



White Paper on the Future of Anaesthesiology
and Intensive Care Medicine

College of Anaesthesiologists of Ireland

Foreword

Dear Fellow,

In the interests of transparency and professional dialogue, the College of Anaesthesiologists of Ireland is publishing the White Paper on the Future of Anaesthesiology and Intensive Care Medicine in Ireland, which was submitted to our Council in June 2025.

This White Paper is the product of extensive work by a group convened to respond to structural, regulatory, and training challenges facing the profession. It outlines a series of recommendations for the future configuration of training, certification and professional recognition in Anaesthesiology and Intensive Care Medicine.

The College of Anaesthesiologists of Ireland emphasises that publication of this document does not imply endorsement of all the recommendations contained within it. Rather, it represents the start of a broader engagement process. The White Paper is a discussion document and its proposals require careful consideration, stakeholder consultation and prioritisation before any implementation decisions are made.

Over the coming months, the College will engage with trainees, our Fellows, the JFICMI, the HSE and Dept of Health and regulatory bodies to explore the feasibility and implications of the recommendations. We remain committed to ensuring that any changes safeguard patient care, maintain training standards and support the sustainability and integrity of our profession.

We thank all members of the White Paper Group for their contribution and welcome constructive engagement from all parts of the anaesthesiology and intensive care community as we move forward.

Best wishes

Prof Donal Buggy

White Paper on Future of Anaesthesiology and Intensive Care/Critical care Medicine in Ireland

Membership:

Stakeholder	Representative
<i>Chairman</i>	John Bates
Chair, Work Group Role Profiling of the Consultant in Anaesthesiology in Ireland	Deirdre McCoy
College of Anaesthesiologists of Ireland	Michelle Duggan
JFICMI	Andrew Westbrook
Association Irish Standing Committee	Rory Page
ICSI	Alan Gaffney
HSE National Clinical Programme for Anaesthesia	Michael Dockery
HSE National Programme for Critical Care	Martina Healy
Model 3 Hospitals	Elise Alexander
Committee Anaesthesiologists in Training	Paul Ryan
Private Hospitals	Jan Steiner
CAI training committee	Camillus Power

Terms of Reference:

The EGM of September 12, 2024 approved this response to the concerns raised by the MCI's decision to change our CSCST.

The objectives of this Working Group are:

1. To produce a White Paper (i.e. a Discussion Document) on the Future of Anaesthesiology, Intensive Care & Pain Medicine in Ireland;
2. As a separate work stream, to Role Profile the post of Consultant in Anaesthesiology in Ireland, which has already commenced under Deirdre McCoy as Chair;
3. To propose new certification in intensive care medicine to be awarded to trainees on satisfactory completion of our CAI CSCST, which will summarise the competencies and experience obtained in our programme;
4. To propose new certification in pain medicine to be awarded to trainees on satisfactory completion of our CAI CSCST, which will summarise the competencies and experience obtained in our programme;
5. To deliver this by 30 September 2025 or sooner if feasible.

The mechanism of achieving these aims will be:

1. Through extensive discussion and consultation with all stakeholders, followed by
2. Drafting summary text with any proposed solutions/next steps (4,000-6,000 words);
3. If consensus on proposed recommendations / solutions/next steps is not feasible, the majority position will be described, with documentation of the concerns of those with alternative viewpoints.

Executive Summary

The White Paper Group were tasked with producing a white paper on the Future of Anaesthesiology, Intensive Care & Pain Medicine in Ireland for the CAI. The group considered the current state and future needs of Anaesthesiology and Intensive Care/Critical Care Medicine (ICM/CCM) and Pain Medicine in Ireland. The paper highlights the comprehensive training program offered by the CAI, which integrates substantial ICM/CCM components. However, recent changes including the introduction of an ICM register and the instruction by the IMC to exclude ICM/CCM references from the CAI's CSCST have raised concerns over legal and professional implications for practitioners.

The dual specialization in anaesthesiology and ICM/CCM is crucial for adequately staffing hospitals, particularly Model 3 hospitals. The document outlines the historical development of ICM/CCM training and the collaborative efforts among various organizations to improve standards and education.

Twenty issues were considered by the group and recommendations are proposed to address current challenges and improve the training and certification framework including but not limited to:

1. Renaming the Anaesthesiology register to "Anaesthesiology and Critical Care" to reflect the dual expertise of Irish anaesthesiologists and align with international standards.
2. Requesting further clarification from the IMC that both the Anaesthesiology and ICM registers are "the appropriate register" for the practice of ICM/CCM with a view to reducing potential legal concerns.
3. Reviewing and broadening the criteria for entry into the ICM division of the register, acknowledging established practitioners with ICM/CCM fellowships and leadership positions.
4. Seeking legal opinion on whether historical CSCSTs could permit inclusion on the ICM register based on past training acknowledgments.
5. Advising the CAI to seek legal advice on the potential medico-legal implications of practicing ICM/CCM without ICM register inclusion.
6. Facilitating SAT trainees to complete 12 months of JFICMI-recognized ICM training modules if they wish.
7. Recognizing 12 months of ICM/CCM training for all SAT trainees, reflecting the actual work and training experience and requiring some adjustments to training.

The group were not in favour of establishing a mono-specialty ICM training program, or an anaesthesiology only program, favouring the benefits of dual training. It suggests issuing a Certificate of General Professional Training in ICM/CCM and Membership of the JFICMI to SAT graduates for formal recognition of their ICM competencies. These recommendations are contingent upon

satisfactory resolution of recognition of ICM/CCM training and legal concerns which can only be fully addressed by implementation of recommendation 1. Suggestions are made regarding the ICM training program for non-Anaesthesiology trainees. Additionally, it encourages aligning clinical roles, training outcomes, and HSE job descriptions to better reflect the dual responsibilities of anaesthesiologists. The recommendations are aimed at ensuring a sustainable future for Anaesthesiology and ICM/CCM in Ireland, addressing practitioner concerns, enhancing training standards, and maintaining high-quality patient care.

Introduction:

The College of Anaesthesiologists of Ireland (CAI) and the Anaesthesiology Training program:

The CAI is the training body responsible for the specialty of Anaesthesiology in Ireland. Established in 1959 as a faculty of the Royal College of Surgeons in Ireland (RCSI) and called the Faculty of Anaesthetists, RCSI, the CAI was reconstituted as a college in 1998 and renamed the College of Anaesthetists of Ireland. In 2018, an application was accepted to have the name changed again, this time to the College of Anaesthesiologists of Ireland. This change was reflected in the name of the specialty as listed on Annex V and the Irish Medical Council (IMC) Specialist Register.

Anaesthesiology consultants and trainees work in operating theatres throughout Ireland and in addition (although not reflected in their title), provide most of the specialist care in Irish ICUs and pain clinics. This is reflected in the Anaesthesiology training program, which is considerably longer and contains more Intensive Care Medicine/Critical Care Medicine (ICM/CCM) training than many of its internationally equivalent counterparts. It is also reflected in the wording of the awarded CSCST, which indicates satisfactory completion of training in “Anaesthesia, including Intensive Care and Pain Medicine”. This dual specialization has several advantages. For example, in Ireland, where 31% of ICM/CCM care is delivered in Model 3 hospitals, it would not be feasible to employ enough clinicians to staff these ICUs without them also covering theatre. The dual specialization also creates a large pool of clinicians with ICM/CCM skills, such that even for Anaesthetists who do not continue ICM/CCM practice after training, their training (combined with their ongoing practice of Anaesthesia) ensures that they retain sufficient competency to be called upon in a crisis (such as COVID). The WPG considers that the term “Anaesthesiology” on the register and the new CSCST does not adequately describe the dual training of anaesthesiologists in Ireland.

The CAI’s six-year training program is based in hospitals accredited by the College. Training is structured to provide a broad range of experience in different types of hospitals and various sub-specialties in anaesthesia. Training comprises a combination of practical experience, clinical learning, and theoretical learning in non-clinical areas, individual study, and mandatory elements including training and simulation courses, completion of the electronic logbook, and the training diary. The course requires success in the Membership and Fellowship of the CAI.

The Specialist Anaesthesiology Training (SAT) program of the CAI is accredited by the Irish Medical Council (IMC). The outline of the program is contained in the e-curriculum (1). This curriculum is under review in preparation for the next accreditation cycle of the IMC in 2026.

Although the IMC and the 2007 Medical Practitioners Act (MPA) only recognize “full” specialties for specialist registration, the postgraduate training bodies recognize subspecialty areas as

essential components of training and specialist interest. The CAI SAT program includes specialist training and competence assessment in the sub-specialties of Paediatric Anaesthesia, Cardiothoracic Anaesthesia, Neuroanaesthesia, Pain Medicine, Intensive Care/Critical Care Medicine, Obstetric Anaesthesia and Regional Anaesthesia. Entry into the SAT program is highly competitive. It produces excellent specialists who are welcomed into the best fellowship programs worldwide and who provide excellent quality of care to patients in the ROI. Departments of Anaesthesiology, Pain Medicine and Intensive Care/Critical Care are held in high esteem around the country because of the outstanding work they do and the service they provide for patients throughout the hospital system.

ICM/CCM developments:

Standards in Anaesthesia and ICM/CCM, including training, organization and delivery, have improved over the years through the efforts of many past and current clinicians. ICM/CCM improvements were aided by the establishment of several formal organizations that gave it a voice separate from Anaesthesia:

1. The Irish Board of Intensive Care Medicine (founded in 1994)
2. Subsequently replaced by the Joint Faculty of Intensive Care Medicine of Ireland (JFICMI) in 2008.
3. The Intensive Care Society of Ireland (ICSI) (founded in 1986)

These organizations fostered collaboration and structured improvements to be made in education, training and delivery of care. The ICSI was established first and remains committed to the development and maintenance of standards and practice in Irish ICUs. Its membership is inclusive and is open to all healthcare professionals with an ICM/CCM practice. The society is governed by a Council that is elected by and answers to the society at its AGM. It advocates and provides advice to statutory and other bodies on ICM/CCM issues and played a significant role in updating and educating the public during the COVID pandemic. The ICSI receives no central funding and relies on annual subscriptions, meeting registration fees and support from the medical trade.

The JFICMI was established in 2008 by its four parent bodies: the ICSI, CAI, RCPI and RCSI. One of its major aims has been to gain IMC recognition of its two-year ICM training program. The 2009 Prospectus Report (2), an independent report commissioned by the HSE to look into standards around the provision of ICM/CCM services in the Republic of Ireland recommended (recommendations 20-23) that with regard to medical education and training, the establishment of the JFICMI be finalized and an ICM training program be introduced. The JFICMI along with its parent bodies and with extensive support from the CAI undertook this task. The JFICMI became a faculty of the CAI in 2018. The ICM training program was recognized in 2019. The stipulations of the 2007 MPA require all training programs to have a designated section of the register and the ICM section of the IMC register was opened by the IMC in 2019.

The membership of the JFICMI includes all fellows of the faculty (similar to other faculties and colleges). Fellowship of the JFICMI (FJFICMI) does not of itself allow registration on the ICM division of the register. All FJFICMI are entitled to be elected to the board of the JFICMI. Elected members, along with the Presidents of the CAI, ICSI, RCPI and RCSI are represented on the board. A significant number of the clinicians providing ICM/CCM specialist care in Ireland are not FJFICMI and are therefore not represented in the body that shapes the future of the ICM training program (other

program (graduates of which are allowed no explicit reference to ICM/CCM in the title of the register or their CSCST) and the amount of training time in ICM/CCM which is not accredited for the two-year ICM training program.

The IMC has stated that “The Anaesthesiology program covers the full spectrum of anaesthesiology practice including modules on intensive care medicine and pain medicine. This program is not changed as a result of reverting to the approved title of Anaesthesiology.” and “The Anaesthesiology training program will remain the same in terms of the design, content, delivery and final outcome/ quality of the qualification.” They have also stated that completion of the CAI training program “does not entitle the bearer to be registered in the specialist division in either of these two specialties (Intensive Care Medicine or Pain Medicine)– only in the speciality of Anaesthesiology”. (3)

The CAI and JFICMI consider all Irish trained anaesthesiologists to be competent to practice ICM/CCM (although a clear public statement on this would be useful). This is based on the extensive ICM/CCM training component of the CAI training program. The HSE “continues to support the SAT curriculum learning outcomes including ICM and Pain Medicine” and “has no plans to change the model of care for Anaesthesia or CCM/ICM, both of which require Anaesthesiologists scope of practice to include Intensive Care Medicine and Pain Medicine”.(4)

The National Treasury Management Agency (NTMA) confirmed that indemnity is not an issue, “as the state’s clinical indemnity scheme provides doctors with indemnity based on their professional role in a hospital, irrespective of the CSCST title.” (3,5) The MPS and Medisec have also confirmed in correspondence to the CAI (Appendix 5 and 6) that anaesthesiologists are not required to be on the ICM register to be covered to practice ICM provided that they have the relevant training and competency.

While the JFICMI regulates the 2 year ICM training program, the CAI is independently entitled to certify the ICM/CCM component of Anaesthesiology training. In this sense, there are two bodies responsible for ICM training - the JFICMI and the CAI. Graduates of both programs are considered interchangeable on rosters providing ICM/CCM but only completion of the 2 year JFICMI training program allows entrance onto the ICM specialist register. Most NCHD service delivery of ICM/CCM in Ireland is provided by anaesthesiology trainees (both CAI and non-scheme).

In addition, ICM is not a specialty like other main specialties - an initial base specialty is needed when training in Ireland. A few countries (e.g. Australia) have mono-specialty training in ICM but it is the exception rather than the rule internationally. Indeed dual anaesthesia and ICM training (7.5 years total training time) has been reintroduced in Australia as the complete separation of the two training programs has led to an ICM/CCM staffing crisis in regional hospitals including smaller hospitals in urban areas. One of the major barriers to staffing their ICU’s and HDU’s with trained intensive care specialists is the requirement for a specialist to cover both anaesthesia and ICM/CCM, especially after hours. Relying on FANZCA-trained specialists to cover ICU has become increasingly difficult because of the limited exposure and training in intensive care medicine during FANZCA anaesthesia training. It is important that this situation is avoided in Ireland.

Dual specialty training with anaesthesia is the norm in Europe although about 30% of ICU beds are managed by non-anaesthesiologists. The ICM training program in Ireland is “supra-specialty” but the concept of supra-specialist training is not recognized by the IMC.

The CAI working group which is profiling the role of the Consultant in Anaesthesiology in Ireland has included ICM/CCM as being part of the role and within the scope of practice of anaesthesiologists.

Notwithstanding this position, many practitioners remain concerned regarding potential medico-legal exposure from practicing ICM/CCM on the anaesthesiology register without being on the ICM register, as their qualifications might be questioned, despite their competence. This has the

potential to reduce the number of anaesthesiologists who wish to continue to practice ICM/CCM in Irish healthcare with potential adverse effects on patient care and working conditions for those who continue to provide ICM/CCM.

The White Paper Group (WPG) considered the following issues and potential solutions regarding the current and future status of Anaesthesiology and, Intensive Care/Critical Care Medicine in Ireland. The recommendations are intended for practitioners trained in Ireland or evaluated by the CAI credentials committee as having equivalent training

Register and Medico-legal issues

1:

The WPG recommends that the Anaesthesiology register be renamed the “Anaesthesiology and Critical Care” register and that the Irish title for Anaesthesiology in Annex V be changed to “Anaesthesiology and Critical Care”.

The stated reason the IMC directed the CAI to remove the “to include Intensive Care and Pain Medicine” phrase from the CSCST was so that the CSCST would be consistent with the name of the register: “The IMC is obliged to comply with the EU Directive on mutual recognition of professional qualifications (2005/36/EC as amended). The title listed for Ireland under point 5.1.3 of Annex V of the Directive is Anaesthesiology. Titles listed in Annex V must correlate with the CSCST being issued in Ireland” (3). If the register title (and consequently the title in Annex V) were changed to Anaesthesiology and Critical Care, it follows that this would also be allowed as wording on the CSCST.

In Annex V, most (16 out of 24) EU countries include some reference to critical care medicine (6) (e.g. reanimation (the French term for Intensive Care Medicine (7, 8)) or intensive care) on the designation of their anaesthesiology register. Of the 3 EU countries with a separate ICM training program (France, Spain and Ireland), both France and Spain include reference to ICM/CCM (reanimation) in their anaesthesiology register, making Ireland an outlier in this regard. (6, 9, 10).

While the terms “Intensive Care” and “critical care” are substantially interchangeable, the group considers that it would be reasonable to use the term “critical care” to denote the specialist ICM/CCM training integrated into the CAI SAT program if this is necessary to avoid administrative confusion with the 2 year JFICMI ICM training program and register.

There are many problems with the current discrepancy whereby most EU programs include reference to ICM/CCM in their Anaesthesiology register and Ireland does not. Many EU anaesthesiology training schemes are shorter (minimum 3 years) and contain less ICM/CCM experience and competencies than the CAI scheme. The WPG believes harmonizing the names of the Anaesthesiology registers in Annex V and the training programs would be beneficial. There is a potential risk of graduates of some European Anaesthesiology training programs (with the term “Intensive Care Medicine” in their CSCST) being entered into the ICM division of the register rather than the anaesthesiology one. Irish-trained anaesthesiologists will be at a disadvantage to the majority of EU-trained Anaesthesiologists who’s CSCST’s include some reference to ICM/CCM despite the CAI SAT program providing more training in ICM/CCM than many of the EU programs.

Renaming the register has many advantages, specifically:

- 1:** All specialist registered Anaesthesiology consultants would be on a relevant specialist register to provide ICM/CCM services.
- 2:** Legal concerns would be alleviated as the specialist register title would reflect all aspects of anaesthesiologists’ work.

3: No changes to the training programs would be required and the time CAI SAT trainees work in ICU would be reflected in their registration.

4: A change in the specialist register title would allow the CAI CSCST to include Anaesthesia and Critical Care. This would benefit doctors traveling abroad as their ICM/CCM experience would be appropriately recognized.

5: It would align Ireland with the majority of countries in Annex V as 16 of 24 include Anaesthesia and some reference to ICM/CCM.

6: The register would more accurately reflect what most Irish anaesthesiologists have on their CSCSTs.

7: The ICM register would remain to distinguish those who have completed the two-year ICM program.

8: There would still be a path to ICM registration for Emergency Medicine doctors, physicians and surgeons.

There was consensus in agreement with this recommendation and the group considers this as the only long-term solution to all the concerns expressed.

2:

It is the opinion of the group that the IMC should provide further clarity on clinicians on the anaesthesiology register practicing ICM/CCM by issuing a statement along the lines of: “the IMC considers all anaesthesiologists on the anaesthesiology division of the IMC specialist register to be competent to practice ICM independently in model 3 and model 4 and private hospitals throughout the ROI in both an on-call and daytime capacity. In this regard the IMC regards the Anaesthesiology register or the Intensive Care medicine Register to be “the relevant register” for the practice of Intensive Care Medicine/Critical Care Medicine in Ireland.” This clarification is required as the HSE Public Only Consultant Contract (POCC) “Information for candidates” stipulates that consultants be on “the relevant register” for their role in the hospital and most anaesthesiologists provide ICM/CCM as part of their role. (11)

Expert legal advice should be sought by the CAI/JFICMI before finalizing the suggested wording in order to provide the maximum legal reassurance to practitioners concerned about exposure arising out of practicing ICM/CCM while on the anaesthesiology register and not the ICM register.

A similar statement should be issued by the CAI, the JFICMI and the HSE.

There was consensus in agreement with this recommendation.

3:

The JFICMI should consider reviewing the criteria for entry to the ICM division with a view to broadening these criteria.

The JFICMI advises the IMC on criteria for inclusion in the ICM division of the register for practitioners (i.e. what constitutes equivalent training to the JFICMI ICM training program). These criteria were drawn up in 2019. Many established practitioners with ICM fellowships and leadership roles in ICU are ineligible for inclusion on the ICM register. The JFICMI should review the current criteria to assess if it is appropriate to broaden the criteria to include established practitioners described above. The WPG also suggests that a mechanism should be established to include PICU consultants on the register if they have been trained in a Paediatric Critical Care Medicine program recognized by the JFICMI.

There was consensus in favor of this recommendation.

4:

Should the CAI and JFICMI pursue the objective of including all current ICM/CCM practitioners in ICM on the ICM division of the register?

This would ensure that all current ICM practitioners have the cover of the ICM register if this is advantageous from a medico-legal perspective.

It would eliminate any perceived elitism regarding ICM/CCM practitioners who are on or not on the ICM register.

It would acknowledge the work done in ICM by all ICM/CCM providers.

It would however establish the practice of having all ICM/CCM practitioners on the ICM register and may make it more difficult for future CAI trainees who have not completed the two-year ICM training program or equivalent to practice ICM/CCM.

Depending on the criteria, which would have to be agreed with the IMC, there is a risk that a small number of current practitioners (i.e. those who took up consultant positions with an ICM commitment subsequent to 2019) might be excluded from the register.

It may be undeliverable as any arrangement would need to be consistent with the 2009 Medical Practitioners Act (in effect it would have to be demonstrated that the ICM/CCM component of the anaesthesiology training program is the same as that of the ICM training program).

There was consensus against this proposal.

5:

The WPG suggests that the CAI seek legal opinion on whether the phrase “including intensive care medicine” on historically issued CSCST’s could allow those consultants inclusion on the ICM register.

There may be a legal argument based on Section 47 of the Medical Practitioners Act which states “every Medical Practitioner who is granted evidence of satisfactory completion of specialist training by a body approved under section 89”, be registered in the Specialist Division.

With a certificate from the CAI saying “completed the approved program of Specialist Training in Anaesthesia, to include Intensive Care Medicine and Pain Medicine”, issued at a time when there was no ICU specialty register, this may imply that they were specialists in Anaesthesia and ICM. Thus, when the ICM register was opened, these specialists should have been allowed inclusion on that register.

There was consensus in favor of this recommendation.

6:

The group considers that independent legal opinion should be sought by the CAI regarding potential medico-legal exposure arising from practicing ICM/CCM while on the anaesthesiology register without being on the ICM register and the impact that removal of reference to ICM on the CSCST may have on this.

There was consensus in favor of this proposal.

Issues pertaining to the CAI and JFICMI training schemes

7:

CAI SAT trainees wishing to complete 12 months of JFICMI-recognized ICM modular training during their training scheme with a view to sitting the FJFICMI exam should be facilitated to do so.

A substantial minority of graduates of the CAI training program wishing to sit the FJFICMI exam are ineligible because they have not completed the required 12 months of modular training, due to an inability to access ICM training modules. Based on a recent CAT survey, 55.6% of SAT trainees intend to sit the FJFICMI exam and a further 7.4% would sit it if they could complete the modular training requirement. This is unfair, as SAT trainees, as well as their non-scheme anaesthesia NCHD colleagues provide the vast bulk of on call and daytime care for critically ill patients around the country.

There was consensus in favor of this recommendation.

8:

Minimum/standard ICM/CCM training component of the SAT training program for dual anaesthesiology/CCM training.

Current options for the ICM component of the Anaesthesiology training scheme:

- A. Standard Anaesthesiology training (6/12 modular training, 18/12 on call, ICM component of FCAI exam)
- B. Anaesthesia with an ICM Fellowship (FJFICMI) (10 months modular training, 18/12 months on call, FJFICMI exam) achievable within the 6 year SAT training period and
- C. Dual Registration (Anaesthesiology + ICM registers) (10 months modular training, 18/12 on call, FJFICMI exam) achievable within the 6 year SAT training period AND 1 year ICM post CSCST achievable in 7 years total training time.

Based on the recent CAT survey (appendix 8), there appears to be a reasonable spread of current trainees who would opt for the 3 current training options, i.e. 39.7% plan to sit the FJFICMI exam (ICM fellowship at a minimum), approximately 60% of those who expressed a preference wish to practice ICM at consultant level and the remaining 40% of those who expressed a preference wish to practice solely in anaesthesia.

While the minimum training period in ICM in the SAT program is currently 6 months, SAT trainees effectively get considerably more training in ICM/CCM than this suggests, i.e.:

Modules in JFICMI accredited ICU's:	4 months
Modules in Model 3 ICU's (currently accredited for ICM training by the CAI but not the JFICMI but under review by the JFICMI)	2 months
On call module (all complete 18/12 ICM/CCM call)	2 months
Competency Modular Equivalence (i.e. non continuous time in ICM/CCM (estimated))	2 months
PICU module (completed by approx. 50% of trainees) or further 2 months in Model 4 ICU	2 months

Recommendation:

The group considers that the minimum period of ICM/CCM training for SAT trainees should be recognized as 12 months based on the above. This is feasible given that most trainees are already getting a year of experience working in ICM/CCM. With regard to the non-continuous time in ICM/CCM, the view of the group is that the move to competency-based training and the use of log books and WBA may allow the capture of some additional value for this time awarding a notional further 2 month module. It is acknowledged that the non-continuous nature of the training is not consistent with other ICM training programs and the JFICMI will have to consider this but the CAI can recognize this 2 month period independent of the JFICMI.

This change to require all SAT trainees to complete 12 months of ICU/CCM training is contingent upon satisfactory recognition of this competency on the anaesthesiology CSCST and register (as per recommendation 1).

This change is capacity dependent and would require the following steps:

- A. The current review by the JFICMI to consider recognition of two month modules in Model 3 Hospitals would need to be successful. The WPG supports the recognition of Model 3 hospitals by the JFICMI for ICM/CCM training. This will require a revision of the current criteria for JFICMI training centers. The criteria would need to be achievable for model 3 CAI training hospitals and not reduce the quality of the ICM training experience. The JFICMI would need to review the criteria for training centers and ensure new training centers would meet appropriate standards with regard to consultant cover, case mix, continuity of care and clinical governance. It is the group's view that this is only achievable in hospitals with the 2+2 model of anaesthesiology cover. The WPG supports the full implementation of the 2 + 2 model. As a faculty of the CAI, the JFICMI should be involved in assessing all CAI ICM/CCM training centers.
- B. Achievement of 12 months ICM/CCM for all SAT trainees will also require the 50% of trainees who do not complete a 2 month PICU module to complete a third 2 month module in an ICU with full (model 4) training accreditation. The recognition of University Hospital Waterford (and potentially Our Lady of Lourdes Hospital, Drogheda) as full (model 4) JFICMI training sites will help with this.
- C. Ensure that all CAI trainees who complete 6 months of ICU on-call in a Model 4 hospital are offered a 2 month module per 6 months on on-call if they so wish. It was noted at the WPG discussions that the CAI already holds the view that to require an NCHD to complete a 6 month period of on call to ICU without facilitating a 2 month module is unprofessional as it prevents the NCHD from experiencing the culture of the ICU during daytime hours.
- D. Sub-specialties are not regulated by the Medical Council and do not necessarily require an associated exam. Given that two compulsory fellowship exams within a 6 year training program may be excessive and could present logistical problems for the JFICMI exam, it is clear that exam reform would be necessary (e.g. utilizing the ICM/CCM component of the FCAI and MCAI exams as the test of knowledge for ICM/CCM subspecialty status). This would need further exploration with the CAI and JFICMI exam committees.

There was consensus in favor of this proposal.

9:

Should the CAI consider an anaesthesiology only program?

Most CAT trainees believe that their ICM/CCM time has enhanced their ability as anaesthesiologists (82% of those who expressed an opinion) and only 25.7% intended to practice as anaesthesiologists

without an ICM/CCM practice. Furthermore, considering the structure of the Irish healthcare service, which relies heavily on anaesthesiologists to provide ICM/CCM services, it may not serve the best interest of the population of the ROI to establish an anaesthesiology only training program. That said, in the recent CAT survey, 37.7% stated that they might opt for an anaesthesia only training scheme with only 6 months of ICM if it were available.

There was consensus against this proposal but contingent upon satisfactory recognition of ICM/CCM competency on the anaesthesiology CSCST and register.

10:

Should the CAI explore the option of 2 rather than the current 3 training outputs, namely?

A: Standard Anaesthesiology Training including 12 months of ICM/CCM and success at ICM/CCM component of FCAI as suggested in recommendation 7 (in effect all would be Anaesthetists SI ICU).

B: Dual registration on both Anaesthesiology and ICM registers (would require 1 further year of ICM fellowship and success at FJFCIMI exam).

In effect this would eliminate the option of sitting the FJFCIMI exam for those who do not intend to complete a second year of ICM/CCM.

The WPG does not make any recommendation on this issue.

11:

Anaesthesiology and ICM programs completed within a 6 year period

(currently requires 7 years):

Given the level of service delivery to ICM/CCM by anaesthesiology services, SAT trainees typically gain about 10-12 months of experience and training in ICM/CCM during their 6 year program. There may however be difficulties in including a second continuous fellowship year consistent with the training experience of the advanced clinical fellow year in the current ICM training program. It may not be possible for trainees to complete all their anaesthesiology competencies with two years of the total training time allotted to ICM.

The WPG does not make any recommendation on this issue.

12:

Mono-specialty training program in ICM:

The WPG considers that a mono-specialty training program in ICM is not desirable as the likely cohort of trainees would likely be too small and it would go against the flexible anaesthesiology-ICM/CCM dual training and ICM supra-specialty dual registration options which better align with healthcare needs in Ireland.

13:

Certification of Competencies of ICM and Pain Medicine to be offered to trainees on completion of the CAI training scheme:

Following the decision of the IMC to instruct the CAI to remove the wording "Intensive care and Pain medicine" from the CSCST, there is a need to certify the competencies of anaesthesiology trainees in ICM/CCM and Pain Medicine. The certification would detail the competencies and knowledge base of graduates, would be issued by the JFCIMI based on modular (6-10 months) and on call (18 months) signoff and the ICM/CCM components of the FCAI exam. This would require agreement between the CAI and JFCIMI exam committees.

The WPG believes that the best option would be to award:

Membership of the JFICMI (based on 8-12 months of ICM training and success at the ICM/CCM component of the FCAI exam)

And

Certificate of General Professional Training in Intensive Care Medicine/Critical Care Medicine, issued jointly by the CAI and JFICMI.

There was a consensus in favor of this recommendation. Crucially, it is also the view of the WPG that the above certification in no way negates the need to progress recommendation 1.

14:

Pain Management/Pain Medicine:

While extensive training (8-12 months) in ICM/CCM is embedded in the SAT training program, the minimum modular time in Chronic Pain Medicine is 2 months. All trainees in Anaesthesiology gain competencies in regional anaesthesia, recovery room care, with further experience in perioperative and trauma acute pain control and all anaesthesiologists are skilled in pain management.

The Faculty of Pain Medicine opted not to participate in the WPG discussions. The WPG makes no recommendation on issues regarding the Pain Medicine register and removal of the term "Pain Medicine" from the CSCST as these are matters which need to be considered by the CAI and Faculty of Pain Medicine.

15:

Issues relating to non-Anaesthesiology ICM Trainees:

A: Anaesthesiology training for non-Anaesthesia ICM trainees:

Structured anaesthesia training time for non-anaesthesiologists is an important part of their training in competencies including airway management, mechanical ventilation, use of anaesthetic and vasoactive drugs, management of hemorrhage and transfusion, vascular access, perioperative medicine, perioperative risk assessment, analgesia and surgical pathology. Currently, non-anaesthesiology ICM trainees acquire their initial airway and vascular access competencies through days in anaesthesia or intermittent theatre visits. The view of the group is that a standardized front loaded structured anaesthesia module of 3-6 months with a defined minimum number of procedures and airway competency signoff would be a more effective way of gaining these competencies. It would allow these trainees to start their ICU training with a stronger anaesthesia skill set, enhancing their initial training experience and may facilitate earlier participation in ICM/CCM call. The JFICMI may also wish to consider a similar period in internal medicine or Emergency Medicine for anaesthesiology based trainees during their ICM training program.

B: Paediatric experience for non-anaesthesia ICM trainees. While SAT anaesthesia trainees are required to complete a minimum of 6 months of paediatric anaesthesia/PICU, there is no mandatory clinical paediatric component to ICM training for non-anaesthesia trainees. Although practitioners in Dublin Model 4 hospitals do not engage in PICU practice, up to 175 critically ill children annually are

admitted to model 3 and 4 hospital ICU's outside of Dublin with 400-450 transferred to CHI from outside Dublin each year.

It is recommended that a minimum period of 3 months of PICU or pediatric anaesthesia practice be mandatory for intensivists taking up consultant positions in hospitals with a paediatric service.

There was a consensus in favor of this recommendation.

This could be defined by asking the HSE to specify a new job title, such as "Consultant Intensivist in a Hospital with a Paediatric Service," and to stipulate a requirement for at least 3 months of paediatric anaesthesia or PICU training.

The group discussed recommending that all ICM trainees complete some clinical training in PICU/Paediatric Anaesthesia. The majority view was that a 3 month period of PICU would be of value to all ICM trainees but there was not a consensus on this issue.

C: In house ICM/CCM on-call requirement: While non-anaesthesiology ICM trainees complete a full 2 years of ICM, it is not clear what their in-house on call requirement is as they may not start call at the very beginning of their ICM training and may complete some remote call in year 2. Given that SAT trainees are required to complete 18 months of in-house ICU call for competency signoff, this should be clarified as the minimum in-house call requirement for non-anaesthesiology ICM trainees also.

Other issues:

16:

Clinical role, Medical Council status, training outcome and HSE job description should be aligned and consistent. Consultant Job Roles/Descriptions may not relate to the job performed (i.e.: many anaesthesiologists work in both theatre and ICM/CCM, without explicit reference to ICM/CCM sessions in their job description or contract). In that sense, there may not be any difference in clinical role between "Consultant Anaesthetist" and "Consultant Anaesthetist S.I. ICU". The specifics of a consultant post (the job description) and the role of the doctor occupying that post (the scope of practice) are dictated by each departments (and hospital's) clinical requirements and the doctor's skills and preferences. Accordingly, the contract between the doctor and the employer is paramount in defining the roles and duties of a hospital consultant. Even though ICM/CCM may be deemed to be part of the role and within the scope of practice of Anaesthesiologists, HSE job descriptions and contracts should explicitly reference ICM/CCM service commitments for anaesthesiologists who are expected to provide ICM/CCM care outside of theatre.

The WPG suggest that the HSE job titles more closely match the consultant role and suggest the below changes to the HSE job descriptions:

Current Job Title (12)	Anaesthesiologist	Anaesthesiologist S.I. ICU	Intensivist	
Suggested Title	Anaesthesiologist	Anaesthesiologists with a sessional commitment to ICU	Intensivist	Intensivist in a Hospital with a Paediatric Service

Training outcome (may be subject to change (see recommendation 8))	6 yrs CAI SAT program (including 18 months O/C and 6 months daytime ICU) FCAI	6 yrs CAI SAT program (including 18 months O/C and 6 months daytime ICU) MJFICMI	5 years base training and 2 years ICM. Base specialty exam FJFICMI or equivalent	5 years base training and 2 years ICM including 3 months of PICU or Paediatric Anaesthesia Base specialty exam FJFICMI or equivalent
Register	Anaesthesiology	Anaesthesiology	Intensive Care	Intensive Care
HSE qualifications for consultant posts (11)	IMC registration in the Specialty of Anaesthesiology	IMC registration in the Specialty of Anaesthesiology MJFICMI	IMC registration in the Specialty of Intensive Care Medicine	IMC registration in the Specialty of Intensive Care Medicine including 3 months of PICU or Paediatric Anaesthesia

17:

JFICMI CCM Standards document:

The WPG recommends reviewing the JFICMI minimum standards for Critical Care Services regarding the qualifications recommended for the Director of a large ICU role and consider accepting an ICM/CCM fellowship including 12 months of ICM training to be an appropriate qualification.

18:

IMC assessment Fee for ICM division:

The WPG recommends that the CAI/JFICMI consider reducing the assessment fee for admission to the ICM register for established practitioners if there are changes to the assessment criteria.

19:

CAI name change:

Given that all training in ICM/CCM in Ireland is delivered by the CAI (the training body) and JFICMI (a faculty of the CAI) and the lack of public awareness of the role of anaesthesiologists and the CAI in ICM/CCM provision, the WPG recommend that the CAI consider including some reference to ICM/CCM in its title to reflect this role.

20:

The WPG recommend that given the extensive discussions around the above issues held by the group (12 hours over 6 months), it would be useful to the CAI to include members of the group in processes arising out of the white paper recommendations.

References:

- (1) <https://www.anaesthesia.ie/wp-content/uploads/2020/07/CAI-Curriculum-2020.pdf>
- (2) <https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/towards-excellence-in-critical-care-report.pdf>: Page 135
- (3) Medical Council's Briefing Note – Anaesthesiology CSCST Title, 13th of August 2024 (Appendix 2).
- (4) Letter from HSE COO to CAI (Appendix 3)

- (5) Communication from SCA to Dr E Alexander (see appendix 4)
- (6) <https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32005L0036> (Page 61-62)
- (7) Intensive Care Medicine: Enterprise and Journey. Kesecioğlu, J: Turk J Anaesthesiol Reanim. 2017 Oct 1;45(5):245–246. PMID: 29114405
- (8) <https://sfar.org/welcome-the-sfar-website/>
- (9) Structure, Organization and Practice of Critical Care Medicine in France In ICU: Management & Practice, ICU Volume 5 - Issue 1 - Spring 2005
- (10) Educational Programme on Intensive Care Medicine in Spain in ICU: Management & Practice, ICU Volume 6 - Issue 2 - Summer 2006
- (11) <https://www.hse.ie/eng/staff/resources/hr-circulars/short-explanatory-notes-pocc23.pdf>
- (12) <https://www.hse.ie/eng/staff/leadership-education-development/met/consultantapplications/quals1/consultant-titles-qualification-list-11-12-2024.pdf>

Documents considered by the WPG:

- (1) NDTP Anaesthesia workforce planning report <https://www.hse.ie/eng/staff/leadership-education-development/met/plan/anaesthesiology-medical-workforce-in-ireland-2023-2038.pdf>
- (2) NDTP ICM workforce planning report <https://www.hse.ie/eng/staff/leadership-education-development/met/plan/specialty-specific-reviews/icm-workforce-plan-2020-final-report.pdf>
- (3) Medical practitioners act 2009
<https://www.irishstatutebook.ie/eli/2007/act/25/enacted/en/html>
- (4) Proposal submitted to WPG by Dr. E Alexander (Appendix 5)
- (5) 2022 INICU report: <https://d7g406zpx7bgk.cloudfront.net/x/ecb6eeefe8/irish-national-icu-audit-annual-report-2022-final.pdf>
- (6) CAT training survey (appendix 7)
- (7) Letter from MPS to Prof D Buggy (Appendix 3)
- (8) Letter from Medisec to Prof D Buggy (Appendix 4)
- (9) Legal advice received by the IMC on change to the titles of CSCST's (including Anaesthesiology CSCST) was not available to WPG (privileged). Excerpt was provided.

Appendix 2: Briefing Note from IMC to CAI

MEDICAL COUNCIL'S BRIEFING NOTE – ANAESTHESIOLOGY CSCST TITLE

Date: 13th of August 2024.

SUMMARY

A Certificate of Successful Completion of Specialty Training (CSCST) is an important document which is issued to doctors upon successful completion of a programme of Specialty Training that has been accredited by the Medical Council. The CSCST is used as evidence by the Medical Council (IMC) to place a doctor on the specialist division of the register of medical practitioners in the speciality named on the CSCST. It can also be used by doctors as evidence of a specific qualification internationally when submitted to international regulators outside the European Union (EU). A CSD (Certificate of Specialist Doctor) is used within the EU.

The designated approved title for Anaesthesiology is **'Anaesthesiology'**. The College of Anaesthesiologists ('CAI) have been issuing CSCST's with the title of **'Anaesthesiology to include Intensive Care Medicine and Pain Medicine'** to doctors who successfully complete their training in Anaesthesiology.

The only title that can be used on the CSCST is the already designated title ('Anaesthesiology') following a previous Accreditation process and subsequently approved by the Education and Training Committee, followed by Ministerial approval.

In its role as a regulator, the IMC have asked the CAI to use the correct title when issuing the Anaesthesiology CSCSTs. The issue is ongoing since the 17th of August 2021, when the draft Accreditation report was issued to the CAI stating the CSCST should state 'Anaesthesiology' only.

The correct CSCST title is required to maintain full compliance with the Medical Practitioners Act 2007, and to convey information in a manner that is clear, equitable and transparent.

There is precedent with similar requests given to other Postgraduate Training Bodies (PGTB's), and the IMC's approach in this instance is in line with the approach taken with other PGTB's. Following a request from Council, several other PGTB's updated their CSCST titles for their programmes to maintain full compliance with the Medical Practitioners Act (2007); the EU Directive; and the Council's regulatory authority.

Further information below.

ROLE OF THE MEDICAL COUNCIL

The IMC is the regulatory body for doctors in Ireland. It has a statutory role in protecting the public by promoting the highest professional standards amongst doctors practising in the Republic of Ireland.

The IMC is responsible for quality assuring medical education and training in Ireland across the continuum, which spans the undergraduate, intern and specialist training stages of professional development. The Medical Practitioners Act 2007 (as amended) sets out the Medical Council's responsibility for accrediting specialist training programmes and the postgraduate training bodies that deliver the programmes.

The IMC is responsible for designating the title for all accredited programmes of specialist training. All titles and designations of qualifications granted by the IMC in the state, to enable a doctor to be registered in the specialist division of the register, must comply with the terms of Section 89(2) of the Medical Practitioners Act 2007 and the EU Directive on mutual recognition of professional qualifications (EU Directive 2005/36/EC as amended).

In summary terms, the IMC have statutory responsibility for a) approving the specialties that are recognised in Ireland, b) the bodies that are approved to deliver specialist training programmes in each of those specialties, and c) accrediting each specific specialist training programme in line with the standards set out by the IMC, including the title to be used in the CSCST.

ROLE OF THE POSTGRADUATE TRAINING BODY

A postgraduate training body (PGTB) is approved by the Council under section 89(3)(a)(ii) of the Medical Practitioners Act as the body which may grant evidence of the satisfactory completion of specialist training. In this case, CAI is the body approved by the IMC for the speciality of Anaesthesiology.

The specialist training programme accreditation report states the designated title and designation of qualification of the CSCST to enable a medical practitioner to secure registration in the Specialist Division of the register, under the terms of Section 89(2) of the Medical Practitioners Act 2007. In this case, the designated title to be used on the CSCST is Anaesthesiology.

Following the accreditation approval process (ETC & Ministerial approval) the CAI are furnished with the finalised approved accreditation report, which lists all the Conditions and Recommendations the CAI need to become fully compliant with the IMC standards. An Action and Implementation Plan (AIP) is developed and a follow-on meeting with the IMC occurs to discuss how the CAI will implement the actions needed.

On a yearly basis, progress is monitored via the IMC Annual Returns process where the CAI are required to update the IMC on the progress and status of the Conditions and Recommendations. The CAI are also required to notify the IMC on any significant changes and / or updates that may impact the quality of education and training of the programme.

APPROVED CAI-RELATED SPECIALTIES (FOR SPECIALIST REGISTRATION)

There are three approved specialties related to Anaesthesiology. Each one has a separate, accredited specialist training programme leading to the award of a CSCST in that speciality. These are:

- Anaesthesiology – the approved training body is CAI, and the accredited training programme is Anaesthesiology. The holder of a CSCST in Anaesthesiology is entitled to be placed on the IMC specialist division register of medical practitioners under the speciality of Anaesthesiology.

- Intensive Care Medicine – the approved training body is the Joint Faculty of Intensive Care Medicine; and the accredited training programme is Intensive Care Medicine. The holder of a CSCST in Intensive Care Medicine is entitled to be placed on the IMC specialist division register of medical practitioners under the speciality of Intensive Care Medicine.

- Pain Medicine - the approved training body is the Faculty of Pain Medicine; and the accredited training programme is Pain Medicine. The holder of a CSCST in Pain Medicine is entitled to be placed on the IMC specialist division register of medical practitioners under the speciality of Pain Medicine.

EU LAW DIMENSION

The IMC is obliged to comply with the EU Directive on mutual recognition of professional qualifications (2005/36/EC as amended). The title listed for Ireland under point 5.1.3 of Annex V of the Directive is Anaesthesiology. Titles listed in Annex V must correlate with the CSCST being issued in Ireland.

PROBLEM STATEMENT

The title that is being used by CAI on CSCST's for the accredited Anaesthesiology training programme is incorrect and is not and never has been approved by the IMC. The title includes references to two other accredited specialties, namely Pain Medicine (PM) and Intensive Care Medicine (ICM). However, this CSCST does not entitle the bearer to be registered in the specialist division in either of these two specialties – only in the speciality of Anaesthesiology. As referenced above, all CSCST titles must comply with relevant EU Directives, and the IMC is statutorily responsible for ensuring that this is the case.

In this context the CSCST title being used by CAI is not approved and could be misleading. The IMC must be trusted by fellow regulators in other countries to provide accurate information upon which they can make decisions with assurance. In addition, the risk of doctors being placed on the wrong or multiple registers outside the EU is raised where the CSCST is the main certification used for registration in such countries.

CONCERNS RAISED BY THE CAI

- **Workforce:** any potential changes to the title could lead to concerns that Anaesthesiologists are working outside of their scope of practice, resulting in Anaesthesiologists potentially withdrawing from ICM and/or PM service and/or may impact negatively on recruitment.
- **Indemnity:** a change to the CSCST could cause potential indemnity risks if an Anesthesiologist was deemed to have acted outside their scope of practice and held liable for any negative outcome.

In respect to the above, the IMC sought advice from both the HSE and the National Treasury Management Agency on the concerns raised.

- **Workforce:** the HSE confirmed that a doctor's role description and workplan should incorporate requirements for the provision of services in ICM and PM. The title on a CSCST does not impact this.
- **Indemnity:** a representative from the National Treasury Management Agency confirmed that this is not an issue. Doctors working in hospitals covered by the state's

- , but rather fall under global indemnity provided to the clinical site in question.

TOPLINE TIMELINE OF DISCUSSIONS

- August 2021: Issue was raised with CAI following the Accreditation process. Multiple engagements since August 2021 to Dec 2023 (5 Stakeholder Meetings; 6 letters and emails).
- February 2024: Meeting between the IMC and CAI representatives; Letter issued from IMC to CAI stating title on CSCST must state Anaesthesiology only; Letter received by IMC from CAI requesting additional time for clarification and transitional arrangements; Letter sent to CAI by IMC approving this request.
- June 2024: Meeting between the IMC and the CAI. Multiple engagements regarding implementation of the decision across different cohorts of trainees followed.

DECISION OF THE COUNCIL

In line with the approach the IMC have taken with other PGTB's who deviated from the designated approved CSCST title, the IMC requested that the CAI must revert the CSCST title to 'Anaesthesiology', which is the title designated and approved by the IMC Education and Training Committee with Ministerial approval, following an accreditation process.

FREQUENTLY ASKED QUESTIONS (FAQ).

1 Will this affect recruitment by HSE?

2 No. The HSE confirmed that reverting to the approved title of 'Anaesthesiology' would not affect their recruitment strategy. The HSE confirmed that a doctor's job description and workplan should specify requirements for the provision of services in ICM and PM.

1 Does this affect indemnity?

2 No. The National Treasury Management Agency (NTMA) confirmed that indemnity is not an issue, as the state's clinical indemnity scheme provides doctors with indemnity based on their professional role in a hospital, irrespective of the CSCST title.

1 Does this restrict scope of practise?

2 No, it does not. The Anaesthesiology programme covers the full spectrum of anaesthesiology practice including modules on intensive care medicine and pain medicine. This programme is not changed as a result of reverting to the approved title of Anaesthesiology.

3 It should also be noted that 'scope of practice' is not something that is fixed in stone throughout the working life of a specialist. While it remains (under maintenance of professional competence rules) the responsibility of each individual to ensure that they maintain competence relevant to their scope of practise, it is understood that this scope may evolve due to the nature of the job they have, research interests and so on.

1 When does this decision come into effect?

2 As noted above, while discussions on this issue have been ongoing since 2021, the College were notified formally on the 9th of February 2024 about the Council's decision on the matter. The decision was due to become effective

from the 1st of March 2024 and apply to all doctors who complete Anaesthesiology training after this date. Any trainees commencing the Anaesthesiology training programme post February 2024 will have the approved title of 'Anaesthesiology' on their CSCST when they successfully complete the programme.

1 **Does this affect those who have already gained their Anaesthesiology CSCST qualification?**

2 No. The decision **will not be applied** retrospectively and will not impact those holders of the CSCST title which references Pain Medicine or Intensive Care Medicine.

1 **How does this affect active trainees enrolled on the Anaesthesiology training programme in the last 6 years (all those prior to Feb 2024)?**

2 For the current cohort of trainees, it has been agreed that upon successful completion of the programme they will be issued with a CSCST with the title of Anaesthesiology to include Intensive Care Medicine and Pain Medicine, subject to inclusion of the following: ***This CSCST entitles the holder to Specialist Division Registration in Anaesthesiology only.*** This sentence must be underneath the title of the CSCST and should be issued to all trainees who are currently on the Anaesthesiology training programme and have not yet received a CSCST.

1 **How does this affect trainees who enrolled and commenced Anaesthesiology training in July 2024?**

2 Trainees due to commence the programme in July 2024 should be issued with a CSCST which states the approved designated title of 'Anaesthesiology' only.

1 **Does this change the quality of the Anaesthesiology qualification in terms of curriculum content and modules covered?**

2 No. The Anaesthesiology training programme will remain the same in terms of the design, content, delivery and final outcome/ quality of the qualification.

1 **Does this change the way the Anaesthesiology programme is delivered or impact the experiences of the trainees on the programme?**

2 No. The format, duration and the delivery of the programme remains the same.

1 **What is the change to the Anaesthesiology programme as a result of the CSCST stating the title of Anaesthesiology only.**

2 There will be no change to the programme. The words 'to include Intensive Care Medicine and Pain Medicine' will be removed from the CSCST. The modules on Pain Medicine and Intensive Care Medicine will still be delivered on the programme.

1 **Why didn't the IMC bring this to the Colleges attention sooner?**

2 Since August 2021, The Council has engaged extensively with the College on this matter. In the process of making this decision, the IMC have also consulted with the Health Service Executive; NTMA and sought legal advice

END.

Appendix 3: Letter from HSE CCO to CAI



240806_Ltr from
CCO CPO to CEO Coll

Appendix 4:

Email from SCA to Dr E Alexander

From: [REDACTED]
Date: 2 September 2024 at 08:59:43 IST
To: [REDACTED]
C: [REDACTED]
Subject: RE: Risk related to change in specialty register {196689}

Good morning Dr. [REDACTED]

I acknowledge receipt of your e-mail query, below.

The Clinical Indemnity Scheme (CIS) indemnifies all doctors working in the public health system under the principle of "Enterprise Liability." Simply put, Enterprise Liability means that the health enterprise assumes vicarious liability for the acts and omissions of its medical practitioners. The CIS, founded on the principle of Enterprise Liability, does not discriminate between classes of doctors once the health enterprise agrees to employ a doctor to provide to it professional medical services. It is exclusively a matter for the health enterprise to ensure the competencies of doctors it employs.

I hope and trust that this answers your query.

Kind regards,

[REDACTED]
[REDACTED]
[REDACTED]

Appendix 5: MPS Correspondence to CAI.

Good Morning [REDACTED]

Thank you for contacting us with your query and we are happy for you to share the below information with any COA member on our status.

Medical Protection position has not changed- "Medical Protection Society will allow a specialist registered anaesthetist to work in ICU without the need for specialist registration in intensive care medicine. "

While we are in touch would you be so kind to let me know who the best person in COA would be to discuss indemnity for IMG and Irish doctors to understand the reasons to have supplementary medical indemnity when working in the HSE.

They are a significant number of NCHD's (including Anaesthesiologists) working in Ireland who don't have their own individual indemnity. We want to ensure they all are aware of why they need Supplementary Medical Indemnity (attached a PDF that explains why)

I also met a younger Consultant Anaesthesiologist recently who didn't see the benefit of having his own supplementary medical indemnity with the new POCC contract- until I explained it to him again, he said that it may be forgotten in the younger doctor who may not want to, for now do any private work.

According to the Medical Council they were **345** new complaints in 2022 (241 Male/109 Female)

1. **29** fitness to practise inquiries concluded
2. **5** Doctor's registration cancelled Vs 1 in 2021/2021

IMC stats show that doctors who are not represented are more likely to have less favourable outcomes than those doctors who are represented.

We have a Clear Communication webinar(45 minutes long) working with the RCSI focusing on over 900 IMGs on their educational program for end of March 2025-this could also work very well for you in the COA if you are interested- there is no cost for this.

If you require anything else, please feel free to reach out to me directly. Have a lovely day.

Read our papers on

Urgent reform needed as doctors under investigation by regulator report toll on mental health - [Understanding the impact of a Medical Council investigation \(medicalprotection.org\)](https://www.medicalprotection.org/understanding-the-impact-of-a-medical-council-investigation)

Clinical Negligence Claims Ireland- the human and financial cost [Clinical negligence claims - the human and financial cost \(medicalprotection.org\)](https://www.medicalprotection.org/clinical-negligence-claims-the-human-and-financial-cost)

Two in five doctors say mental health is worse now than during the pandemic- [Press releases \(medicalprotection.org\)](https://www.medicalprotection.org/press-releases)

Please avail of our confidential counselling service if you may need it - [Counselling service \(medicalprotection.org\)](https://www.medicalprotection.org/counselling-service)

Warm regards

[REDACTED]

Appendix 6: Letter from Medisec to Prof D. Buggy



Medisec Ireland CLG
7 Hatch Street Lower
Dublin 2, D02 AW92

Tel: +353 1 661 0504
Email: info@medisec.ie
Web: www.medisec.ie

Prof Donal Buggy
College of Anaesthesiologists Ireland
22 Merrion Square North
Dublin 2

8.11.2024

Re: Professional Indemnity Insurance

Dear Prof Buggy

Thank you for your email in relation to indemnity for consultants in anaesthesiology working in intensive care units in the private sector.

Medisec as a membership organisation is not the insurer, but we arrange professional indemnity insurance for both medical and dental practitioners' members, including consultant anaesthetists, with our underwriters/insurers MedPro, a part of the Berkshire Hathaway family.

We have been in contact with MedPro on receipt of your query and they have confirmed that cover under their policy of insurance, subject to the usual policy terms and conditions and any applicable regulatory or legal requirements, will extend to a specialist registered anaesthetist working in ICU without the need for specialist registration in intensive care medicine, provided of course they have the necessary training, skills and competency. I trust this answers your query.

If at any stage you or your colleagues in the College of Anaesthesiologists would like to meet with us or our business partners MedPro, to highlight the services we offer and our commitment to risk and best practice, or to draw on the global data of MedPro in your field we would be very happy to do so.

Please do not hesitate to reach out to me at any stage or my colleague Niall Rooney again if you have any query.

Kind regards

Yours sincerely

A handwritten signature in black ink that reads "Ruth Shipsey".

Ruth Shipsey
Chief Executive
Medisec Ireland CLG

Appendix 7: Proposal Submitted by Dr. E. Alexander:

I believe the Medical Council review of the CAI Training Scheme is rapidly approaching and this seems to be an ideal time to make changes. However, much discussion and decision making needs to happen prior to this. The white paper group is meeting on Tuesday evening for a focused discussion on the future of the Anaesthesia training scheme. It seems sensible to have a structured idea in mind prior to the meeting, so that we have a starting point for the discussion. I would welcome feedback (good and bad) as this should really be a College wide discussion. I would really appreciate if someone would double check my calculations and assumptions in the Appendix section, in case I have made an error.

Regarding Anaesthesia and ICM

Currently the system doesn't make sense:

- 139 Consultants working in ICU aren't on the relevant specialist register.
- Consultant Job Roles/Descriptions may not relate to the job performed (ie: many employed in an Anaesthesia role, without ICU sessions in job description, but working in both theatre and ICU).
- There is a gross disparity in ICU service provision between trainee Anaesthetists vs Surgeons/Physicians, with almost all of it done by anaesthetists. Minimal service provision is provided by ICM trainees when viewed as a proportion of the whole. This is bizarre considering ICM is now considered a separate specialty.
- There is inequity in the minimum duration of ICM clinical experience required for Anaesthesia trainees vs Physicians/Surgeons to obtain an ICM CSCST (ie: Anaesthetists have to do much more).
- The current ICM training scheme doesn't ensure ALL doctors awarded a CSCST in ICM have all CoBaTrICE competencies (ie: the minimum standard for ICM clinicians in the EU - for example one of the 12 domains is Paediatric care).

- CAI training is unchanged despite significant change to the CSCST and a new ICM register.

As described in the CAI Airway day last week - The most relevant factor in terms of safety (for patients and staff) is the design of a system.

Therefore the system should be changed so that there is coherence between:

- The IMC Specialist Register
- HSE Job Roles and Job Descriptions
- CAI/JFICMI Training

- European Union?...(CSCST change came about because of alignment with the EU)

In addition to the above there needs to be:

- Adequate Service Provision at a NCHD level.
- Adequate numbers of Consultants.
- Adequate inflow into ICM and Anaesthesia schemes to provide adequate future staff.
- Excellent Training Standards that produce competent Consultants.
- A system of training that trainees feel confident in and wish to apply to.
- A bright future for both ICM and Anaesthesia
- A way for patients to easily verify that a Consultant has adequate training and qualifications to work in a particular specialty (this would normally be checking the IMC Register, as a Consultant's CV, Job Role/Description is not accessible to the public).

It is also advantageous if:

- There is a large pool of clinicians with ICU skills to pull upon in a crisis (like COVID).
- Physicians and Surgeons are more comfortable with the ward management of deteriorating patients even if not ICM qualified.
- More Physicians/Surgeons/Critical Care doctors qualify in ICM.
- Physicians/Surgeons/Critical Care doctors trained in ICM can also contribute outside of Dublin hospitals.

What I think ICM and Anaesthesia should look like in the future.....

*This does not refer to the current Consultants, as their Job Roles and descriptions have already been decided and to my knowledge cannot be altered without both employer/employee agreement.

** A separate plan would be needed for the current trainees that have been caught in this messy transition. It is essential they aren't forgotten, particularly after their enormous contribution during COVID.

REGISTER

- There should remain separate Registers for ICM and Anaesthesia

Discarded ideas included:

- Abandoning ICM register altogether
- Two registers but renaming the Anaesthesia register "Anaesthesia and Critical Care"

These ideas were abandoned after informal communication with the IMC suggested that they were not paths they would consider.

HSE ROLES (I haven't covered Pain roles or Paediatric Critical Care/Anaesthesia)

1. Consultant Anaesthesiologist

- Registered on the Anaesthesiology register.
- Works as an Anaesthesiologist and doesn't work in ICU

2. Consultant Anaesthesiologist including Intensive Care Medicine

- Registered on both the Anaesthesiology and ICM register.
- Works in both ICU and theatre.
- Satisfies all the CoBaTrICE competencies.

3. Consultant Intensivist

- Registered on the ICM Register.
- Satisfies all the CoBaTrICE competencies.
- Only works in ICU.

4. Consultant Intensivist for Adult Hospitals (could exclude this role if ICM training modified)

- Registered on the ICM Register
- Only works in the ICU of Hospitals where Acute Paediatrics does not present.

I suspect the roles as above will be unpopular with some JFICIMI/CAI members:

- Some doctors working in ICUs will have more training than others and those doctors understandably wish that to be recognised. That this extra experience isn't identified at the level of HSE Job Roles/Registration may concern them. However a doctor's training can be distinguished from another's, using job specifications and by examining CVs (as was done before the ICM register). Specialist Registration and Job Roles on the other hand, should be used to regulate practice in a specialist field, so that only those that meet the minimum requirements of skills/competency can be employed (ie: training is "satisfactory", hence the "S" in CSCST).
- The fourth role of "Consultant Intensivist for Adult Hospitals" may seem unnecessary. However, at the EGM it became apparent that there isn't a clear understanding of ICM/Anaesthesia job requirements in areas outside of Dublin and the importance of acute paediatric experience in safely resuscitating, stabilising and transporting. Relying on new ICM Consultants to only apply to those jobs appropriate to their skill set, or on potential employers to correctly identify training weaknesses, seems less safe than regulation at the level of Job Roles. Ideally ICM training should be modified so that Acute Paediatrics is mandatory for all ICM trainees and then this role wouldn't be needed at all.

Discarded ideas included:

- Current roles as described by HSE: <https://www.hse.ie/eng/staff/jobs/eligibility-criteria/>

consultant.pdf

The current roles no longer suit the changed situation in ICM and Anaesthesia. Roles should reflect scope of practice and qualifications/competency. Why have a role of “Anaesthesia with special interest in ICM” if the scope of practice, qualifications, competency and registration is no different from another existing role.

FUTURE TRAINING SCHEME

DUAL ANAESTHESIA AND ICM TRAINING

- A 6 year dual training scheme, giving all trainees the opportunity to leave with both ICM and Anaesthesiology CSCSTs.
- 18 months of ICM modules. This would be more hours than the current minimum time required of Non-Anaesthesia Trainees on the ICM scheme. (Please see Appendix A for calculations and graph below for comparison of trainee hours)
- ICU on-call should only be done during an ICM module as the Dean of the JFICMI does not feel hours worked outside of a module have the same value as time during a module and will therefore not count it in an equivalent way. Any hours outside of modules would take time from Anaesthesia training opportunities.
- Two separate Fellowship Exams.
- Can graduate with two CSCSTs if completes training and passes both Fellowship Exams.
- Can graduate with one CSCST if completes training and passes one Fellowship Exam (either ICM or Anaesthesiology CSCST depending on the exam passed).
- Anaesthesia subspecialty modules as normal - including Paediatric, Neurosurgical, Obstetric, Cardiac etc.
- At least 6 months of ICM experience outside of Dublin and at least 2 months in a model 3 hospital.
- Must satisfy all CoBaTrICE competencies prior to ICM CSCST award.

The above scheme would have the same quantity of Anaesthesia training as other international training programmes (eg: 4.5 years of Anaesthesia modules and 6 months of ICU would be standard in Australia). It would also have more ICM clinical hours than the current minimum requirement for the ICM training scheme (see graph above). It is worth noting that the graph above does not include the many extra hours done by Anaesthesia trainees outside of modules. This would mean the blue and purple bars should be considerably higher if those hours were counted as they should be. Below is a graph of a sample of actual training hours.

If the final position of the powers that be is that a dual training scheme requires a minimum of 7 years, a possible solution might be to return to a system where the extra year is a Fellowship year done prior to CSCST completion (as was previously allowed for the old 7 year programme). This could be a clinical year in an Anaesthesia subspecialty or perhaps a year of research. [REDACTED] made interesting suggestions during the ICSI regarding varied training pathways, including academia, education and leadership. Perhaps this could be explored by some in a Fellowship year if it was included.

NON-ANAESTHESIA ICM TRAINING

- Base-specialty CSCST (this can be any number of years as programmes vary around Europe).
- 18 months ICM modules with 18 months ICM on-call.
- At least 6 months of ICM experience outside of Dublin and at least 2 months in a model 3 hospital.
- Minimum of 3 months of Acute Paediatrics (ie: Paediatric Anaesthesia or Paediatric ICU).
 - This could be prior to ICM training but if not already done it would need to be done during training and prior to CSCST award.
- Prior to working in ICU the trainee would need a 6 month Anaesthesia rotation.
 - This could be prior to ICM training but if not already done it would need to be done during ICM training and before starting work in ICU.
 - This rotation would ensure a minimum level of airway and vascular access proficiency, allowing the ICM trainee to start call safely and immediately when finally commencing ICU modules. It would also allow the trainee to learn these skills on patients that weren't critically unwell, where a mistake could potentially have a more significant impact. With adequate airway/vascular proficiency and by starting call immediately, a trainee would be able to contribute more adequately to ICM service provision and take some pressure off Anaesthesia trainees (trainees tell stories of hospitals with less demanding on-call roles/expectations for non-anaesthesia ICM trainees vs other NCHDs doing ICU on call).
 - The current system of one day per week in theatre over two years instead of a 6 month module, is only advantageous in that it obscures the fact these trainees are doing less time in ICM compared to trainees that start with airway proficiency. By making it a six month anaesthesia module instead, 6 months worth of ICM modules would be freed up for Anaesthesia trainees (there are currently issues with ICM module access in large Dublin hospitals) but without the non-anaesthesia ICM trainee doing any fewer ICM hours in total.

Those hours would also be more continuous, which is a priority for the JFICMI. A win for everybody!

- Must satisfy all CoBaTrICE competencies prior to CSCST award.
- Fellowship Exam

Discarded Ideas:

An 6 month ICU module for Physicians and Surgeons during their base specialty training. It would decrease the total time for them to get an ICM CSCST and give them more confidence with deteriorating patients even if they didn't go on to do ICM. It would also appear to relieve some of the pressure of service provision experienced by trainee anaesthetists. However, without the airway and vascular skills it would be unsafe for them to do on-call which is where the worst of the service provision issues exist. The likely development would be that daytime sessions would be given to the non-anaesthetists and the anaesthetists would ending up doing predominately on-call out of hours. I believe this would worsen the situation rather than improve it.

APPENDIX A - Background Numbers

* When people talk about years, months or modules it is very difficult to compare trainees. For this reasons I am doing the calculations below in hours (like flying hours for pilots) because it better describes the actual clinical experience Anaesthesia and ICM trainees are receiving.

- 52 weeks in a year with 6 weeks annual leave and 2 weeks study leave (I think it can be 4 weeks study leave but I did a conservative estimate so that nobody would think I was being unfair).
- Therefore 44 working weeks in 12 months (so 2 years has 88 working weeks and 6 months is 22 working weeks).
- I think the NCHD contract is for 39 hours per week plus call but there is a mandated maximum 48hour work week for all NCHDs (Anaesthesia and ICM). Although it is the maximum, most trainees do approximately this in hours per week. For the purposes of the calculations below I have assumed both Anaesthesia trainees and ICM trainees to be doing the maximum hours per week. This certainly seems to be the case during the years of ICU on-call.
- Anaesthesia trainees have one Non-clinical day (NCD) per week in their 6th SAT year but this isn't commonly when they do their ICU modules. Therefore when they do their ICU modules and ICU on-call they have no NCDs.
- Six month ICM modules for an Anaesthesia trainee: $22\text{wks} \times 48 = 1,056$ ICM clinical hours
- So 12mnths ICM modules for Anaesthesia trainees: $44 \times 48 = 2,112$ ICM clinical hours
- Please note that the above calculations is just modular hours and is not representative of the

hours CAI trainees are actually doing when non-module shifts and on-calls are included.

- If the dual scheme went ahead, 18 months ICM is: $2,112 + 1056 = 3168$ ICM clinical hours
- ICM trainees have one NCD per week throughout their scheme.
- The ICM scheme is two years for non-anaesthesia trainees and one year for Anaesthesia trainees (if they have 12 months of modules already completed during Anaesthesia training).
- If the ICM trainee has not had previous anaesthesia experience (most medical and surgical ICM trainees) they also do a day a week in theatre to gain airway experience.
- Non-Anaesthesia ICM trainees with airway experience (eg: ED background)
 - $2\text{ yrs} \times 44\text{ wks} \times 40\text{ hrs}$ (8 hours deducted for NCD) = 3, 520 ICM clinical hours
- Non-Anaesthesia ICM trainees without airway experience (eg: most medical trainees)
 - $2\text{ yrs} \times 44\text{ wks} \times 32\text{ hrs}$ (16hours deducted for NCD + theatre day) = 2,816 ICM clinical hrs
- Anaesthesia ICM Trainees
 - 1 yr modules during training: 2,112 clinical hours as above
 - A further year during the ICM scheme: $44\text{ wks} \times 40\text{ hrs}$ (8hrs deducted for NCD) =1,760
 - Therefore a total of 3,872 modular ICM clinical hours... not including the many uncounted non-module and on call hours done during Anaesthesia training.

Appendix 8: Results of CAT Trainee survey:

Appendix: Trainee Survey

Specialist Anaesthesiology Trainees (SATs) spend a considerable proportion of their training working in Intensive Care Medicine (ICM). This training is undertaken in both Model 3 and Model 4 hospitals around Ireland over the course of the six year training programme. The provision of ICM in Ireland is heavily dependent on the contribution of SATs. The exclusion of SATs from ICM would cause major staffing issues in ICUs across the country.

A review of the logbooks of three Year 6 trainees showed that the cumulative number of hours spent in ICM during the course of their training was in excess of the minimum volumes of practice required to achieve competency in ICM. This training in ICM received by SATs results in the production of skilled, competent and well-rounded Anaesthesiologists that are valued and recognised internationally.

In September 2024 the Committee of Anaesthesiology Trainees (CAT) undertook a survey of all SATs in order to collate and accurately represent their views and concerns. There was good engagement and a good response rate across all years of training. In total, 192 SATs responded to the survey.

The responses to the questions of most relevance to this White Paper are included below in graphical form (all data available on request from cat@coa.ie). While acknowledging the valuable impact of ICM training on their overall skillset, SATs emphasised that the lack of access to and accreditation of ICM modules, as well as prolonged periods spent on ICU call at the expense of time in theatre, had led many to feel disillusioned and underappreciated.

There were also free-text sections where SATs were given the opportunity to anonymously express specific concerns. The most prominent themes that were evident were:

- 1) The change in CSCST nomenclature to exclude ICM does not accurately reflect the significant training received in ICM during the SAT programme.
- 2) The change in CSCST nomenclature to exclude ICM does not reflect the considerable service provision to ICM by SATs and the burden of on-call time spent in ICM, particularly compared to non-Anaesthesiologists practicing ICM. This had led many SATs to feel undervalued.
- 3) Concerns about access to modules in JFICMI accredited centres for those who are interested in ICU and wish to sit the JFICMI exam.
- 4) Lack of accreditation for time spent working in ICM in Level 3 Hospitals.
- 5) Concerns over potential litigation issues that could arise as a consultant practicing ICM.
- 6) Concerns over international recognition of the CSCST and the ability to obtain overseas fellowships and consultant posts.

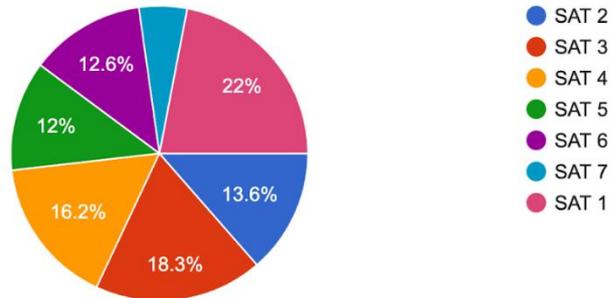
There was also concern expressed by the SAT 1 year group that commenced training in July 2024, that they would be awarded a different CSCST to those graduating ahead of them. They requested that any proposed changes should only be applied prospectively to trainees commencing from July 2025 onwards with advance knowledge of this CSCST change.

Proposed solutions from survey responses included:

1. Protected training modules for SATs interested in ICM.
2. Appropriate recognition of time spent training in ICM.
3. Recognition of ICM service in Model 3 hospitals.
4. FJFICM exam to be more accessible to SATs with an interest in ICM.
5. Recognition of existing consultants with expertise in ICM.

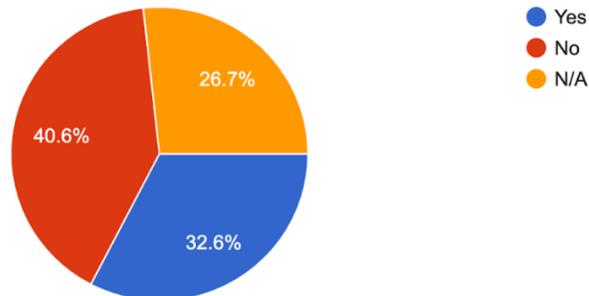
Stage of training

191 responses



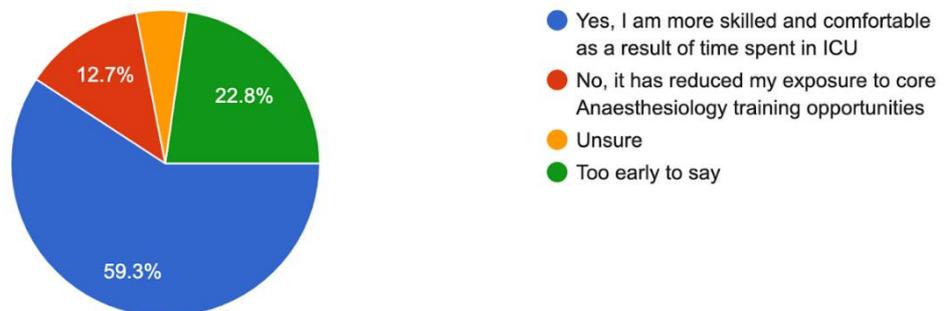
For anyone who started out the SAT programme interested in Intensive Care Medicine, have you changed your mind since?

187 responses



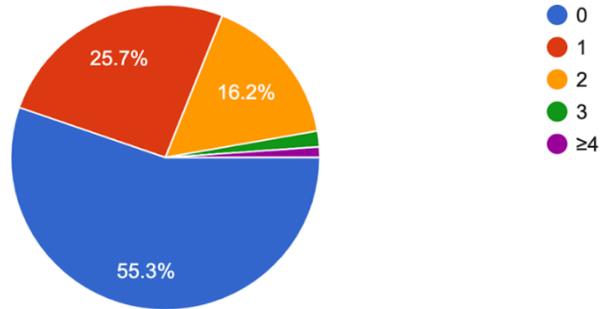
Do you think that your Intensive Care training has enhanced your ability as an Anaesthesiologist?

189 responses



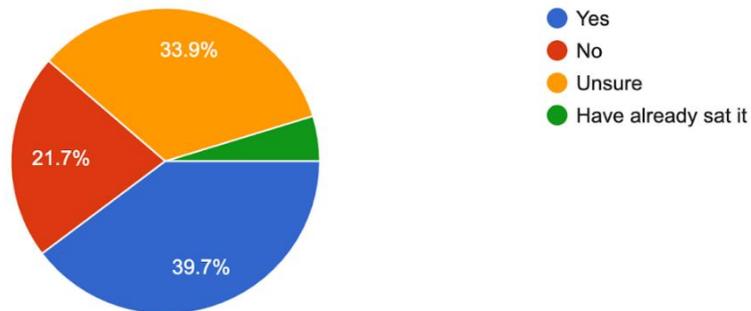
How many times have you rotated through a JFICMI accredited hospital and requested an ICU module but not been given one?

179 responses



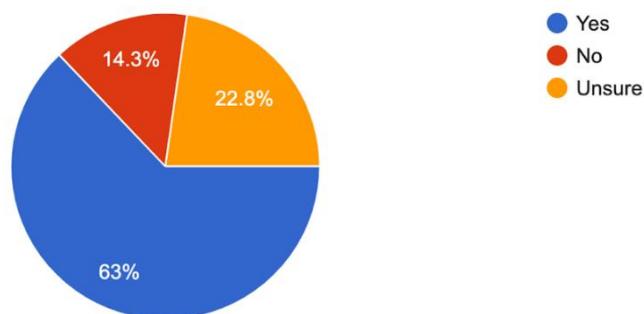
Do you intend to attempt the JFICMI examination?

189 responses



If you had sufficient modules complete to do the JFICMI examination, would you do it?

189 responses



Do you intend to practice Intensive Care Medicine in your consultant career?

191 responses



There are variations in SATs long-term intentions to practice ICM after CSCST.

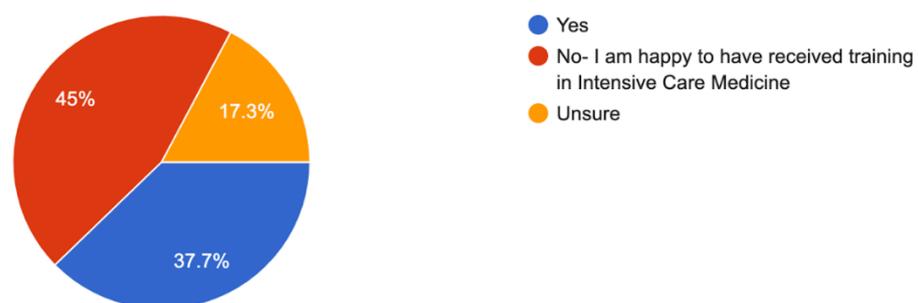
The survey found that:

1. 25% of trainees indicated that they wish to practice exclusively Anaesthesiology as a consultant, with no ICM commitments.
2. 45% of trainees indicated that they intend to practice ICM in some capacity as a consultant (either in a tertiary or regional or paediatric centre, or in a minority of cases overseas).
3. 30% were undecided as to whether they wish to practice ICM longer-term. Presumably this cohort's practice will be influenced by what is required of them in their specific consultant job description.

The majority of those who indicated a preference to practice ICM wish to do so alongside regular Anaesthesiology commitments, with only 3% indicating a preference for practicing exclusively ICM.

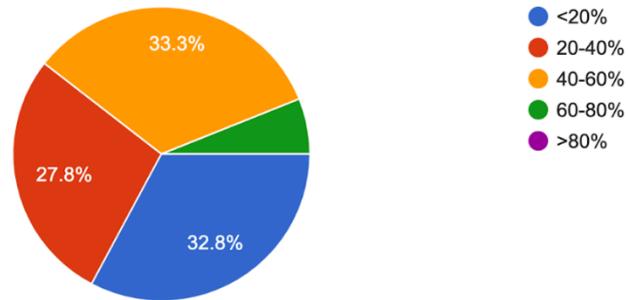
If you had been given the option of an exclusive Anaesthesia training scheme where you would only complete a six month placement in ICU, would you have taken that option?

191 responses



Roughly what percentage of your training scheme to date would you estimate has been spent in ICU?

180 responses



Do you feel that your exposure to Intensive Care Medicine during your training has been:

189 responses

