Guest Editorial

FIRST, DO NO HARM:
LESS TRAINING ≠ QUALITY CARE

By Michael H. Baumann, MD, MS, FCCP, Steven Q. Simpson, MD, FCCP, Mary Stahl, RN, MSN, ACNS-BC, CCNS-CMG, CCRN, Suhail Raoof, MBBS, FCCP, MACP, FCCM, Darcy D. Marciniuk, MD, FRCPC, FCCP, and David D. Gutterman, MD, FCCP, on behalf of the American College of Chest Physicians and the American Association of Critical-Care Nurses

Editor’s Note
In an attempt to transform the health care system in the United States to improve upon the inadequacies and deficiencies of our current model, the Robert Wood Johnson Foundation and the Institute of Medicine created a collaborative partnership to spell out what aspects of our health care system need to be remodeled. They envisioned that “interprofessional collaboration and coordination would be the ‘norm,’” because no discipline functions in isolation of others, certainly not in our intensive care units. In this spirit of interdisciplinary collaboration, the American College of Chest Physicians (ACCP) and the American Association of Critical-Care Nurses (AACN)—physician and nursing societies, respectively, with combined memberships totaling more than 110,000 practicing critical care practitioners—have spoken with one voice in the editorial that follows about how and how not to address the shortage of critical care physicians. Because our critical care nurses work side by side with our intensivists, shouldn’t they have a say in how intensivists are trained? The ACCP and AACN think so, and we agree.

Richard S. Irwin, MD, Master FCCP
Editor in Chief, CHEST

The Society of Critical Care Medicine (SCCM) and the Society of Hospital Medicine (SHM) recently published a position paper regarding the ongoing critical care workforce shortage in the United States. They proposed a 1-year expedited critical care training program leading to board eligibility for hospitalists who have completed 3 years in practice. This attempt to craft a solution to the workforce shortage by incorporating a new hospitalist-training track for critical care certification should be applauded. The effort falls far short, however, with some of the limitations outlined in the position paper and its accompanying editorial. To paraphrase that editorial, a rose is not a beautiful rose when grown without proper care and feeding! The American College of Chest Physicians (ACCP) and the American Association of Critical-Care Nurses (AACN) believe that 1 year is an inadequate training period for hospitalist physicians to achieve competence in the subspecialty of critical care medicine. Such a hospitalist “rose” may be most remembered for its thorns.

Our concerns stated here reflect a consensus from the current ACCP president’s group, the Critical Care NetWork Steering Committee, and the ACCP Strategic Work Action Team, composed of the chairs of our Chest Medicine Affairs Committee, Practice Management Committee, Guidelines Oversight Committee, Council of Networks and Quality Improvement

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It must also be recognized that the workforce shortage extends beyond physicians to other professionals, including nurses.

About the Authors
Michael H. Baumann is professor of Medicine, Division of Pulmonary, Critical Care and Sleep Medicine, Chief Quality Officer, University of Mississippi Medical Center, Jackson, Mississippi, and President-Designate, American College of Chest Physicians. Steven G. Simpson is professor of Medicine, Director, Fellowship Training, Division of Pulmonary and Critical Care Medicine, University of Kansas, Kansas City, Kansas, and Chair, American College of Chest Physicians, Critical Care NetWork. Mary Stahl is a clinical nurse specialist, medical cardiology, at the Mid America Heart Institute, Saint Luke’s Hospital, Kansas City, Missouri, and was President, American Association of Critical-Care Nurses, at the time this editorial was written. Suhail Raoof is professor of Clinical Medicine, Weill Medical School of Cornell University, New York; Chief, Division of Pulmonary, Critical Care and Sleep Medicine, New York Methodist Hospital, Brooklyn, New York; and President, American College of Chest Physicians. Darcy D. Marciniuk is Ferguson Professor of Medicine Head, Division of Respirology, Critical Care and Sleep Medicine, University of Saskatchewan, Saskatoon, Canada, and Past-President, American College of Chest Physicians. David D. Gutterman is Northwestern Mutual Professor of Cardiology, Medical College of Wisconsin, Milwaukee, Wisconsin; and Immediate Past-President, American College of Chest Physicians.

Corresponding author: Michael H. Baumann, MD, FCCP, Division of Pulmonary, Critical Care, and Sleep Medicine, University of Mississippi Medical Center, 2500 N State St, Jackson, MS 39216 (e-mail: mbaumann@umc.edu).
patients’ outcomes, including morbidity and mortality.5,15,16 Tacit to such findings is the incorporation of well-trained intensivists. The SCCM/SHM position paper2 notes that “the impact that critical-care trained hospitalists will have on the quality and safety of patient care in the ICU will require evaluation and study.” The paper’s authors presume “that inserting this new cohort of intensivists into previously unmanaged or undermanaged ICUs will improve care … but … should be subject to rigorous and objective examination through additional clinical research.”2 Clearly if this approach were to be adopted, close study would be required. But would we be harming patients for an unforeseeable time until results of such studies became available? Why abandon successful training models for a model that is yet untried that may place patients in harm’s way? Remember, we as patient care providers should first, do no harm!

What should we do? We have no doubt that the shortage in critical care physicians exists, and the ACCP and AACN remain concerned. We suggest reinvigorating past interdisciplinary collaborative efforts4-7 to address the shortage, but within the framework of existing and proven training pathways. No, the perfect should not be the enemy of the good in our efforts to craft solutions. But the current imperfect SCCM/SHM proposal is an enemy of the existing good training processes already in place. A simple, immediate solution is to have hospitalists with critical care interests enter the existing proven training pathways.

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2. Siegel EM, Dressler DD, Dichter JR, Gorman MJ, Gorman MJ, Lipsitt L. Decrease for 1 year, and settle for training that does not compare favorably with other trainee tracks. This conundrum is compounded by the training time math. For the time committed to the proposed hospitalist track, a physician can alternatively train, for example, initially in internal medicine, then immediately obtain 2 years of critical care training, and be ahead of the hospitalist track with 1 year to spare, while receiving superior critical care training. Why would one choose the proposed hospitalist track?

Cognitive skills remain integral to critical care medicine but must be complemented by mastery of multiple procedural skills. Although several approved critical care tracks are currently available,1 including some that require only 1 year of additional training to become certified, most of these currently approved critical care tracks rely on significant residency-acquired procedural skills, achieved over multiple years of training. The 1-year surgical and anaesthesiology critical care training tracks have 3 and 4 years, respectively, of procedure-intensive programs preceding the 1-year critical care training requirement. Hospitalists often come from the internal medicine training track,12 with the ABIM offering a Certification in Internal Medicine with a Focused Practice in Hospital Medicine. The current Accreditation Council for Graduate Medical Education13 defers to the ABIM13 to define the procedural competence requirements for internal medicine trainees. The ABIM requires no competence in performing invasive procedures for these trainees except for collecting venous or arterial blood samples and placing a peripheral venous catheter. This paucity of procedural exposure is compounded by mandating that one-third of the training years be in an ambulatory setting, with only 3 months of exposure required in the critical care setting.13 This flaw would undoubtedly be magnified for other hospitalists with even less “rigorous” training backgrounds. The heterogeneity in hospitalist training and experience compounds the inadequacies of the proposed training track.

We believe the paramount emphasis on patients’ needs is ultimately deemphasized in the SCCM/SHM proposal. In the end, is this proposal best for critically ill patients and for the relationship between the provider and the patient? Adequately staffing critical care units with intensivists can improve patients’ outcomes, including morbidity and mortality.5,15,16


