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 al. 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. 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 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. 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, with general and specialty ICUs run by “pure” intensivists, anesthetists, 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 outcome, rather than merely discussing who should be the driving force or leadership of critical care.

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.

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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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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DOI: 10.1378/chest.14-0186

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Pulmonary and Critical Care Medicine in China

To the Editor:

We read with great interest the recent article by Qiao et al 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 authors’ analysis with respect to the valuable roles pulmonologists play in critical care medicine (CCM). However, we would like to point out that, in the statement, many important facts linked to the contemporary development of CCM in China were neglected.

First, as far as we know, CCM is a multidisciplinary field of medical specialty of which respiratory medicine (RM) is an integral part, but not the only driving force. This concept of an interdisciplinary medical approach being the mainstay of CCM is widely acknowledged. In China, it is well known that the first real ICU, established in Beijing in 1982, originated from general surgery. Meanwhile, a multiple organ failure unit was also established in Tianjing. These departments developed over time and became autonomous. Therefore, it is unreasonable to regard RM as the origin of CCM in China.

Second, we could not agree with their assertion that “there are now no formal or consistent pathways to train and develop expertise in CCM (in China).” Since 1997, at least three nationalized autonomous. Therefore, it is unreasonable to regard RM as the origin of CCM in China.

Second, we could not agree with their assertion that “there are now no formal or consistent pathways to train and develop expertise in CCM (in China).” Since 1997, at least three nationalized autonomous. Therefore, it is unreasonable to regard RM as the origin of CCM in China. Autonomous CCM societies have successfully provided many years of specialist training programs to enrich the expertise of doctors and nurses who desire to work in ICUs.

Third, the scope of medical practice of each specialty or specialist is clearly defined in Chinese health regulation law. The unjustifiable move to merge CCM and RM as a new subspecialty, PCCM, will definitely lead to unnecessary conflicts among specialists. The saying goes, “Never run faster than your guardian angel can fly.” It is worth noting that, in China, the potential consequences of the rapid expansion of RM into all kinds of related professions, including CCM, will ultimately dilute its core value. Therefore, we suggest that providing solutions to the difficulties facing CCM in China should be prioritized, rather than resorting to the formation of a new PCCM specialty.

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Response

To the Editor:

We read with great interest the correspondence about our recent commentary in CHEST that proposed establishing the subspecialty of pulmonary and critical care medicine (PCCM) in China. Drs Du and Weng cite the importance of critical care as a specialty in China, that “general” ICUs achieve equivalent or superior survival rates compared with “specialty” units, and that critical care is best delivered in a multidisciplinary environment. They correctly point out that ICUs may be led by physicians from various backgrounds, including anesthesiology, emergency medicine, and pulmonary medicine. However, we disagree with the implication that intensivists with training and experience in PCCM would not embrace a multidisciplinary approach. Indeed, the program requirements for accreditation for US fellowships in PCCM state, “critical care medicine is multidisciplinary in nature [and] the program must provide opportunities to manage adult patients with a wide variety of serious illnesses and injuries requiring treatment in a critical care setting.” Training requirements in PCCM explicitly call for the knowledge and skills outside of respiratory medicine that Drs Du and Weng deem necessary. We can all agree that regardless of the primary specialty of who leads the critical care team, proper training and experience are required; Du and colleagues have noted that there are currently no formally accredited fellowship training programs in critical care medicine (or other subspecialties) in China.

Dr Huang and colleagues share concerns that pulmonologists/intensivists would not espouse the importance of an interdisciplinary approach to critical care and remind us that critical care is a recognized Chinese specialty that started in surgical units. However, despite decades of evolution, there is still a severe shortage of critical care physicians.

We do not maintain that only PCCM specialists should lead critical care units. All intensivists must have similar knowledge and skills and an interdisciplinary approach, regardless of their primary specialty, and achieving that requires rigorous training and certification. In the United States, the great majority of ICU physicians are subspecialists trained and certified in both pulmonary and critical care medicine. These physicians continue to fill a void left by diminishing numbers of anesthesiologists, surgeons, and internists who choose a practice consisting of only critical care. We believe that recognition by China of PCCM as a subspecialty, with a standardized curriculum, training path, and certification process, will dramatically increase the number of well-trained and skilled physicians urgently needed to care for the growing numbers of critically ill patients. We look forward to collaborating with our “pure” intensivist colleagues in advancing the science and practice of critical care medicine for the benefit of our patients.

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