Author has nothing to disclose with regard to commercial support.

by the American Board of Surgery, in 2003. This measure, among others, has led to the availability of 4 pathways to certification in thoracic surgery.³ An example that is more relevant to the current discussion is the introduction of the mechanisms of certification for congenital cardiothoracic surgery. As with establishing a new subspecialty, a period of transition is to be expected. During this period, the board has recognized those who are fully educated, trained, and experienced surgeons who are dedicated to this particular field of practice and granted them subspecialty certification along a “grandfather” pathway.⁴ A similar measure can be considered for cardiothoracic surgeons who chose cardiothoracic surgical critical care as a career. As the educational curriculum, training, and experiential criteria for this subspecialty matured, this pathway was eventually eliminated. Similarly, cardiothoracic surgeons recognized for an active interest, dedication, and experience in cardiothoracic surgical critical care may serve as transitional program directors for the emerging subspecialty.

Other measures for the establishment of cardiothoracic surgical critical care as a distinct subspecialty are already underway. The broad lines for an educational curriculum have been proposed.⁵ Efforts to establish training and experiential criteria are ongoing, thanks to the Foundation for

the Advancement of Cardiothoracic Surgical Critical Care conferences, and other symposia, courses, and conferences sponsored by the Society of Thoracic Surgeons, American Association of Thoracic Surgery.

These suggested mechanisms would be beneficial for practicing cardiothoracic surgeons who have chosen cardiothoracic surgical critical care as a career pathway, in obtaining and maintaining privileges in hospitals and clinical institutions. In fact, this approach may be less cumbersome and time consuming than having to enroll in a Critical Care Fellowship with the American Board of Surgery, as is the current situation. We laud these efforts by the American Board of Thoracic Surgery to further advance and promote the leadership role of cardiothoracic surgeons, as they set a most welcome and commendable precedent for professional organizations in the global community.

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FIGURE 1. Cardiothoracic surgery (CTS) encompasses 4 distinct yet overlapping areas of clinical practice: Adult cardiac surgery, congenital cardiac surgery, noncardiac thoracic surgery, and cardiothoracic surgical critical care (CTSCC).

REDEFINING OUR CARDIOTHORACIC SURGICAL INTENSIVE CARE UNITS: CHANGE IS GOOD

Reply to the Editor:

*The secret of change is to focus
all of your energy, not on fighting the old, but on
building the new.*

—Socrates

To evaluate fully the evolving nature of critical care in cardiothoracic surgery, it is helpful to take a step back and evaluate how we define our specialty. According to the American Board of Thoracic Surgery,¹ thoracic surgery “encompasses the operative, perioperative, and surgical critical care of patients with acquired and congenital

pathologic conditions within the chest.” As with many areas of medicine and surgery, however, this traditional definition is challenged in the modern era by the increased pressures of subspecialty focus. The cardiothoracic intensive care unit (CTICU) is no exception to this challenge because of the importance of critical care education.² As thoracic surgeons, we need to lead this conversation and guide our colleagues through these uncharted territories, both to provide the best care possible for thoracic patients and to avoid the potential marginalization of our roles in the CTICU by outside forces.

Throughout the decades, thoracic surgeons have learned the value of championing their subspecialty areas. The field of critical care as a subspecialty area is one that is growing rapidly and has certainly already matured in other surgical subspecialty areas. Traditionally, thoracic surgeons have provided care to patients alongside nonthoracic surgical physicians and medical professionals. Thus far, this model has been adequate; in the area of increasing specialization of procedural care and outcomes pressures, however, the current system may require restructuring, with thoracic surgeons being the ones to lead the charge. In fact, Whitman and colleagues³ reported the potential impact of involvement of a Thoracic Board–certified intensivist, demonstrating a 1.5-day decrease in postoperative stay and a 2.2-day decrease in overall stay. Thoracic intensivists also accomplished these results less expensively, with lower drug costs. Several individuals sharing the same sentiment include Dr Nevin Katz, who serves as president and executive director of the Foundation for Advancement of Cardiothoracic Surgical Care, and Dr Hisham M. F. Sherif, both of whom have been longtime advocates for the American Board of Thoracic Surgery to develop a cardiothoracic surgery critical care subspecialty certificate.⁴⁻⁷

The evolution of cardiothoracic surgical critical care (CTSCC) indicates the need to create credentialing and recertification procedures that are modeled after those used for other medical and surgical specialties. Currently, Dr Katz has reviewed the certification process with the American Board of Thoracic Surgery and the American Board of Surgery, and active discussions have been underway to define the requirements for certification of thoracic surgery trainees.⁴ Curriculums for CTSCC have also been proposed.⁶ We believe that now is the time to act and to use what has already been proposed as being the next step in this process. In reviewing guidelines set forth by the Accreditation Council for Graduate Medical Education, new specialties are required to maintain a minimum number of active programs and residents nationally.⁸ It is imperative for thoracic surgeons across the country all to play an active role in this endeavor. We therefore have to continue to increase awareness of this ongoing process within the thoracic surgical community and to define our roles locally. As our specialty evolves, it will be important to be respectful of how we

will navigate the challenges of what this means to those of us who are well trained in critical care as part of the core training but have not elected to pursue the advanced certification. That is, would some hospitals only grant CTICU privileges to CTSCC-certified surgeons? It would make sense to have our CTICUs remain open to trained but uncertified surgeons, such that the subspecialty certification is not viewed as being a burden and therefore unwelcomed. What then would be the potential value of certification? Those pursuing certification would be the leaders of our CTICUs and drive protocols, practices, and research initiatives to define them as centers of excellence. They would not obstruct those of us who still love to manage our own critically ill patients and to remain expertly involved by bringing our subspecialty-specific knowledge to daily care. In fact, these CTSCC-certified surgeons would only protect our long-term interests of maintaining quality and reducing morbidity for an increasingly complex population. In addition, the CTSCC-certified surgeon would lead the collaborative design of our units locally with other critical care specialists as needed. The time to come together on this process is now so that we can develop a viable plan to ensure that this is done correctly and putting aside the concern about being marginalized by certification. The thoughtful design of this new future in our subspecialty may move with clarity once this concept has been fully embraced. We believe that this movement is what we would want for our critically ill loved ones, and centering decisions on this theme universally guides us down the correct pathway for the future.

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