HEART OF THE MATTER

Who Runs the CCU?

BY SIDNEY GOLDSTEIN, M.D.

The development of the coronary care unit in the mid-1960s was a seminal event in clinical medicine. It recognized the gravity of the first few hours and days of an acute myocardial infarction and revealed a dimension of pathology previously unknown to the clinician.

These observations led to an expansion of clinical research and therapy in cardiology, which continues today. Patients with acute myocardial infarction, a clinical event first described by Dr. James Herrick in 1912, were well known. But it was not until the opening of CCUs in medical centers in the United States and England that we began to fully understand the clinical events that resulted from coronary artery thrombosis. The CCU was the launching pad from which that research evolved over the next half century.

Initially, the CCU was largely an arrhythmia-monitoring unit, but it soon became a clinical laboratory aimed at the recognition of left ventricular failure and homodynamic instability based on monitoring of cardiac function with the Swan-Ganz catheter. It became the site where we first examine the role of catecholamines and vasodilators in the treatment of hypotension and shock.

The CCU has changed significantly since then.

The spectrum of cardiac pathology has broadened with the development of biomarkers that expanded our understanding of the early expression of ischemia. These biomarker determinations identified the previously unrecognized magnitude of coronary ischemia. Cardiologists became more interested in the acute coronary syndromes and early angiographic expression of disease.

As a result, the CCU is now largely the repository of complicated ST-segment elevation myocardial infarctions, post complex percutaneous coronary intervention, and the treatment of patients with homodynamic instability and left ventricular failure.

The CCU has also blended into the hospital complex of intensive care units. In many institutions, the boundary between ICU and CCU has become blurred beyond recognition.

During a recent rounding rotation on our consult service, I was struck by the expansion of ICU beds in our institution and the role that the intensivist plays in the administration and care of patients in these units. The management of a broad spectrum of diseases, from pulmonary failure to postoperative neurosurgical problems, is no longer the responsibility of the medical discipline of origin. It is assigned instead to the domain of the generic intensivist once the patient enters the ICU.

The same pressures to provide round-the-clock care have led to the gradual invasion of the CCU by the ubiquitous intensivist. Health planners, including one of the leaders in the reinvention of health care, the Leapfrog Group, has proposed that all intensive care units, including the coronary care unit, should be under the control of a resident intensivist, who often doubles as a hospitalist. They point to studies that show an improvement in ICU mortality by up to 40% in such units (www.leapfroggroup.org/about_us/leapfrog-factsheet).

The American College of Chest Physicians and the Committee on Manpower of Pulmonary and Critical Care Societies have led the expansion of the role of the intensivist. In a recent report to Congress, the groups specifically emphasized the short supply of intensivist and their important role in the care of ICU patients (Senate Report 108-81).

Generic use of intensivists in ICUs because of their round-the-clock availability in the hospital is not necessarily a step forward. There is no question that immediate physician availability is essential to the care of the critically ill patient. But the physician best equipped to render this care is the one who is trained to deal with that specialty. To fulfill our responsibility for cardiac care, we must provide more CCU experience during cardiology training. Those challenges are outlined in an excellent editorial by Dr. Jason Katz and colleagues that emphasizes the need for intensivist training in cardiology programs (J. Am. Coll. Cardiol. 2007;49:1279).

There is reason to be concerned that training has become subservient to the demands of technologies that are more lucrative but less than supportive of our role as cardiologists. In order for cardiologists to render quality care in the future, more CCU experience is essential in our training programs.

The CCU remains an essential clinical laboratory for the care of the cardiac patient and we must maintain our role in that environment. ■

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LETTERS

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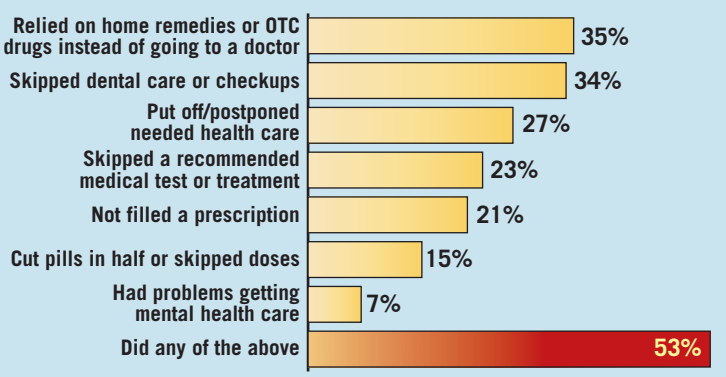

Note: Based on a survey conducted Feb. 3-12, 2009, among a nationally representative random sample of 1,204 adults.
Source: Kaiser Family Foundation