Section on Critical Care Distinguished Career Award
Presentation To Russell C. Raphaely, MD, FAAP

Transcript - October 29, 2000

Let me begin by saying I'm very grateful to the section and also to Roche Laboratories who sponsored the awards, for choosing me as the recipient of the 2000 Distinguished Career Award from the Section.

Good fortune, some ability, and support of individuals, some of whom are here today to share this moment with me, enabled me to have a career recognized by this award. Drew Costamane, who I considered Associate Director of the division when I directed the Division of Critical Care at the Children's Hospital of Philadelphia, helped me in many ways, but especially in the division's training and research programs. He was a valued coworker and remains a good friend. We shared many humorous moments together. Jack Doares who lead the department for 24 years is a role model for me. Having won this award in 1996, I am especially pleased to be recognized for accomplishments similar to his. His influence brought me to the Children's Hospital of Philadelphia for subspecialty training in pediatric anesthesiology and critical care. He suggested that critical care would be a satisfying career for me; his suggestions proved correct and his support, in no small measure, made it possible for me to obtain this award. Marianne, my wife, initiated her very valued counsel by encouraging me to go to medical school rather than dental school and has continued to provide welcomed, sound, loving advice throughout my career. She also, by the way, surprised me by arranging for my sons Chris and Jim, their wives, Julia and Cynthia and my sister and brother-in-law, Catherine and Tony Sirico to celebrate the receipt of this award. They are all seated here and I'm very grateful for them coming.

I have always regarded the AAP as an organization, though principally consisting of the members of the specialty of pediatrics, as one which welcomed and allowed other specialties committed to the care of children to participate in its affairs. The Academy supported me as an anesthesiologist in my efforts to obtain consensus of interested sections and critical care providers as to whether critical care would be part of the existing Section on Anesthesiology as some at the time preferred, or, as I preferred, and many more advocated a separate section status.

When clarified, I was given the responsibility to form the section and was honored to serve as its first chairman. If my memory serves me correctly, Dan Levin shared the first section's scientific program and Murray Pollack the second during my 2 years of section leadership. I served initially as the liaison to the Committee on Hospital Care of the Academy. I campaigned for a voting position and successfully persuaded the committee to include a representative from the section to serve in that role. I certainly am proud to be a member of the section and humbly accept this award. I am cautioned, however, about exhibiting too much humility by the words of the great leader and stateswoman, Golda Meir, "Don't be so humble, you're not that great."

I have chosen to discuss 3 challenges that I foresee confronting critical care providers. The first is our contribution to ensuring patients' and families' confidence in our ability to provide safe care in an invasive, technology-laden environment where extended treatment occurs, numerous encounters create opportunities for error and margin of error because of profound illness remains very narrow. The Committee on Quality of Health Care in America of the Institute of Medicine, an entity established in 1970 within the National Academy of Sciences to secure the services of eminent members of appropriate professions in the examination of policy matters pertaining to the health of the public, issued the report, "To Err is Human: Building a Safer Health System" in March of this year. The IOM acts under the responsibility given to the National Academy of Sciences by its congressional charter to be an advisor to the federal government and upon its own initiative to identify issues of medical care, research, and education. The report received much attention from the media and President Clinton. The public which has been inundated with illustrations of the failure of the US medical system and the high cost of providing care to the US inhabitants once again had their confidence in our ability to care for them shaken. In the executive summary, the IOM states, "the combined goal of the recommendations contained in this report is for the external environment to create sufficient pressure to make error costly to health care organizations and providers so that they are compelled to take action to improve safety." Citing several anecdotal reports and 2 large studies, I conducted in Colorado and Utah, the other in New York, the committee projected from 44 to 95,000 US inhabitants die each year as a result of medical error. The committee defined error as a failure of an action or planned action to be completed as intended or the use of a wrong plan to achieve an aim.

To achieve a 50% reduction in errors over 5 years, a goal which the committee contends expecting anything less would be irresponsible, the IOM proposed a 4-tiered approach which: establishes a national focus to create leadership, research, tools, and protocols to enhance our knowledge about safety; identifies and learns from errors through immediate and strong mandatory reporting efforts, as well as encourage voluntary efforts, both with the aim of making sure the system continues to become safer for patients; raises standards and expectations for improvements in safety, through the actions of oversight entities, group purchasers and professional organizations, creates safety systems within healthcare organizations through the implementation of safe practices of delivery at the level which is the ultimate target of the recommendations proposed by the IOM.

continued on page 4
Distinguished Career Award Presentation Transcript

T Brennan, a senior author of one and co-author of the other of the 2 reports used to estimate the prevalence of errors nationwide offers several impediments to achieving the IOM goal. In his comments appearing in the sounding board section of the 13th April 2000 issue of the New England Journal of Medicine, he cites cost, medical legal action, the absence of actual nationwide instances of medical error, and the limitations of the epidemiologic science of error detection as obstacles to overcome if we are to meet the target proposed by the IOM. In addition, Brennan points out that the data cited in the IOM report indicates injury rate in that due to medical care has declined. It was 46 in California in 1976, 37 in New York in 1984, and 29 in California and Utah in 1992. Projected across the nation, Brennan concludes that deaths from medical error declined from 92,000 in 1984 to 25,000 in 1992. While advocating caution in extrapolating from these locations where the studies were performed to the entire nation, evidence does suggest that doctors, nurses, allied health professionals, and health care institutions have improved the safety of medical care. Nevertheless, an effort by us to indicate our enhanced commitment to improve the safety defined by the IOM as freedom from accidental injury of the care of critically ill and injured children, has merit. The AAP has urged the Agency for Health Care Research to assign a high priority to 6 areas enumerated in a summary statement available through the Academy’s Department of Practice and Research. The Society of Critical Care Medicine has established the Foundation for Critical Care Medicine, the mission of which is to obtain funding for education and research to improve the safety of clinical care. Participation in these efforts should be our response to the IOM report. I contend, so that we can contribute to restoring public confidence in the safety of the US medical system.

A recent communication, which appeared on the PediatricWeb site, drew my attention to a second challenge confronting those who provide critical care to children, - the organ-specific intensivists and their integration into the existing groundwork of pediatric critical care. Honoring the principle of announcing one’s potential conflict of interest, among my 25 years at the Children’s Hospital, I have spent my patient care activity to children and occasionally adults suffering from congenital and acquired heart disease. During that time, I directed the Division of Critical Care Medicine which included physicians who provided general intensive care and served as Medical Director of the Pediatric Intensive Care Unit where all the care of critically ill and injured children beyond the age of 30 days occurred. Changes in the leadership of the Division of Cardiovascular Surgery and Cardiology occurred, which resulted in the concept of a separate cardiac focused intensive care from the general intensive care, for which a prior cardiac surgery and cardiology leadership had campaigned. I then directed my effort between the organ-specific ICU and a general ICU and in 1997, left CHOP to direct my attention to a unit which focuses entirely on the care of neonates, infants, children, and adolescents through 17 years of age suffering from congenital and acquired heart disease. Furthermore, I currently sit on a Board of Directors charged with establishing the Society of Pediatric Cardiac Intensive Care. I mention this history to establish some credentials and alert you to the experience which I contend enables me to comment on the evolution of organ- and system-specific pediatric intensive care providers and units.

The author of the communication to which I refer feels organ-specific intensivists will have a negative impact on the care of critically ill children. Certainly at this time we have little or no information addressing the impact of the outcome from critical illness or injury resulting from the care provided in organ-specific critical care units. Indeed, we have limited, albeit increasing, data that critical care specialists have an impact on the outcome from critical illness or injury. Nevertheless, the subspecialty of critical care is now well established. In the absence of this information, we must refrain from taking the position which champions or condemns either general or organ-specific critical care, and develop information which enables us to conclude whether organ-specific critical care enhances or diminishes efficiency, survival, speed of recovery, magnitude of disability, analgesia, satisfaction of patients and families, or expense. You might remember or recognize those terms as what I contend are the features of quality of pediatric critical care. We must recognize vigorous advocates will exist for organ-specific critical care effort while this information is being obtained and be tolerant of their position until data clarifies its value.

A matter which I consider to have influenced organ-specific critical care is the following. As medical knowledge increases, demand for manual skill in performing invasive procedure escalates and clear judgment of what is the best and when to intervene is required to provide the optimal care for patients, individuals who will have to be geniuses, gifted in manual skill and practical, timely, and passionate with treatments that have burden as well as benefit. Intellectually gifted Michael Jordan’s of medicine who devote a majority of their waking hours to patient care in the care of children necessary care is his individual to possess these qualities. Alternatively, limiting the universe with which one has to contend by choosing to work in an organ-specific unit may enable us to succeed in providing optimal care. After all, isn’t the specialty and subspecialty movement in medicine in general been a reaction to contending with the above qualities we must possess to provide optimal care?

To my knowledge, success in generating persuasive arguments for pediatric organ-specific critical care efforts has been limited to those individuals who focus on congenital and acquired diseases of the heart and great vessels. Tiffard et al reported in the August 2000 issue of Pediatrics, an inverse relationship exists between patient volume, mortality risk, and length of stay. Since length of stay correlates with cost, an inverse relationship also exists between patient volume and expenses generated by providing critical care. A key factor

continued on page 8
Distinguished Career Award Presentation Transcript

continued from page 4

despite the justification for organ-specific units would be a sufficient number of patients so that length of stay and outcome are optimal. Since approximately 1% of neonates born in the US have some form of heart disease, an organ-specific unit for their care and focused professionals may meet the standard advocated by Tildford et al.

The third challenge I see for critical care providers is to maintain interactions between members treating critically ill or injured patients as some of them compete for payment of the services rendered. I refer specifically to the advanced practice nurses who seek and have found a role in the critical care team. I currently provide care in an environment where APNs and PAs have prominent roles. Furthermore, I chair the Task Force of the American College of Critical Care Medicine which is charged with developing guidelines for the role of APNs and PAs on the critical care team.

Most physicians view the acute care advanced practice nurse (ACAPN), a clinical nurse specialist (CNS), as substitute for physicians in post graduate training or professionals who perform tasks medical doctors assign a lesser priority within their work day. I prefer ACAPN to nurse practitioner since the individual who provides “conventional” nursing care at the bedside is in fact a nurse practitioner, rather than call them a nurse practitioner.

However, a conversation I have had with one acute care advanced practice nurse and a member of the faculty of a university program for pediatric critical care advanced practice training leads me to conclude they disagree with the physician perspective of their contribution to the care of critically ill or injured patients. Acute care advanced practice nurses describe physicians as focused on the science of medicine. They contend ACAPNs emphasize the art and caring portions of medicine. I vigorously disagree with that. ACAPN assessment of physicians and contend we both have equal interests in the science and caring of medicine.

Cost containment of medical care in the US continues to emphasize reducing payment for hospital and professional services, improving efficiency in providing medical care, and reducing the variability in medical practice. This focus will continue until evidence surfaces which indicates medical care of the US citizen has suffered or economists conclude additional savings can be obtained from these measures. Only then will the unpopular limitation of services available to US citizens become an additional component of controlling costs of medical care.

Competition remains an important dimension for obtaining high-quality service at low cost in the free enterprise system which, to date, has dominated the US medical care delivery system. Increasing government manipulation of the system with an escalating role as a payer for medical services continues to be the US public encounter obstacles to receiving medical care they desire under the free enterprise system. An example of government involvement in the system and an illustration of competition lie in US Public Law 103-33 which occupies a part of the Balanced Budget Act of 1997. This provision now enables ACAPN and CNS to receive direct payment for Medicare Part B services they provide to beneficiaries of that Federal government entitlement program. Previously enacted legislation - the Omnibus Budget Reconciliation Acts of 1989 and 1990 - restricted direct payment to APNs to those who provided services in skilled nursing facilities in which a Medicare and CNS may receive payment for services ordinarily covered when provided by a physician according to the health care financing administration's interpretation of the law in published in the final rule published on November 1999 issue of the Federal Register. The services must meet the medically reasonable necessity and other Medicare requirement standards and exist in the scope of services, the ACAPN and CNS have been authorized to perform by their state license boards. In states where no law governs the MD advanced practice nurse clinical specialists' collaborative relationship, the ACAPN must record their scope of practice and indicate their relationship they possess with the physician to contend with issues outside of their scope of practice. The payment to the acute care advanced practice nurse and clinical specialist equals 80% of the lessor of either the actual charge or 85% of the Medicare physician schedule payment for the service. The services for which the ACNP/CNS receive payment include all the current procedural terminology, evaluation, management, and procedures codes. Other payors I contend that Medicare will likely adopt similar positions if their subscribers envision obtaining care which satisfies them and reduces their premium.

The American Academy of Pediatrics states its position on the role of the nurse practitioner (or advanced practice nurse) and physician intensivist in the care of hospitalized children published in the May 1999 issue of Pediatrics. In that issue, the comment refers to studies which support the ACNP and CNS who went through Medicare payment receive less money for the same services that physicians provide, however, the overall costs would be the same since ACANPs and CNSs spent more time during each encounter and a limit to the number of hours they can work per week compared to physicians would demand more of them to provide the service. Anesthesiologists perhaps have the greatest experience with advanced practice nurses providing services similar to that which an anesthesiologist provide. Although, I think maybe anesthesiologists and midwives have a rather long interaction. Having been in the system meeting the demands for anesthesia care to infants in the US for many years, the Clinical Registered Nurse Anesthetist (CRNA) remains critical to that which the anesthesiologists provide. Penumbra that the quality of...
Distinguished Career Award
Presentation Transcript
continued from page 3

Anesthetic care provided by CRNAs does not differ from that provided by anesthesiologists, thus, should acceptance of service from CRNAs as an acceptable standard of care. CRNAs actively campaign for independent practice without anesthesiologists’ direction.

Competitive balance between the two disciplines has resulted in a harmonious interaction becoming a strained one. Indeed, what was formerly a long-lasting harmony has deteriorated into an adversarial relationship at least on the part of the national professional organizations, the American Society of Anesthesiologists, and the American Association of Nurse Anesthetists representing these providers of anesthetic care.

Another issue related to our responsibility includes offering the public an explanation of why we encourage and accept the movement of individuals from a role of critical care nurse for which a projected shortage will exist into a role which duplicates in many instances the function of a physician of which, some contend, there is an excess supply.

As one accomplished ACANP stated, “We should not limit choices individuals have for career options if the ACAPN role appeals to appropriately prepared nurses. The liberty to serve in that capacity should indeed exist.” Theresa S. Raymond and others, in the paper titled “Reimbursement for Acute Care Nurse Practitioner Services,” published in the May 2000 issue of the American Journal of Critical Care, state... "the Balanced Budget Act of 1997 provides an opportunity for advanced practice nurses to take advantage of the financial opportunities in all settings and geographic locations. Indeed, these individuals should be rewarded fairly for the services they provide. Satisfaction with which is in all settings is the same. Work performed has an impact that will attract and retain the most accomplished individuals. Physicians have welcomed the pioneers in the career of advanced practice nurses who have performed admirable work by their accomplishments and expectations that their value would be recognized in the future. Their efforts have persuaded us of the importance of their contribution to the critical care team. Our challenge is to ensure that the competition encouraged by cost containment effort does not decrease the quality of critical care we provide to infants and children.

In conclusion, let me thank you very much for your attention, and this distinguished career award.

Russell C. Raphaely, M.D., FAAP

---

**AAP Section on Critical Care:**
New Investigator Award

**APPLICATION DEADLINE: MAY 1, 2001**

This is the 6th year that the American Academy of Pediatrics Section on Critical Care will fund a New Investigator Research Award. The 2001 award will be for $10,000 and is available to section members during their pediatric critical care fellowship, or within 2 years of completing an accredited critical care fellowship. The award, which is competitive, will provide support to an individual who has demonstrated an interest in clinical or basic science research and who presents a sound plan of investigation. Section on Critical Care membership is required.

The award will be judged on scientific merit, clarity of presentation, likelihood of productivity by the investigator, sponsor's evidence of appropriate academic environment, and relevance to critical care.

The New Investigator Award Grant Application 2001 (Microsoft Word document, 120K) is available as a direct download at:
http://PedsCCM.wustl.edu/ORG-MEET/AAP/AAP_Crit_Care_grant.html

Please contact Sue Tellez at 800/433-9016 (x7395) or e-mail her at stellez@aap.org for further information.

---

Visit the Pediatric Critical Care Medicine (PCCM) Web site at:
http://PedsCCM.wustl.edu/

For a listing of other critical care-related upcoming conferences:
http://PedsCCM.wustl.edu/ORG-MEET/Other_confs.html