



EDITORIAL

Importance of political decisions in the safety of the critical patient

Trascendencia de las decisiones políticas en la seguridad del paciente crítico

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The news

A confidential document from the *London Deanery* has recently been leaked to the press, alerting to the low qualification of the physicians attending critical patients in some hospitals of the United Kingdom.¹ As expected, this report has had important repercussions, since it points to a serious healthcare defect - the responsibility of which extends beyond the clinical setting. Prestigious professional circles have called for the creation of the specialty of Intensive Care Medicine, and political decisions are awaited aimed at addressing this evident lack of safety among critical patients.²

This news has come as no surprise to many Spanish intensivists who have visited Intensive Care Units (ICUs) in other countries and have seen that particularly after six in the afternoon and until the following morning, care of the critical patient is far below the desirable standards. Thus, although the news comes from the United Kingdom, similar

situations might also be found in other countries belonging to what we call the "developed world".

The situation in Spain

The situation in Spain is very different. The practically universal coverage on the part of intensivists in Spanish ICUs allows us to feel assured that situations such as those denounced in *The Independent* are very unlikely to occur in this country.

The political decision adopted in Spain in 1978 allowed the creation of the specialty of Intensive Care Medicine, and undoubtedly has contributed in a notorious manner to the scientific and healthcare development of this field. From the healthcare perspective, the existence of ICUs staffed by adequately trained intensivists in practically 100% of all Spanish hospitals allows us to trust in the availability of quality patient care. Although there are no comparative cost-effectiveness studies among developed countries in relation to the global care of critical patients, the estimates found in the literature are very favorable to our country.³

The scientific development of our discipline can be measured in several ways, one of which is the volume of

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scientific publications. In this sense, the number of Spanish scientific publications in the area of Intensive Care Medicine stands fifth in the world ranking.⁴ All the other specialities in Spain are clearly below this level, ranking in eighth place. The political decision to create the specialty of Intensive Care Medicine was undoubtedly a good decision. However, despite these results, there is strong pressure to modify our specialty to bring it more in line with the rest of Europe. It is of course logical and legitimate to find different opinions and even tensions among related specialties, and confrontations of this kind generally exert a stimulating effect that can derive in improved patient care. However, it is more difficult to understand pressure exerted from political circles, and the effect is frankly discouraging, since the idea is transmitted that preparation and excellence are not the values to be pursued, and that what some acquire through five years of training can be achieved by others in only three to six months.

The figure of the intensivist is presently accepted throughout the world, and the activity of these specialists is considered vital for the care and survival of critical patients.⁵

Training of the intensivist is what may be subject to debate. Up until four or five years ago the situation in Europe could be classified as chaotic in this sense. This undoubtedly is what favored the creation by the European Society of Intensive Care Medicine (ESICM) of a work group composed of specialists from different countries and disciplines implicated in critical patient care, and which has finally produced a consensus document (COBATRICE) defining the skills, competences and timelines to be covered by an intensivist in order to be regarded as such. At present, in Spain these requirements can only be met by completing training in the specialty of Intensive Care Medicine.⁶

In wait of a political decision

The solution contemplated in the specialties legislation draft, based on truncal areas and possible exchange among related specialties with well defined delimitations may prove adequate. However, there has been talk for over 20 years about this solution, which would make it possible to solve many conflicts, but we are still in wait of a political decision which for now seems remote, and in view of the current circumstances we do not know whether the project will receive approval in the near future.

A political decision which has not been long in waiting affects the most populated country in the world. In effect, recently the Chinese government has taken the decision to create the specialty of Intensive Care Medicine in China.⁷

This decision represents a hard setback for the Chinese Medical Association, which in 1996 formally opposed the creation of a Chinese Society of Intensive Care Medicine. The traditional specialties represented by the Association

were reluctant to accept the creation of such a discipline, assuming as their own the leadership in critical care. However, after more than a decade and in view of the evident lack of efficacy of the proposal, the Chinese government has had to intervene in defense of the interests of the critical patient.⁷ This is a clear example of the futility of waiting for an organism composed of specialists among which Intensive Care Medicine is not represented to favor the creation of a specialty potentially affecting a field which they have come to view as their own. A similar case can be found in Europe with the European Union of Medical Specialists (UEMS). Under these circumstances a political decision is required which above the particular interests of any given specialty seeks to address the general interest of the patient (the critical patient in our case) - this after all being the necessary reference for all those dedicated to healthcare.

Conclusion

Quality care of the critical patient is the shared responsibility of different specialists. In this context, many specialists play a key role in the care of such patients, though their intervention is on a point basis. In contrast, it is the responsibility of the intensivist with certified competences to ensure continuous patient follow-up, 24 hours a day, seven days a week, and thus afford integral patient care in the ICU. Political decisions, whether fortunate or not, can significantly affect the safety of critical care patients.

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