Intensive Care Medicine: Different Recipes for Shared Goals

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First of all, we would like to thank Professor Kesecioğlu (1) for his historical perspective: it is important to put this discussion in the right context: as we all might be influenced by our personal experiences and the work environment where we grew up. We share with our colleague the commitment to improve and homogenise the standards of care in our intensive care units (ICU), and the call to improve skills and education of healthcare professionals, whose final goal is taking care of the critically ill patient. We recognize that from the polio epidemic to nowadays, the competences required to face critical conditions have gradually changed and different skills, apparently belonging to other specialties, have become crucial in the practice of intensive care medicine (ICM). Nonetheless, it is quite common, among different specialties, that a medical professional need to acquire additional competences not strictly related to his or her original background but shared with other specialties, in order to guarantee adequate management of the patient.

Our patients are characterized by a complex overlap of several conditions, affecting his or her health status and commonly involving infections or acute cardiovascular, neurological, respiratory and renal function impairment (2). In taking care of these patients, a unique professional figure with a multidisciplinary preparation has to dedicate his or her work time entirely to the management of the illness per se, as well as related factors such as patients' and relatives' psychological status. The intensivist has to exercise his own leadership in order to coordinate all health professional roles that work around the critically ill patient, namely being a reference and also an interface between the patient and other specialists, when the competences of a single professional are insufficient. All these purposes are mandatory and not necessarily in contrast with the definition of the intensivist's professional role, whose education in ICM can be built based on other specialties, such as anaesthesiology as it is often the case in Europe. ICUs organization is different in many European countries and political and administrative measures have to be realized in order to create an optimal workplace to take care of critical patients (3). We are convinced that differences in ICUs management have to be solved at the local level, and creating a primary specialty would not necessarily be a solution. However, the Multidisciplinary Joint Committee in Intensive Care Medicine (MJCICM) should make efforts to have ICM recognized as area of 'particular expertise' at the European level (4). This kind of solution would not require changing the ICM education path in most of European countries, while gaining an institutional recognition suitable to obtain ICUs administrative and political

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improvement at the local level. For some of us, the imperative is building intensivists' community has been influenced by the need to negotiate with hospitals and governments in order to implement ICUs organization and intensivists' recognition. From this perspective, ICM training programs could only be seen as an instrument to reach this aim. In contrast, we think that they should rather represent the natural response to the need of improvement of quality of care and clinical outcomes and to face the several challenges related to the development of ICM. We are in favour of an implementation of training programs already existing in the different European countries, comprising certified education assessment with a final exam or diploma supplement (5-7). Clinical activity, training of younger colleagues and research are three fundamental aspects of medicine and interest in all these aspects must be promoted to motivate residents and students in the field of ICM.

In conclusion, while we do not propose a single recipe to solve all problems of ICM in Europe: we have a common ground and common aims, let's move forward together.

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