In Defense of Medical Education

To the Editor:

I read with great interest the recent Point/Counterpoint editorials by Blumenthal\(^1\,\text{2}\) and Pastis and Strange\(^3\,\text{4}\) in a recent issue of CHEST (March 2015) debating whether nurse practitioners should perform transbronchial biopsies. In making the case for her “yes” stance, Blumenthal\(^1\,\text{2}\) finds the use of the term “nonphysician” egocentric. What is not egocentric is the belief that medical education, including medical school and years of postmedical school training, is a necessity to the proper delivery of high-level medical care.

The desire to perform bronchoscopy with transbronchial biopsies is illustrative of one of the most troubling aspects of the nurse practitioner advancement, which is the impression that most medical care can be delivered after a period of technical training. This fails to acknowledge the vast amount of time required to develop a fund of knowledge and the intense training necessary to add judgement to that knowledge base. This is a process that entails up to 10 postgraduate years for many physicians. A physician performing a procedure is not simply supplying a technical skill based on algorithmic decision-making, but drawing on years of integrative thinking. Medical education was not conceived as an arduous obstacle course designed to reduce competition but as a necessary path to the attainment of that thoughtful approach. This process cannot be distilled down to 2 to 3 years of postgraduate education. Access concerns should be addressed by markedly increasing opportunity to this path for those who wish to provide patient care without bypassing the intensity and style of it. This would be welcome and reassuring.

The ideals of quality and access referred to are unfortunately not balanced in our present health-care environment as the former is often secondary to the latter. As well, the attempt to perform a procedure that is generally performed by pulmonary physicians with 9 to 10 years of postgraduate training is revealing not only for its concerning boldness but also as proof that access concerns can no longer be used as the default rationale for the ever-widening advancement of nurse practitioners’ scope of practice. Claims of cost savings are also questionable as increased resource utilization (referrals, testing) may ultimately counter any upfront savings. Additionally, Blumenthal\(^1\) comment that nurse practitioners and physicians view clinical dilemmas from a different perspective is a critical understatement. She states that our different academic paradigms are immaterial. They are actually the core of the debate.

Nurse practitioners have not hesitated in their drive to independently practice medicine. It is time for physicians to defend medical education as a prerequisite for that practice. It is our duty to patients and certainly not an egocentric one.

Paul J. Failla, MD, FCCP
Baton Rouge, LA

AFFILIATIONS: From the Department of Medicine, Pulmonary/Critical Care, School of Medicine, LSU Health Sciences Center Baton Rouge.

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CORRESPONDENCE TO: Paul J. Failla, MD, FCCP, Department of Medicine, Pulmonary/Critical Care, School of Medicine, LSU Health Sciences Center Baton Rouge, 5246 Brittany Dr, Baton Rouge, LA 70808; e-mail: pfaill@lsuhsc.edu

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Performing Pulmonary Interventions

Pulmonologist or Pulmonary Interventionist

To the Editor:

We read with great interest in a recent issue of CHEST (March 2015) the Point and Counterpoint editorials by Blumenthal\(^1\) and Pastis and Strange\(^3\). We agree that trained nurse practitioners (NPs) can perform several medical procedures, including intubation, CPR, and others.\(^3\) However, performing transbronchial lung...
biopsy (TBLB) requires not only training in flexible bronchoscopy but also several other aspects that a clinician acquires only after years of experience. Blumenthal suggests the training for flexible bronchoscopy received by the NPs and physicians is the same. However, this is debatable.

In India, training of a physician involves 4½ years of medical school followed by 1 year of internship. This is followed by 3 years of training in internal medicine and another 3 years of fellowship in pulmonary medicine before he or she can perform flexible bronchoscopy skillfully. In these 12 years, a physician is trained in various aspects of medicine (eg, etiology, pathogenesis, clinical features, diagnostic approach) apart from performing diagnostic procedures. The training program for NPs in India involves 3 to 4 years of training in various aspects of nursing care, with only an overview of anatomy, physiology, and other subjects. At least in India, the training schedule of a physician differs vastly from that of an NP. Whether the training program of a NP in the United States is different from other places is not clear.

Before performing any procedure, it is important to understand the indication for the procedure and assess the risk-benefit ratio. In carrying out TBLB, one needs to be trained not only in the art of flexible bronchoscopy (including management of complications associated with TBLB, such as bleeding and pneumothorax) but also in the interpretation of chest imaging (chest radiography and CT scans of thorax). Moreover, in several diseases, more than one procedure will be required. In sarcoidosis, for example, additional procedures, including endobronchial biopsy or transbronchial needle aspiration (either conventional or endobronchial ultrasound guided) may be needed. This requires an NP to be trained in the entire gamut of pulmonary procedures. We doubt that this would be practical.

Finally, TBLB is not a very complex procedure associated with high complication rate, as presented by Pastis and Strange. In fact, TBLB is a routine bronchoscopy procedure that is safe and is performed on an outpatient basis by a trained pulmonologists. Whether it can be performed by nonpulmonologists is the question.

Inderpaul Singh Sehgal, MD, DM
Ritesh Agarwal, MD, DM, FCCP
Chandigarh, India

AFFILIATIONS: From the Department of Pulmonary Medicine, Postgraduate Institute of Medical Education and Research.

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.

CORRESPONDENCE TO: Inderpaul Singh Sehgal, MD, DM, Department of Pulmonary Medicine, Postgraduate Institute of Medical Education and Research, Chandigarh-160012, India; e-mail: ipdoc_2000@hotmail.com

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Response
To the Editor:

Promoting the practice of nurse practitioners (NPs) does not diminish the role of physicians. Nor is there any evidence to support the suggestion that advancing the scope of NP practice threatens the health of the patients. Point of fact, beyond the previously referenced studies that describe the safe performance of invasive procedures by NPs, there is myriad evidence that speaks to the benefits of collaborative practice (also indicated in the first article of this debate).

Perhaps reassurance can be found in the review of a few of the salient points of the argument in favor of NPs performing transbronchial lung biopsies. Health care should only be delivered by clinicians who have been trained and credentialed according to professional standards set forth by their governing agencies. Mastery of skills is achieved through rigorous training, extensive practice, and vigilant support. Individualized and routine assessment by a clinical expert is essential to determine and maintain competency within the system wherein the provider practices. The guidelines defined by the American College of Chest Physicians (CHEST)<sup>9</sup> provide the architecture for training and standards of competency appropriate to all bronchoscopists regardless

<sup>9</sup> Chest. 2015;147(3):594-595.
of discipline. NPs and physicians adhering to every one of these qualifiers meet the standards to perform transbronchial biopsies.

Although this editorial was written with the American health-care system in mind, its premise could be expanded beyond the United States provided that the supportive structures are in place. Specifically, scope of practice, access to training and certification, and professional licensure would have to endorse the performance of transbronchial biopsies by advanced practice nurses.

Respondents to the debate have overlooked one of the most important benefits associated with the expansion of the role of NPs: partnership. Through collaborative practice we have the opportunity to deliver care that is informed by both medical and nursing science. The evidence2-4 supports that collaborative care is cost-effective and high quality. It is good for patients and practical for providers.

Fear mongering is uncalled for, unsubstantiated, and, frankly, works against the ideals of modern health care. Patients deserve better. It is time to get to work… together.

Nancy P. Blumenthal, DNP, ACNP-BC
Philadelphia, PA

AFFILIATIONS: From the University of Pennsylvania Lung Transplant Program; and the Doctor of Nursing Practice Program, Yale University, West Haven, CT.

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CORRESPONDENCE TO: Nancy P. Blumenthal, DNP, ACNP-BC, University of Pennsylvania Lung Transplant Program, 3400 Spruce St, Philadelphia, PA 19104; e-mail: nancy.blumenthal@uphs.upenn.edu

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