Letters

Integrated critical care: an approach to specialist cover for critical care in the rural setting

Michael J O'Leary 510

Neil T Matthews 511

John Stokes 511

Craig T Hore, William Lancashire, John B Roberts, Robert Fassett 512

Integrated critical care: an approach to specialist cover for critical care in the rural setting

Michael J O'Leary

Intensive Care Physician, St George Hospital, Gray Street, Kogarah, NSW 2217. m.oleary@unsw.edu.au

To the Editor: Hore and colleagues argue for "integrated critical care" as a solution to the problem of providing intensive-care cover for patients in rural and non-tertiary metropolitan hospitals.[1] They claim that such an approach is required uniquely in these hospitals, whereas in tertiary centres "subspecialists would be involved in each phase of the management process".

That this occurs is undisputed; however, it is far from the optimal model of care.[2] Over the past 3 decades, the management of critically ill patients has evolved to require its own specialty. Other than in the traditional critical-care disciplines of anaesthesia and emergency medicine, training in critical care is not a significant component of specialty training programs. Within tertiary hospitals, therefore, the requirement that critically ill patients be cared for by specialists trained in critical-care medicine (and not a "committee" of subspecialty experts) is no less important than in the rural setting. There is consequently little difference between the skills and experience required of tertiary and rural critical-care specialists, and the continuum of critical care is the same in both settings.

The recent creation of the Joint Faculty of Intensive Care Medicine by the Royal Australasian College of Physicians (RACP) and the Australian and New Zealand College of Anaesthetists (ANZCA) has enabled many of the past artificial barriers to effective critical-care training and accreditation in Australasia to be broken down. It is now possible to enter intensive-care training from varied training programs, including those of the Australasian College for Emergency Medicine, the RACP and the ANZCA. Completion of training is recognised by successfully passing a broad-based critical-care examination.

The argument that training could and should include rural practice is well made. However, any comprehensive critical-care training will inevitably require some high-volume experience only available within a tertiary institution.

That there are differences in emphasis in the workload of our rural colleagues should be recognised. However, our job is essentially the same. There is no need for a separate specialty, but there is a need to ensure provision of high quality critical-care services to all patients into the future.

1. Hore CT, Lancashire W, Roberts JB, Fassett R. Integrated critical care: an approach to specialist cover for critical care in the rural setting. *Med J Aust* 2003; 179: 95-97.
2. Pronovost PJ, Angus DC, Dorman T, et al. Physician staffing patterns and clinical outcomes in critically ill patients. A systematic review. *JAMA* 2002; 288: 2151-2162. ❏

Neil T Matthews
Dean, Joint Faculty of Intensive Care Medicine, Australian and New Zealand College of Anaesthetists and Royal Australasian College of Physicians, 630 St Kilda Road, Melbourne, VIC 3004.
jficm@anzca.edu.au

To the Editor: The article by Hore et al[1] raises many important issues for acute-care medicine in rural settings, including the need for specialists to be multiskilled and collaborate across disciplines, the lack of professional support for rural training programs and rural specialists, and the difficulty of overseeing multidisciplinary credentialling.

These issues are not unique to acute-care medicine or to the Joint Faculty of Intensive Care Medicine (JFICM). They are problems for other faculties and colleges, rural healthcare facilities and governments. Many rural specialist services in Australia and New Zealand have the benefit of considerable expertise provided by medical practitioners who are not necessarily Fellows of the relevant specialist colleges. They should be supported by collaborative efforts of the relevant colleges, which should develop initiatives to increase the numbers of specialist medical practitioners working in rural settings.

The JFICM, representing some 464 Fellows and 391 trainees, has been developing frameworks to support rural intensive care. JFICM's goals are to develop a more flexible training program to encourage rural training; to establish a rural officer on the JFICM Board; to support a rural focus group, working through rural structures with the Committee of Presidents of Medical Colleges; and to explore liaisons with other colleges.

The argument for developing a specialty of integrated critical-care medicine implies that current programs are deficient and cannot provide a holistic, integrated approach to rural acute care. Hore and colleagues argue that "there is no formal program for training specialists for multidisciplinary rural critical-care practice". I must correct them on this point. Their proposal in fact eloquently describes the elements of the JFICM training program, which has existed since 1977. An internationally recognised and comprehensive intensive-care/critical-care training program, its status has been confirmed with its successful accreditation by the Australian Medical Council.

The authors also suggest that "critical care" is in some way different from "intensive care". This is not contemporary reality. The terms "intensive care" and "critical care" are one and the same.

Healthcare workers in rural and remote locations have collaboratively developed multidisciplinary working relationships that provide comprehensive acute and non-acute healthcare. The same approach should be used by authoritative bodies to resolve important issues for rural specialists and training programs. The issues do not require establishing a separate specialty.

The above comments notwithstanding, the suggestion by Hore and colleagues that specialties involved in acute care lead a collaborative process to strengthen clinical links is to be applauded. The discussions need to be inclusive of medical specialists working in intensive care medicine.

1. Hore CT, Lancashire W, Roberts JB, Fassett R. Integrated critical care: an approach to specialist cover for critical care in the rural setting. *Med J Aust* 2003; 179: 95-97. ❏

John Stokes
Director of Intensive Care, Mater Private Hospital, Fulham Road, Pimlico, QLD 4812.
john.stokes@matertsv.org.au

To the Editor: Hore et al[1] raise some very pertinent issues relating to the delivery of integrated critical care in the rural setting and raise the possibility of a new specialty to help solve the problem.

The issue of providing many services in rural, remote and regional Australia will not be solved by more subspecialisation, which is actually having the effect of centralising services in major metropolitan centres distant from important and productive portions of our population.

Rather than propagate another group of subspecialists, our medical colleges, and in particular the Australian Medical Council (AMC), need to look at new ways to empower specialists and generalists who work in regional areas to continue to provide services without their expertise being undermined in the eyes of the public. We need to encourage state governments to spread services more widely rather than to centralise and remove rural services.

The push for so-called "centres of excellence" that draw all patients to a few centres is for the convenience of the few and is financially attractive to governments. Artificial standards for care (produced by the medical colleges), with restrictions on practice related to the number of patients treated or the number of patients ventilated, are unrelated to the quality of care delivered to individual patients. These restrictions may soon lead to many specialties not being sustainable outside capital cities or major urban centres because of insufficient caseload to meet the guidelines. In regional areas, specialists (such as anaesthetists) who have the experience to provide additional services (eg, intensive care), but not the formal recognition, are being discouraged from doing so by the college guidelines and the current legal climate.

My observation of the actions of most medical colleges is that, by their good intention to maintain standards, they are supporting the concentration of services but are discouraging the wide delivery of services. Surely, when we do studies that demonstrate that care is better delivered in special or centralised units, the aim should be to find out why, and to seek ways to deliver that expertise in less

specialised and more decentralised units, rather than to immediately call for more centralisation of services. This, I believe, is the real challenge for our AMC and our Committee of Presidents of Medical Colleges.

1. Hore CT, Lancashire W, Roberts JB, Fassett R. Integrated critical care: an approach to specialist cover for critical care in the rural setting. *Med J Aust* 2003; 179: 95-97.

Craig T Hore,* William Lancashire,† John B Roberts,‡ Robert Fassett§
* Director of Critical Care, † Director of Critical Training, ‡ Director of Emergency Medicine, Port Macquarie Base Hospital, PO Box 2466, Port Macquarie, NSW 2444; § Director of Renal Unit, Department of Medicine, Launceston General Hospital, Launceston, TAS.
hore@maynegroup.com

IN REPLY: We thank the correspondents for their interest, insights and discussion. In general, there appears to be much common ground between our views and theirs, although a few points of clarification need to be made.

We do not argue that a "committee of subspecialty experts" undertakes critical care in tertiary centres, as O'Leary suggests. The subspecialists we refer to are those within the discipline of critical care, particularly intensivists, emergency physicians and anaesthetists. In tertiary settings, these specialists operate predominantly within their base critical-care "subspecialty". In rural settings, they are also involved in the other phases of critical care on a regular basis. Hence, while the principles of critical care are similar in rural and metropolitan settings, their effective delivery differs.

We do not question that the Joint Faculty of Intensive Care Medicine (JFICM) provides a comprehensive intensive-care training program. However, there are very few JFICM-accredited intensive-care units in Australia outside metropolitan centres, and few JFICM-endorsed specialists working in the public sector in rural and remote intensive-care units.[1] Unfortunately, this suggests that the current JFICM program is not addressing the needs of rural and remote centres. Indeed, in their recent review, the Australian Medical Council encouraged the JFICM to give more opportunity and encouragement for trainees to gain rural experience.[2] The steps being undertaken by the JFICM that Matthews outlines are encouraging.

We believe the statement by Matthews that "intensive care and critical care are one and the same" is insular and at odds with the reality of critical care, especially outside tertiary metropolitan centres. It is pleasing to note that O'Leary includes emergency medicine as a "traditional critical-care discipline". There are strong clinical and curriculum similarities between emergency medicine and intensive-care medicine that cannot be overlooked. In this respect, rural centres may be leading the way in further breaking down barriers. The formation of the JFICM has been a positive step, but it remains a liaison of only two bodies. A greater presence from emergency medicine, rural anaesthesia, rural medicine and surgery would be beneficial and a significant step towards a truly multidisciplinary specialty.

We reaffirm that, to ensure high standards of critical care for rural patients, solutions need to match the existing realities of rural practice. We agree that these must be collaborative and inclusive. The integrated critical-care model has been successful in a number of rural hospitals and offers potential for wider implementation.

1. Anderson T, Hart GK. Review of intensive care activity 1999/2000. Melbourne: Australian and New Zealand Intensive Care Society, December 2001.
2. AMC report. Joint Faculty of Intensive Care Medicine. 2003. Available at: www.jficm.anzca.edu.au/publications/amcrpt/conclusion.htm (accessed Sep 2003).

MJA Advertisers' Index

Australian Taxation Commission
Temporary Residents p479
Bayer/Glaxo
Levitra p458
Corinth Healthcare
Medical Recruitment p474
Johnson & Johnson
Neutrogena Acne Wash p497
Neutrogena Face Lotion p469
National Prescribing Service
Radar p465
Novo Nordisk
Novomix 30 .... p494
Panasonic & Telstra
Panasonic Phone System p488
Pfizer Australia Pty Ltd
Zybox......................... p505
Schering Pty Ltd
Diane-35 .... Inside front cover
Androcur-100 .... Inside back cover
Betaferon............ Outside back cover
Servier Laboratories
Coversyl PLUS p484

The Medical Journal of Australia

Editor
Martin Van Der Weyden, MD, FRACP, FRCPA
Deputy Editors
Bronwyn Gaut, MBBS, DCH, DA
Ruth Armstrong, BMed
Mabel Chew, MBBS(Hons), FRACGP, FAChPM
Ann Gregory, MBBS, GradCertPopHealth
Manager, Communications Development
Craig Bingham, BA(Hons), DipEd
Senior Assistant Editor
Helen Randall, BSc, DipOT
Assistant Editors
Elsina Meyer, BSc
Kerrie Lawson, BSc(Hons), PhD, MASM
Tim Badgery-Parker, BSc(Hons)
Josephine Wall, BA, BAppSci, GradDipLib
Proof Readers
Raymond Carroll, Christine Binskin, BSc
Editorial Administrator
Kerrie Harding
Editorial Assistant
Christine Tsim
Production Manager
Glenn Carter
Editorial Production Assistant
Melissa Sherman, BA
Librarian, Book Review Editor
Joanne Elliot, BA, GradDipLib
Consultant Biostatistician
Val Gebski, BA, MStat

Content Review Committee: Leon Bach, PhD, FRACP; Adrian Bauman, PhD, FAFPHM; Flavia Cicuttini, PhD, FRACP; Marie-Louise Dick, MPH, FRACGP; Mark Harris, MD, FRACGP; David Isaacs, MD, FRACP; Paul Johnson, PhD, FRACP; Jenepher Martin, MEd, FRACS; Adrian Mindel, MD, FRACP; Michael Solomon, MSc, FRACS; Campbell Thompson, MD, FRACP; Tim Usherwood, MD, FRACGP; Owen Williamson, FRACS, GradDipClinEpi; John Wilson, PhD, FRACP; Jeffrey Zajac, PhD, FRACP

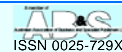
Australasian Medical Publishing Co Pty Ltd
Advertising Manager: Peter Butterfield
Media Coordinator: Julie Chappell

The Medical Journal of Australia (MJA) is published on the 1st and 3rd Monday of each month by the Australasian Medical Publishing Company Proprietary Limited, Level 2, 26-32 Pyrmont Bridge Rd, Pyrmont, NSW 2009. ABN 20 000 005 854. Telephone: (02) 9562 6666. Fax: (02) 9562 6699. E-mail: ampco@ampco.com.au. The Journal is printed by Offset Alpine Printing Ltd, 42 Boorea St, Lidcombe, NSW 2141.

MJA on the Internet: http://www.mja.com.au/

None of the Australasian Medical Publishing Company Proprietary Limited, ABN 20 000 005 854, the Australian Medical Association Limited, or any of its servants and agents will have any liability in any way arising from information or advice that is contained in *The Medical Journal of Australia (MJA)*. The statements or opinions that are expressed in the Journal reflect the views of the authors and do not represent the official policy of the Australian Medical Association unless this is so stated. Although all accepted advertising material is expected to conform to ethical and legal standards, such acceptance does not imply endorsement by the Journal.
All literary matter in the Journal is covered by copyright, and must not be reproduced, stored in a retrieval system, or transmitted in any form by electronic or mechanical means, photocopying, or recording, without written permission.

Published in 2 volumes per year.
Annual Subscription Rates for 2003 (Payable in Advance) to: AMPCo, Locked Bag 3030, Strawberry Hills, NSW 2012
Individual Subscriptions (includes 10% GST)
Australia–$A291.50, Medical students (Australia only)–$A60.00
Overseas Economy Air–$A370.00, Airmail–$A505.00
NZ & PNG Economy Air–$A340.00
Indexes are published every 6 months and are available on request as part of the current subscription.
Single or back issues contact: AMPCo (02) 9562 6666.
Advice to Authors—
http://www.mja.com.au/public/information/instruc.html

27,579 circulation as at 31 March, 2003

ISSN 0025-729X