary-facial.

In addition, you may wish to ask about opportunities to gain overseas experience. Up to six months may be recognised by IBTICM but only towards advanced level training.

### JOB APPLICATION

A&E specialist registrars invariably possess a number of skills and attributes relevant to intensive care that should be emphasised on your CV and at interview. Some of these are shown in box 1.

### STARTING THE JOB

Once in post discuss your training objectives with your ICM trainer within the first few weeks. Register with the IBTICM and start your educational training record (ETR) including case summaries as soon as possible. A blank copy of the ETR

#### Box 1 Skills and attributes of particular relevance to ICM

- Resuscitation skills.
- A broad clinical experience.
- Teamwork and team leadership.
- Flexibility.
- Experience in dealing with all specialties.
- Problem solving ability.

#### Box 2 Future entry requirements for SpR post in ICM

- three months SHO in ICM
- six months anaesthesia
- six months medicine

and advice on completing it, details of the Diploma in Intensive Care Medicine and information on the activities of the Trainees Division may all be found at the ICS web site.

While getting the most out of your intensive care training it is also important to ensure that you do not neglect your continuing A&E professional development. Keep in touch with your A&E training programme and attend conferences whenever possible.

### THE FUTURE

The Specialist Training Authority has approved CCST in ICM. Competency based training recommendations have been developed so that dual A&E/ICM accreditation will be possible in the near future. It will still be necessary for trainees to take their NTN with them from their base specialty as NTNs in ICM are not planned. To encourage multidisciplinary development of ICM it is proposed that some training posts will be reserved solely for (and specifically advertised for) non-anaesthetists.

From an A&E trainees perspective the most important proposed change is that trainees could not be appointed into an SpR post (for CCST in ICM) unless they have already satisfied the requirements shown in box 2.

### PERSONAL VIEW

Over the next few years some A&E trainees who are towards the end of their training and who do not meet the proposed entry requirements may find it difficult to train in ICM. Other SpRs and senior SHOs intending to train in ICM will need to plan their training very thoroughly, early in their careers. They will need encouragement and help with this.

I believe that it is desirable for A&E trainees who want to train in ICM to be able to do so as part of one SpR rotation designed to meet the necessary training requirements for both specialties. A rotation of this kind is now being organised in the North West region to permit intermediate level training. Six month rotations with anaesthetics have also been proposed.<sup>11</sup> Generally trainees are looking for imaginative schemes that will permit them to develop their further interests.

SpR rotations of this kind would be well supported by SHO rotations offering experience in a combination of A&E, acute medicine, intensive care, anaesthetics, and other acute specialties, for example, paediatrics, general surgery. Depending on their composition, rotations such as these may be attractive to doctors intending careers in anaesthetics, medicine or even paediatrics as well as A&E. They would allow SHOs to get a broad clinical experience and, if desired, at the same time meet the basic level and complementary specialty requirements for ICM training.

Training in intensive care has given me a breadth and depth of experience in the initial and continuing management of patients with life threatening illness and injury. I have had further training in the safe and appropriate transfer of critically ill patients, both interhospital and intrahospital. My decision making and communications skills have undoubtedly developed and I have been challenged by a variety of ethical dilemmas. I now have a much clearer understanding of the integrated approach to critical care.<sup>8</sup>

The new competency based ICM training syllabus is progressive, structured, and comprehensive. Obtaining the

requisite knowledge, skills and attitudes while keeping up to date in A&E as well as ICM presents a significant but worthwhile challenge.

### SUMMARY

There are a number of compelling reasons why some A&E doctors may also wish to train in ICM. Although there are currently some obstacles to completing dual training, the evolution of intensive care training programmes and the development of imaginative and innovative A&E rotations (at both SpR and SHO level) will hopefully overcome most of these difficulties.

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