standing of the effects of work schedule on these outcomes. ICUs are especially important venues for studying transfer of care because of the high acuity of illness, the high risk, and consequences of errors.8,9 The urgency imposed by the physiologic instability common in ICUs demands rapid responses by fully informed physicians. We need to develop and validate not only improved procedures and tools for the transfer of patient information but also methods for effective communication.

It is the role of the American College of Chest Physicians along with other professional societies that promote outstanding critical care to provide leadership to meet the needs of our critically ill patients. In addition, it is essential that we design a positive intensive care training experience for our residents and fellows so that we can attract enough qualified physicians to meet our expanding workforce needs. Crafting work schedules that eliminate extended-duration shifts may not only improve provider and patient safety but will also help to attract the best professionals to critical care. Meeting the needs of an older, sicker, growing patient population, addressing the data on the dangers of extended work shifts, and filling the all-too-acute need for effective staffing and communication solutions requires fundamental reconsideration of our systems for delivering critical care. The American College of Chest Physicians, the American Thoracic Society, the Society of Critical Care Medicine, and other societies that support critical care professionals are in a unique position to advocate for the resources to address our knowledge gaps, develop solutions, and drive needed improvements in quality. Changing care for the better requires leadership and teamwork. All of the societies that support critical care professionals should be involved in coordinating these efforts through active dialogue, coordinated advocacy, and task forces.

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Pulmonary Physicians in the Practice of Sleep Medicine

The leaders from the American Thoracic Society (ATS), the American College of Chest Physicians (ACCP), and the American Academy of Sleep Medicine (AASM) have met to address means by which the three societies could work together to enhance patient care with respect to the practice of sleep medicine and advance the interests of these groups, their constituencies, and their patients. In this editorial, we focus on those areas most pertinent to pulmonary physicians in the practice of sleep medicine, which has now been recognized as an independent specialty.

Sleep medicine is a multidisciplinary field with contributions by practitioners and researchers in many disciplines. Pulmonary medicine has made important contributions to the field of sleep medicine for many years. Our societies wish to foster continued contributions from pulmonologists already within the field and to promote access to training and clinical practice for pulmonary physicians wishing to enter the specialty of sleep medicine. Furthermore, although the focus of this meeting was on issues of particular relevance to pulmonary physicians, the three societies reaffirm the essential role of all specialties that have been key participants in the development of sleep medicine, including neurology, psychiatry, otolaryngology, pe-
diabetics, and internal medicine. Practitioners in other specialties are encouraged to take the same opportunity (see following) to become certified in sleep medicine. Moving forward, future leadership meetings will include representatives from all contributing specialties.

Sleep medicine is a dynamic and rapidly growing field in which opportunities for physicians of many backgrounds abound. The newly recognized status of the field and the establishment of a certification examination by the American Board of Medical Specialties (ABMS) will accelerate the growth of the field and increase the importance of board certification of practitioners. The public will increasingly expect that physicians who provide comprehensive sleep medicine services will have ABMS Sleep Medicine board certification. The new ABMS examination, starting in 2007, will be co-sponsored by the American Board of Internal Medicine, the American Board of Psychiatry and Neurology, and the American Board of Pediatrics with the addition of the American Board of Otolaryngology pending ABMS approval.

There are three pathways that qualify physicians to sit for the new examination: (1) certification by one of the primary sponsoring boards and the current American Board of Sleep Medicine (ABSM); (2) certification by one of the primary sponsoring boards and completion of training in a 1-year sleep medicine fellowship program, not overlapping with any other residency or fellowship; and (3) clinical practice experience: this clinical practice experience pathway consists of a 5-year “grandfathering” period open to physicians who are board certified in one of the sponsoring specialty boards and who can attest that he or she has the equivalent of 1 year of clinical practice experience in sleep medicine during the prior 5 years. This experience could, for example, be gained by an individual practitioner who has devoted one third of his or her practice to sleep medicine over 3 years, or by someone who spent 25% of their practice in the field over the past 4 years. Physicians in the clinical practice pathway will also have to attest to a specified minimum number of patients seen and polysomnograms and multiple sleep latency tests read. At the end of this initial 5-year period, the only route to board eligibility will be through an accredited fellowship training program. This creates a one-time, unprecedented opportunity for pulmonologists, neurologists, psychiatrists, and other physicians already working in the field to sit for the board examination.

While no one knows the number of “unboarded” sleep medicine practitioners, we are confident there are a considerable number of pulmonologists and other specialists who practice sleep medicine who could, with a little work, become board certified in the next 5 years. The necessary work might include strategic use of continuing medical education activities in sleep medicine, reading review articles and texts, reviewing cases with experts, and board review courses. The three societies will assist physicians in acquiring the training and education needed to prepare for the sleep boards. We believe a larger number of boarded sleep medicine physicians will be good for the field and, additionally, good for patient care, and will help address future workforce issues in sleep medicine. The ATS, ACCP, and AASM strongly encourage and offer support to pulmonary and other physicians seeking ABMS board certification in sleep medicine.

Another important aspect of current sleep medicine practice is the accreditation of sleep laboratories. Just as the ABMS board examination will signify individual competency in sleep medicine, sleep dis- orders center and laboratory accreditation by the AASM ensures a uniform and consistent standard of quality care. Reimbursing parties increasingly view accreditation as an objective indication of quality. Accreditation signifies a commitment to quality and competency and insurance in case third-party payers or regulators begin to require laboratory accreditation for sleep study interpretation reimbursement. The AASM recognizes two levels of sleep facilities: the comprehensive sleep center that can handle all aspects of sleep medicine, and the sleep-related breathing laboratory, a facility that focuses on sleep-disordered breathing. Comprehensive sleep centers must maintain an ABSM or ABMS sleep medicine diplomate on staff. A pulmonologist who is eligible to sit for the current ABSM examination or the new ABMS examination may direct a sleep-related breathing disorder laboratory. Re-evaluation of this standard by the AASM, with input from the ATS and ACCP and other involved organizations, will occur before the conclusion of the ABMS grandfathering period. The AASM has approved a streamlined version of the accreditation requirements to make the accreditation process more accessible and quicker. The three societies strongly encourage pulmonary physicians to work toward AASM accreditation of their sleep laboratories or centers.

The three societies have collaborated on developing evidence-based guidelines for the use of portable monitoring in the diagnosis of sleep-disordered breathing. The resulting documents were published in the journals of each society.1–3 Discussion is under way to develop practical guidelines for the utilization of portable monitoring for specific indications and to evaluate the research priorities in this important area of sleep medicine.

The AASM, ATS, and ACCP agree that there is an
enormous need for research to improve the understanding and treatment of sleep disorders. Thus, the three societies strongly advocate for increased research support in this critical area. In addition, the societies support initiatives to enhance the number of well-qualified researchers in the broad area of sleep medicine. The societies have agreed to sponsor a workshop in the coming year, which will include representatives from all concerned specialties, to explore means to foster research and identify potential areas for cooperative research.

The field of sleep medicine is in a time of rapid growth and maturation. The ACCP, the ATS, and the AASM will continue to collaborate on initiatives that further the growth of the field, help our members and, above all, help our patients. The societies have agreed to explore ways to enhance quality of care and access, and to mount efforts to ensure adequate numbers of well-trained sleep technologists. We will also continue to discuss relevant issues in sleep medicine, and explore opportunities to enhance physician education and patient care. We urge all concerned with the future of sleep medicine to participate actively and collaboratively as we move forward together.

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Noninvasive Ventilation for Acute Respiratory Failure

But How Severe?

Over 15 years have passed since the publication of the initial report of noninvasive mechanical ventilation (NIV) to avoid endotracheal intubation in patients with acute respiratory failure (ARF). Since then, we have gained much knowledge supporting the use of NIV in a variety of clinical situations. NIV to treat patients with hypercapnic respiratory failure due to COPD is considered a “standard of care.”

And there is general consensus that treatment with NIV should be strongly considered in patients with acute pulmonary edema (APE) and pneumonia in immunocompromised hosts, and is an option in a number of other clinical scenarios. Many questions remain, however, including the issue of whether there is a severity of ARF beyond which NIV should not be used.

In this issue of CHEST (see page 3916), the study by Honrubia et al asks how NIV efficacy compares to that of conventional mechanical ventilation (CMV) in patients with severe ARF of various etiologies who meet the standard criteria for intubation. Sixty-four patients were randomized, with 31 receiving NIV and 33 receiving CMV. In the NIV group, 18 patients (58%) were intubated, compared to all 33 patients (100%) in the CMV group (relative risk reduction, 43%; p < 0.001). The ICU mortality rate was 23% (7 patients) in the NIV group and 39% (13 patients) in the CMV group (p = 0.09). The hospital mortality rate was 32% in the NIV group and 42% in the CMV group (p = 0.30). Complication rates and ventilator durations were slightly but not significantly lower in the NIV group, and ICU and hospital lengths of stay were similar. Patients who did not respond to NIV fared no worse than those assigned to CMV from the start, which is an important observation considering that a recent NIV trial associated increased mortality in the NIV group with delayed intubation.

There are a number of limitations of the study. Although the inclusion criteria unquestionably selected patients who had severe respiratory failure, they did not preclude the use of NIV. Thus, it is not surprising that the authors significantly reduced the