Critical care response teams: A step forward in patient care, or a step closer to an emergency physician manpower crisis?

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In this issue of *CJEM*, Upadhye and associates discuss the potential roles for emergency physicians (EPs) in the formation and implementation of critical care response teams (CCRTs) in Canadian hospitals.[1] They suggest that EPs could be valuable members of such teams, even playing the role of team leaders in hospitals where there are inadequate numbers of, or no intensivists. The stated purpose of these teams is to "bring critical care expertise to the bedside of patients outside of ICUs [intensive care units]," thereby impacting the "early care of critically ill or deteriorating patients in order to improve outcomes and potentially reduce the rate of, or shorten the duration of, ICU admissions." As written, this goal of better patient outcomes seems laudable. Certainly, Rivers and colleagues have demonstrated clear benefit of early, goal-directed therapy for patients in shock.[2]

The need for CCRTs has arisen because of current inadequacies in acute health care. As acute care beds have closed, so too have intensive care beds. With increasing utilization of outpatient services and day hospitals, remaining patients in acute care beds are relatively sicker. The proportion of beds for intensive care patients should therefore be greater than ever, yet health care systems have not responded to this need. The use of CCRTs seeks to bring intensive care to the patient rather than bringing the patient to intensive care. It attempts to circumvent the need for more intensive care unit (ICU) beds and more intensivists. If the health care system was responding appropriately to demand by correcting these deficiencies, we would not be considering such a concept. Optimal care would occur in the ICU, after initial resuscitation in, and immediate transfer from, the ward or the emergency department (ED). We have known for decades that concentration of specialized care into focused units optimizes results, be they the coronary care unit, the ICU or stroke units. Before installing CCRTs across Canada, staffing requirements, overall cost, and patient outcomes should all be compared with proper staffing and a greater number of ICU beds. Initial reports of improved outcomes from CCRTs are based on straw-man comparisons: that of current care. Such comparisons should not be made, for current care routinely has inadequate staffing with inadequate resources throughout the hospital. Furthermore, it is likely that use of CCRTs will require more staffing than do specialized units.

To propose spreading ourselves even thinner by becoming actively involved in CCRTs further weakens the definition of who we are and perpetuates an image we all find repugnant, that of the non-specialist, "everybody's intern."

Even more problematic is the suggestion that EPs should be active members of CCRTs. There is no disputing that trained EPs possess the skills and knowledge required.

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However, in Canada, one of the most pressing problems in emergency medicine is that of inadequate human resources. Emergency nurses are in appallingly short supply. Difficult working conditions in emergency medicine have created a critical shortage of physicians willing to work in EDs. In Ontario alone, 25 to 30 EDs were at risk for closure last summer for this reason. More than 10 000 hours per month of ED shifts are not covered in that province. Why then do Upadhye and associates suggest that some of our best and most competent EPs should further reduce their roles in the ED to take on this new role? Those EPs who do choose to participate will do so, in part, to avoid our dysfunctional EDs and to find better working conditions and remuneration. Our specialty cannot afford further loss of manpower. We not only need to maintain our current numbers, but we also need to rapidly find ways to train more residents and retain more physicians. Perhaps we should be aiming to provide what EPs seek within the confines of the ED.

Yet another concern is that EPs as a whole have failed to properly define our role within the field of medicine. We have spread out into multiple related domains such as toxicology, prehospital care, hyperbaric medicine, and intensive care, without first establishing who we are. This is not to suggest that physicians in these areas have not accomplished excellent work, for they have. Rather, we have not completed the necessary initial steps before such diversification: we have not insisted on defining our specialty and work conditions so that all other physicians recognize the unique skill set we offer and the environment required to provide it. If we had, we would not be facing ongoing overcrowding, flagrant misuse of the ED by consultants and daily misperceptions of our role in acute care. Proof of this is seen in the US model, where EDs now require certification to receive children, patients with strokes, or trauma patients,[3] as if an ED with a trained EP is no longer sufficient. To propose spreading ourselves even thinner by becoming actively involved in CCRTs further weakens the definition of who we are and perpetuates an image we all find repugnant, that of the non-specialist, "everybody's intern." No other defined specialty keeps trying to take on new roles outside their domain at the rate EPs do.

Care for critically ill patients may be improved by EP involvement in CCRTs, but as our physician numbers diminish "at home" in the ED, we may not be able to say the same for the vast majority of patients left behind, waiting for ever longer periods before receiving care. The outcomes of those patients being neglected due to inadequate resources and manpower should be included in any analysis before we start proclaiming improved results for the few included in the proposed new model.

It would seem that a much stronger advocacy for improved critical care could be made by lobbying for appropriate space in larger ICUs, and for adequate trained staff for both the ICU and the ED. Furthermore, both provincial and national emergency medicine associations should be actively working with other health care groups to find solutions for our broken health care system, rather than fragmenting EP resources into yet another practice category. The CCRT may be a solution for a small subset of all emergency patients, but not without a negative impact, as yet unevaluated, on all other patients. The time is not now for this "solution."

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