The Territorial Imperative

As two Canadians who have been involved in critical care in North America for many years, we are uncomfortable in writing this invited editorial. We hope that our American colleagues will forgive us as we critically glance to the south, to comment on the organization and educational process associated with the continuing growth of critical care in the United States. It has been with friendly concern that we have witnessed a progressive balkanization of critical care, as a discipline, in the United States. It would seem that the multidisciplinary commonality of purpose displayed throughout critical care's infancy in the 1960s and 1970s has now given way to potentially divisive territoriality and turf issues in the 1980s. It is our gratuitous opinion that, if left unattended, this current process may ultimately lead to problems in patient care, in resident training, and in the reasonable allocation of dwindling health care resources.

Critical care medicine is clearly a "horizontal" specialty, one that cuts across the traditional "vertical" boundaries of established specialties. Therefore, critical care medicine ranks with an increasing number of synthesizing activities in medicine, such as oncology, infectious diseases, clinical pharmacology, and clinical epidemiology. There is no longer any doubt that critical care represents a clearly definable body of knowledge and competency that frequently relates to a rather stereotyped final common clinical pathway of multisystem organ failure. For example, it matters little to the clinician or the lung whether the respiratory system has been "hammered" by a bus, a virus, or pus in the belly—the common presentation of respiratory failure, with its attendant need for life supportive measures, is remarkably similar in all three circumstances. It, therefore, seems a disservice to the patient, and certainly to the profession, to suggest that only an internist (or chest physician) can understand the phenomena of multisystem organ failure in a "medical ICU," or that only a surgeon can fathom the same clinical complexities in a "surgical ICU."

Nature abounds with examples of territorial behavior, most apparently designed to preserve prerogatives in association with mating, food gathering, or in boundary and group identity maintenance. Mankind has not been immune to this sort of behavior, perhaps best illustrated by the Guild systems of the Middle Ages from which the professions and specialties are derived. The development of no fewer than four Boards (are there more to come?) for Critical Care in the United States must be viewed as having territorial and Guild system overtones, designed, at least in part, primarily to benefit the Guild's membership. It is unquestionable that each of the traditional "vertical" specialties has a legitimate concern with the problems surrounding the evaluation and subsequent management of multisystem failure. What is less clear, however, is the wisdom of, or the need for, each traditional specialty offering its own educational processes leading to separate certifying examinations. In order to avoid the inevitable fragmentation of patient care, the development of biased training programs in critical care (conceivably with the multiple Boards, there could be several critical care training programs in the same institution!), and a proliferation of specialty-based intensive care facilities in hospitals, it would seem to us that the more sensible route would be to embody the development of a cooperative, multidisciplinary approach to patients who are seriously ill.

In Canada, the Canadian Critical Care Society (CCCS) and the Royal College of Physicians and Surgeons (RCPS) have gone a different route. Quite frankly, they have found the territoriality and fragmentation occurring in the United States a positive stimulus toward encouraging consensus around the creation of a critical care training program. In September of 1986, the Royal College, the official body responsible for accreditation of specialty training programs and certification of specialists in Canada, gave formal recognition to critical care medicine and thereby created a Specialty Training Committee which was charged with the task of overseeing an experiment known as "Accreditation without Certification"—a process that primarily focuses on the educational aspects of training programs. This program is based upon an Educational Objectives document that was written over a two-year period by the Canadian Critical Care Society and the Royal College Advisory Committee on Critical Care. The development of this document involved all the specialties concerned with critical care issues. The Educational Objectives document was specifically designed to describe the care that trainees would be expected to provide during independent practice in critical care. Thus, it identified specific terminal and enabling objectives. Career stream specialty training in critical care in Canada...
now requires the successful completion of training and certification in any one of the traditional primary specialties, with the addition of two further years of critical care in a Royal College accredited, university-based program. One of the two critical care years may be taken within the four- to five-year primary specialty-training program; specific elements of prior training relating to critical care may be recognized by program directors as fulfilling no more than one year in the two-year Critical Care Training Program. Training, within accredited critical care programs, and based upon the Educational Objectives document, may also be designed according to specific career goals of the trainee. It is nonetheless understood that there exists a commonality of fulfilling objectives for all candidates regardless of their primary discipline. This process of training will not be difficult, as many critical care units in Canada are of a “multidisciplinary” nature.

It must be emphasized that the experiment of creating the Accreditation without Certification Program, and the prerequisite of producing the associated Education Objectives document, was a multidisciplinary effort involving coordinated input from anesthesiology, surgery, medicine, pediatrics and the Canadian Critical Care Society. This process required extensive discussion in order to establish consensus, not only regionally across the country, but also between vested specialty interests. It seems likely that the harmonious development of this multidisciplinary approach was assisted by the unitary control exerted over the credentialing, accrediting, certifying and examining training components by the Royal College. The Canadian National Health revenue, characterized by: (1) universal patient access, (2) global-budgeting for hospitals, (3) and a single source third-party reimbursement system, also may have been contributing factors. With agreement and understanding of all disciplines represented by the Royal College of Physicians and Surgeons, critical care training in Canada will combine and utilize the talents of anesthetists, surgeons, pediatricians and internists in the multidisciplinary, life-support environment.

We genuinely feel that this cooperative approach will best serve the seriously ill patients for whom we care, as well as the profession. At a time when most primary disciplines have fragmented into numerous subspecialties and superspecialties in the 1970s and 1980s, it is imperative that the growth of formalized critical care training in Canada emphasize a multidisciplinary and comprehensive approach to training in the care of the seriously ill patient. Having put a colossal amount of work into developing this collegial attitude, we feel its virtues justify our advocacy of the multidisciplinary approach not only to education, but also to care provision and research expressed in this editorial.

Perhaps it is not too late for American critical care constituents to reawaken earlier ambitions for multidisciplinary cooperation in the development of critical care training programs. Territoriality maybe fine for the insect, bird and animal world, but it is bound to deprive patients and trainees of points of view that are important for their welfare. If our two countries continue along their disparate paths, it may be ultimately possible to compare the merits of the two systems. In the meanwhile, as neighbors, we ask that if you must have territorial disputes, please keep the ruckus down so that property values do not fall in the entire neighborhood.

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REFERENCE
1 Audrey R. Territorial imperative: a personal inquiry into the animal origins of property and nations. New York: Atheneum, 1966

Training and Certification of Critical Care Medicine in the United States

Drs. E. Garner King and William Sibbald are internationally recognized scientific and professional leaders in critical care medicine. Their guest editorial in this issue entitled "The Territorial Imperative" projects the thoughtful concern of compassionate Canadian colleagues with the way in which we have approached the formal training and subspecialty certification process in critical care medicine in the United States. They view the separation of the training and certification process between specialists in internal medicine, general surgery, anesthesiology, and pediatrics as violating a more rational multidisciplinary approach which would better serve the interests of optimal patient care. They confirm that critical care medicine is a legitimate discipline with an appropriate body of knowledge; that it differs from the traditional "vertical" organ-based specialties in that it is "horizontal" in the sense that it concerns itself with life-threatening and multiple organ impairment. Accordingly, care of the critically ill, by definition, is a multidisciplinary commitment.

These Canadian leaders address both the organization and the educational processes which would be likely to optimize the delivery of critical care services by well-qualified experts. They reluctantly conclude