

Professional Competence and Teamwork in the Treatment of Patients With Acute and Critical Heart Disease. Response



Competencias profesionales y trabajo en equipo en pacientes con enfermedades cardíacas agudas y críticas. Respuesta

To the Editor,

We appreciate the comments of Martín Delgado et al concerning the article in which we defend a greater involvement of cardiologists in the care of acutely and critically ill patients.¹ We are surprised that anyone would dispute the rights, and the duty, of cardiologists in their desire to do their utmost in the care of all heart disease patients, but take this opportunity to clarify certain aspects and to give voice to our position in a larger forum.

Our editorial was not intended as an attack on anyone; rather, the objective was to stir the conscience of the cardiology community so that it accepts its responsibility in the heart disease setting as a whole, in accordance with the extraordinary changes experienced by our specialty. Furthermore, we base our considerations on the good clinical outcomes obtained in the centers in which this is the norm. Outcomes which, by the way, were misinterpreted by Martín Delgado et al. The data we present on mortality do not correspond to the article they mention,² but are the fruit of a thorough review performed ad hoc for this document. We acknowledge that the analysis may have certain limitations (it is retrospective, based on the hospital CRMD, and refers only to death due to acute myocardial infarction), but by no means can we accept the unwarranted and undocumented affirmation that “patients attended exclusively by members of cardiology departments are less serious and complex”. In addition to presenting the overall and risk-adjusted mortality, the hospitals were divided in accordance with the criteria of the European consensus statement on the structure and organization of cardiac critical care units, thus minimizing the possibility of selection bias. Moreover, if the study had been biased, the result would be an underestimation of the real benefits of the care provided in cardiac critical care units, since most of the hospitals in which cardiologists manage the critically ill patients are referral centers, in which the volume and complexity are greater.

We refuse to accept the affirmation that we defend vertical, compartmental management, not centered on the patient, but on certain murky interests. Nothing could be further from the truth. Our article clearly highlights the idea of integrated, multidisciplinary management at the service of the patient. However, any process of this type should have a single coordinator. And here lies the discrepancy: from our point of view, the coordinator should be a cardiologist.

We do not understand why anyone would be uneasy about our encouraging the cardiology community to acquire training and become accredited for this task wherever cardiologists have yet to undertake it. We understand even less the fact that, because of this initiative, we are questioned and accused of being “rash”. We agree with Martín Delgado et al that the skills for the care of patients in the critical phase of the disease process are not acquired during residency in cardiology, but neither is it possible to attain all the necessary knowledge of cardiology during the few months that a resident in intensive care medicine rotates through cardiology. For this reason, we defend our proposal that those who are going to

assume direct responsibility for cardiac critical care units obtain accreditation from the European Society of Cardiology by undergoing a demanding examination, after 2 years of “superspecialization”, and demonstrating that they have acquired comprehensive practical capabilities. All this is in line with the long tradition of the European Society of Cardiology, thinking of patient safety, in the accreditation of its professionals (interventional cardiologists, electrophysiologists, specialists in cardiac imaging),³ with excellent results in terms of quality. We believe that this initiative integrates and guarantees an outstanding level of training in cardiology and in critical care, far superior to that acquired in a simple residency period in either of the 2 specialties.

We regret that some of our colleagues have felt ill at ease with our position. Some of us are experts in heart disease and others in the critical situations that arise in many other diseases, and both can contribute their knowledge and experience in many cases. We should trust one another, increase the present level of collaboration, and continue to learn together, without distrust or discredit, because our patients need that from us.

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