A Multidisciplinary Approach Is Key to the Development of Critical Care Medicine in Mainland China

To the Editor:

We read the recent article in CHEST (January 2014) by Qiao et al1 with great interest. The authors asserted that there are limitations to an “integrated” ICU and proposed a system of specialty ICUs led by pulmonologists in mainland China.

In China, modern critical care medicine began with surgical ICU in the early 1980s and now presents in all tertiary hospitals and many regional hospitals, with general ICUs accounting for >50% of critical care resources.2 The debate about general vs specialty ICU has been ongoing for decades, with conflicting results. A cohort study in the United States suggested that diagnosis-appropriate (“ideal”) specialty ICU care offered no survival benefit over general ICU care for selected common diagnoses, whereas non-ideal specialty ICU care was associated with increased risk-adjusted mortality.3 Experience in China confirmed these findings.

In fact, the critical care subspecialty has already existed for decades in China within some primary specialties, for example, pulmonology, surgery, emergency medicine, and anesthesia. Furthermore, critical care medicine has been officially recognized as a primary specialty since 2009;2 with general and specialty ICUs run by “pure” intensivists, anesthesiologists, emergency physicians, and/or pulmonologists. In addition, critical care systems in Australia (anesthetist-led) and Japan (emergency physician-led) are excellent examples that alternative infrastructure of critical care training and patient management can also be successful. All of the previously mentioned phenomena strongly emphasize the importance of adopting a multidisciplinary approach to improving patient outcomes, rather than merely discussing who should be the driving force or leadership of critical care.1 This also indicates that pulmonary medicine, though very important in the practice of critical care, is only a part of all relevant critical care knowledge and skills, including sedation/analgesia, resuscitation, hemodynamics, infectious disease, renal disorders, nutrition, and even surgery.

As in the United States, failure of some previous pulmonary and critical care medicine training programs in China might be explained by the concerns of negative lifestyle perceptions.3 In addition, it might also be related to underrecognition of the value of a multidisciplinary approach. More importantly, these barriers could not be automatically resolved by reintroducing the pulmonary and critical care medicine subspecialty.

We, therefore, strongly encourage our pulmonology colleagues to develop a multidisciplinary subspecialty training program, and we also welcome them to be more involved in other well-established critical care specialty and subspecialty training programs in China.

After all, the beauty of the world lies not in its identity but in its diversity.

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References

Pulmonary and Critical Care Medicine in China

To the Editor:

We read with great interest the recent article by Qiao et al1 in CHEST (January 2014) concerning a joint statement regarding the proposed establishment of a new subspecialty, pulmonary and critical care medicine (PCCM), in China. We appreciate, to some extent, the concerns of negative lifestyle perceptions. In China, we believe that the development of critical care medicine is still at its infancy. Critical care is only a part of all relevant critical care knowledge and skills, including internal medicine, surgery, emergency medicine, and anesthesia. Though very important in the practice of critical care medicine, pulmonary medicine is only a part of all relevant critical care knowledge and skills.

As in the United States, failure of some previous pulmonary and critical care medicine training programs in China might be explained by the concerns of negative lifestyle perceptions. In addition, it might also be related to underrecognition of the value of a multidisciplinary approach. More importantly, these barriers could not be automatically resolved by reintroducing the pulmonary and critical care medicine subspecialty.

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Financial/nonfinancial disclosures: The authors have reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.
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