

FIRST, DO NO HARM: LESS TRAINING ≠ QUALITY CARE

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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,'"¹ 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.

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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.² 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.³ 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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Committee, and from the President of The CHEST Foundation, after review of the position paper and its accompanying editorial. This article also reflects a consensus from the leaders of AACN after a similar review of the SCCM/SHM papers.

Attracting and adequately training additional critical care physicians is a goal shared by most professional participants in the critical care arena, including the ACCP and AACN at every level.^{4,7} It must also be recognized that the workforce shortage extends beyond physicians to other professionals, including nurses.⁵ As proposed in 2004, further expansion of the role of critical care nurses, pharmacists, and respiratory therapy practitioners into the critical care environment would be important to improve outcomes for patients in intensive care units (ICUs).⁵ Subsequently, a past president of AACN and of the ACCP outlined how collaboration between nurses and physicians could be strengthened, how doing so would drive improved ICU outcomes, and the steps to implement change in the ICU working

environment to build such collaboration to achieve the goal of patient-focused care.⁷ A recent survey of academic medical centers reflects the growing success of such endeavors, with 27% of responding critical care program directors reporting that advanced practice nurses with critical care training are available in the ICU environment.⁸

Other critical care delivery models can also help bolster excellent patient-focused critical care while effective workforce solutions are developed. Several such models are briefly alluded to in the SCCM/SHM editorial,³ including critical care transfer networks,⁹ tiered regionalization, and ICU telemedicine.¹⁰ Previous multisociety efforts included the SCCM, the American Thoracic Society, AACN, and the ACCP, who collaboratively proposed in 2004 a *comprehensive* approach to improving critical care delivery in the United States. That proposal not only included the use of ICU telemedicine and tiered models but suggestions to the Health Resources and Services Administration to increase the supply of critical care providers, including both short-term and long-term solutions.^{4,6} These recommendations remain relevant today. Subsequently, an AACN-ACCP collaborative publication emphasized the need to foster an interdisciplinary critical care environment that places the patients' needs central to these efforts to improve care delivery by underscoring the partnership between provider and patient.^{7,11}

Critical thinking and cognitive skills in critical care medicine come from ongoing supervised training exposure to the clinical critical care environment and to research in this setting, the latter of which is absent in the proposed hospitalist path. The SCCM/SHM position paper suggests that the American Board of Internal Medicine (ABIM) Focused Practice in Hospital Medicine Maintenance of Certification program and prior exposure to quality improvement projects can suffice to supplant the research requirement found in other pathways, a suboptimal assumption at best.² The cognitive complexity of the critical care environment requires clarity of thought that we believe is best acquired through rigorous scientific training. Another pragmatic flaw that is not clearly confronted in the proposal is the question of why a hospitalist would leave practice after 3 years, absorb an income

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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,² 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.¹³ The current Accreditation Council for Graduate Medical Education¹⁴ 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.¹⁴ 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} 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 efforts^{4,7} 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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