IHCD Training requirement for endotracheal intubation.
Joint recommendation from AETAG/JRCALC Airway Group November 2004

Although there are pressures to reduce the IHCD requirement for 25 endotracheal intubations JRCALC can neither recommend nor advise such an adjustment. We would wish to emphasise that the teaching of airway skills for all staff should form a continuum with the objective of achieving an adequate airway that ranges from the simple jaw-thrust at one end and progresses through use of the LMA to paramedic endotracheal intubation at the other. Emphasis should be laid on not only the "technical" aspects of interventions but also on "management principles" relating to the compromised airway, and there should be less acceptance of the unwritten principle that technicians use LMAs and paramedics use ET tubes.

There is no evidence to suggest that the figure of 25 for intubations to be undertaken during training is anything but pragmatic, and was originally chosen for the (then) realistic expectation that the figure would be easily achievable. Furthermore, this magic number even if achieved cannot be taken to give any assurance of subsequent ability. Lawler et al[15] in 1991 in a communication relating to "Assessment of training in anaesthesia and related skills" point out that log books "...give no clear idea of skill or of progress and merely record 'exposure' to a skill or technique." Taking tracheal intubation as an example they suggest the use of a graphical demonstration of adequacy of training and skill acquisition, with adequacy of training being defined as, for example, 20 successful consecutive intubations. Such a standard could be set (and altered) at will, but this still does not address the problem of those in whom 20 consecutive successes may take a much greater number (and therefore time) to achieve. Kestin[13, 6] in 1995 addressed this same challenge in "A statistical approach to measuring the competence of anaesthetic trainees at practical procedures". The progress of anaesthetic trainees learning 4 practical procedures (but not ET intubation) was monitored from their first attempt using cusum analysis. The significance of the paper in our context here is that a wide variation was observed in the speed that trainees became proficient, and that "Satisfactory competence cannot be assured by defining a minimum number of successful procedures…". In anaesthesia the learning process for tracheal intubation has been widely studied with an equally wide variety of results[19].

To summarise, the IHCD figure of 25 intubations may be arbitrary but improvements in patient care will not come from a reduction in training standards and for now our view, in the absence of any evidence to support change, is that this standard should remain. Improvements in patient care will only come from investment in the training process, and any resultant extension of the duration of time spent in the hospital/theatre environment should be regarded as a fundamental objective for the future.