The High (Personal) Cost of Critical Care Medicine

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In the late spring of 1984, I completed my pulmonary fellowship training at the University of Pennsylvania. I accepted a position with a practice admitting to Hartford Hospital. After passing my pulmonary boards, I experienced a tremendous sense of relief and believed, erroneously, that I would never again hear the words, “Pick up your #2 pencil, break the seal, and begin.” I did not anticipate the birth of Critical Care as a medical specialty, nor did I realize the impact that this new subspecialty would have on my life.

In 1984, it was not at all clear that Critical Care, as a medical subspecialty, would take root. This was evidenced by an editorial in the *NEJM* in 2008. There was a growing controversy regarding the field of Critical Care as a new and separate subspecialty, and which administrative body would serve to regulate, develop, and monitor the new discipline. Additionally, Critical Care did not appear to have a clear “identity in the scientific arena.” Shortly after my arrival in Hartford, the American Board of Internal Medicine (ABIM) developed an examination for Critical Care to be administered to interested physicians certified in Internal Medicine. The Critical Care certification would be effective for 10 years and would be given every two years. The ABIM also provided a six-year period in which physicians certified, at that time, in Internal Medicine, would be ‘grandfathered’ to take the examination.

I did not sit for the first because I was stubborn and refused to pick up another #2 pencil for another set of boards. Two years later, I worried that if I did not take the Critical Care examination, I might be excluded from rounding in the Medical ICU, and feared my refusal to take the boards would threaten my medical career and my livelihood. So I capitulated and I took the examination in the fall of 1989 and passed. I was the first person in the Hartford Hospital Department of Medicine certified in Critical Care.

In 1990, following my passing of the Critical Care boards, I was asked to assume the position of Acting Director of the Medical Intensive Care Unit – a 12-bed ICU. I accepted despite the fact that I did not have any prior management experience outside my tenure as a Chief Medical Resident. Approximately three weeks after my appointment, JCAHO arrived for a recertification visit of the MICU, asking questions and wanting to know if I had “closed the loop” on a variety of topics. It was the hot lingo at the time; needless to say, I was relatively clueless and the visit was a minor disaster. I remained in the position of Acting Director for three years during which time the hospital searched for a full-time director. During those three years, I began to enjoy managing the MICU, developing a cohesive and productive team, and establishing processes and procedures to improve patient outcomes and care. Hartford Hospital approached me and offered me the Directorship, and I accepted on a handshake. I recertified two additional times in Critical Care and served as the Director of the Hartford Hospital MICU for 25 years. On December 31, 2015, I stepped back and relinquished the role of Director of the MICU to one of my highly capable younger partners, and I now serve as the Assistant Director.

During my tenure as the Director, there were enormous changes in the Critical Care landscape. In 1990, the MICU was a 12-bed unit, inserting at least 3 to 4 Swan-Ganz catheters a week. In 2015, our MICU grew to a 16-bed ICU and a 12-bed intermediate care (step down) unit. Today, the MICU may have approximately 3 – 4 Swan-Ganz catheters placed in an entire calendar year. The length of stay in the MICU declined from a high of 9.6 days in 1990, to 3.4 days in 2015. The mortality rate dropped from a high of 26% down to a rate of 11%.

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Our house staff program was originally based at Hartford Hospital, but now is administered by the University of Connecticut School of Medicine, and we grapple with the impact of the house staff’s restricted duty hours on coverage and patient care. Twenty-five years ago, there were no advanced practitioners working in the MICU. Today, we require no less than 17 to fill in the coverage gaps. Our MICU team is comprised of 10 physicians certified in Critical Care Medicine, but it took 20 years to build that team. In 2005, we had 18 patients who were 90 years or older, whereas this past fiscal year the MICU cared for 79 patients who were 90 years or older.

I cannot conclude this recollection without discussing the impact my medical career has had on my family. My wife NEVER did anything to make me feel guilty. She never became upset with me for coming home late and missing the majority of family dinners, missing many life events of family and friends due to my call schedule, being physically tired, being grumpy, being short-tempered, being distracted, and failing to listen. I could never have been the physician that I am or cared for my patients without her unflagging love and support. We have been together since medical school and she has said that early on she realized that we were lucky that no matter what our domestic problems were (teenage challenges included), those issues never rose to the level of the medical challenges and tragedies that were encountered daily in an urban MICU. At times, this unfairly minimized issues of great concern to her and us.

At times, my absences may have unfairly burdened her as she had to address significant family issues, but I was lucky that she was adept at serving as a “single parent” when the need arose while still being able to address her career challenges. This is not to say that as I care for the families of others, my family did not pay a price at times. I would have relished sharing more every day experiences (meal times, sporting events, school programs) with my children as they were growing. There was one Saturday when I was not on call and had time. I said to my then 13-year-old daughter, “I have time off; why don’t we do something?” And she replied, “You don’t have time for me when I want to spend it with you, so now I don’t have time for you.” Although I did understand she was a young teenager, nonetheless her words stung. My son was more reserved about my absence, but he too harbored resentment when he was younger, for the weekend soccer and lacrosse practices and games that I missed.

Today my son and daughter are dealing with the rigors of establishing their own careers (not in medicine), and raising young children. Following my “stepping down” as the Director of the MICU, I sat with them and discussed the toll my career in Critical Care took on them. I attempted to apologize for missing games, plays, and recounting the myriad of ICU patient problems at the dinner table. Before I could even finish, they accepted my apology and completely understood and it was amazing. I emailed them copies of the announcement changing my status from Director to Assistant Director. My son replied, “While you may not have been around as much as we all would have liked, when A and I were growing up, I always understood that it was because you were doing work that was of true and measurable importance. That fact had a profound impact on me. You instilled in me, by virtue of the day-to-day example you set, a desire to do something of real consequence. I hope to make my kids as proud of me, one day, as I am of you.” And from my daughter, “I owe my work ethic to you. Watching you has been inspiring and motivating and I hope my daughters feel the same way about me one day, and I am exceptionally proud of you. You have been a great model and I am so proud to call you my dad.”

I am very lucky to have such an amazing family and such a challenging and amazing career. As of today, as the Assistant Director, I am enjoying not being in the proverbial driver’s seat and I have decided not to recertify, for a fourth time, in 2019.

REFERENCE