Out-of-hours intensive care unit cover by nurse practitioners: does this have a detrimental effect towards critical care exposure to the cardiothoracic trainee?

Vijay Joshi*

Department of Cardiac Surgery, Trent Cardiac Centre, Nottingham, UK

* Corresponding author. Trent Cardiac Centre, Nottingham City Hospital, Hucknall Road, Nottingham NG5 1PB, UK. Tel: +44-7870135795; e-mail: vijayjoshi@doctors.net.uk (V. Joshi).

Received 20 January 2013; accepted 12 April 2013

Keywords: Cardiac surgery • Intensive care medicine • Education and training

The article by Skinner et al. in the January issue highlights the value of utilizing advanced care nurse practitioners (ACNP) in the intensive care unit (ICU) setting based on their experience in Nottingham, UK. Their use in out-of-hours cover for ICU frees up the junior doctor from resident on-call commitment. This provides a good solution for problems encountered with organizing junior doctors’ rota with the European Working Time Directive (EWTD) in place [1]. Criticisms of the implementation of such a system are the detrimental effect it will have on the degree of ICU exposure to cardiothoracic trainees and poor efficacy in other European countries. In the same issue, Markewitz [2] emphasizes a loss of experience, competencies as well as insights into the importance of critical-care training as a cardiothoracic surgeon. I would debate that the implementation of out-of-hours cover by ACNP does not have such a negative effect.

Competency-based learning has been clearly shown to have educational merit [3]. Current trainees in cardiothoracic surgery in the UK are required to attain such competencies related to the specialty in order to progress. Additionally, trainees are formally examined towards the end of their training. Critical care is a component of both.

Sádaba et al. surveyed trainees in various countries within the European Union. He has highlighted variability in the structure of cardiothoracic training among various countries. Outside the UK, very little, if not any, emphasis is placed on regular evaluations to elicit competency, nor is the completion of an exit examination compulsory [4]. Without the implementation of a structured training curriculum, there is no way to ensure trainees are attaining competencies in all the necessary components of a specialty.

Markewitz also postulates that reduced exposure with regard to actual time spent on ICU may reflect negatively on a trainee’s experience. Thus, the cardiothoracic trainee may not be competent to manage ICU patients who frequently have complex multiorgan pathologies [2]. Schijven et al. [5] examined and objectively compared practice-ready surgeons from Canada and the Netherlands. The latter group underperformed in examinations focusing on managing patients with complex problems.

This was presumed to be due to the difference in working hours between the two countries (80 vs 48 h). However, no evidence is provided to demonstrate homogeneity between the training curriculum and educational opportunities for trainees within the two countries.

Skinner et al. emphasize that junior doctors are contacted when escalation of patient care is needed, ensuring they are kept in the loop when important decisions need to be made [1]. Thus, the trainee can still achieve competencies while working in a centre that is EWTD compliant. I must disclose that I am currently a cardiothoracic trainee rotating through Nottingham. This, I feel, gives me good insights into training in a centre with a strongly implemented ACNP programme. It seems illogical to presume a loss of critical-care training in the presence of a structured and curriculum-based programme. In countries that do not possess such a training structure, this may be in fact the fundamental issue that needs addressing.

Conflict of interest: The author is currently a trainee in cardiothoracic surgery rotating through the Trent Cardiac Centre. This is the same centre where the article by Skinner et al. is based.

REFERENCES


