Guidelines for the Definition of an Intensivist and the Practice of Critical Care Medicine
I. Guidelines for the Definition of an Intensivist

An Intensivist:

A. Is trained and certified through a primary specialty. Has successfully completed an Accreditation Council for Graduate Medical Education approved training program in critical care medicine and/or has a certificate of special qualification in critical care or, through January 1995, has equivalent qualifications.

B. Promotes quality care in the ICU and efficient use of critical care resources.

C. Devotes greater than 50% of professional time to the practice of critical care medicine.

D. Willingly participates in a unit-based, hospital-approved coverage system that provides 24 hr/day, 7 day/wk coverage by physicians who possess similar credentials in critical care.

E. Is able to perform the usual critical care procedures, including, but not limited to:

1. Maintenance of the airway to include tracheal intubation and mechanical ventilation

2. Arterial puncture for collection of arterial blood samples.

3. Placement of intravascular catheters and monitoring devices including:
   a. Arterial catheters
   b. Peripheral venous catheters
   c. Central venous catheters
   d. Pulmonary artery catheters

4. Placement of temporary transvenous pacing wire (optional for pediatric intensivists)

5. Cardiopulmonary resuscitation

6. Tube thoracostomy

NOTE: The ability to perform therapeutic bronchoscopy, peritoneal dialysis, continuous arterial-venous hemofiltration, and placement of intra-aortic balloon counterpulsation device may be desirable.

F. The role of the intensivist has two major components:

1. **Patient Care:**

   The intensivist should be able to serve as the team leader providing managed care within
the ICU, integrating and titrating the care of the patient with complex illness or injury including multi-system failure. The intensivist may provide these services as the patient's attending physician or as a physician providing concurrent care in collaboration with the patient's attending physician. Is able to manage patients with commonly encountered critical care conditions including, but not limited to:

a. Hemodynamic instability
b. Respiratory insufficiency or failure, with or without a need for mechanical ventilatory support
c. Acute neurological insult including treatment of intracranial hypertension
d. Acute renal failure or insufficiency
e. Acute life threatening endocrine and/or metabolic derangements
f. Drug overdoses, drug reactions, and poisonings
g. Coagulation disorders
h. Serious infections
i. Nutritional failure requiring nutritional support

2. Unit Management:
The intensivist participates actively in daily unit management activities necessary for the efficient, timely, and consistent delivery of ICU services to the patients of the hospital. These activities include but are not limited to:

a. Triage and bed allocation, discharge planning
b. Supervision of the application of unit policies
c. Participation in ongoing quality improvement activities including supervision of data collection
d. Interaction with other departments as necessary to facilitate the smooth operation of the ICU

To provide these services, the intensivist must be physically present in the unit or hospital and free from competing obligations such as operating room or office responsibilities.

G. Maintains continuing education in critical care medicine:

1. Keeps current with the medical literature
2. Participates in continuing medical education programs

NOTE: Participation in relevant research and presentation at the local, regional, and national level is desirable.

H. Is available and willing to participate in interdisciplinary quality improvement activities. Endorses and actively participates in collaborative management of critical care units.

NOTE: Participation as a member of, or consultant to, the hospital’s Ethics Committee is desirable.

II. The Practice of Critical Care Medicine

The practice of Critical care medicine is hospital-based, dedicated to and defined by the needs of critically ill patients. Critically ill patients include:

A. Those patients who are physiologically unstable requiring continuous, coordinated physician, nursing, and respiratory care, necessitating particular attention to detail, in order to provide constant surveillance and titration of therapy.

B. Those patients who are at risk for physiologic decompensation and thus require constant monitoring and the ability to provide immediate intervention by the intensive care team to prevent adverse occurrences.

Critically ill patients have special needs for monitoring and life support which must be provided by a team, including a physician with the knowledge base, technical skills, time commitment, and physical presence to provide ongoing and titrated care. This care must be continuous and proactive in nature, assuring that the patient is managed in a safe, humane, and effective manner, utilizing finite resources in a fashion designed to provide a high quality of care and optimal outcome. Critical care is patient driven and can be provided in a variety of settings.

C. Critical Care Services

Critical care medicine physician services must be provided by intensivists, who are individuals formally trained and capable of providing such services, and who are free from competing obligations, such as operating room or office responsibilities. Practicing intensivists must participate in a system that guarantees the provision of these critical care medicine services on a 24-hour-a-day basis. The relationship of this organized critical care service to other hospital departments and services must be defined in the hospital’s overall organization.4

More than one critical care service can exist in a single institution. For example, trauma and coronary care services may be organized separately from general medical-surgical critical care services. When more than one critical care service exists, there should be a forum for the interaction between these services to efficiently coordinate the distribution of resources, unit policies and procedures, quality improvement, and other common concerns.

Areas of responsibility of the critical care service include: (1) patient care; (2) unit administration; (3) education; and (4) research. The need for each of these services will vary depending on the level of each unit4, but all four will be required to some extent in all intensive care settings.

1. Direct Patient Care Practice

Specific areas of patient care provided by intensivists have already been defined. The care provided by intensivists is coordinated through an organized critical care service.

The relationship of this critical care service to individual patients may range from managing all aspects of the patient's care to more limited aspects of care in collaboration with other physicians and other critical care providers.

When the majority of the therapeutic plan and care are provided by the critical care service, primary care is said to be provided. Ordinarily, under this model, the patient is transferred to the critical care service.

When these responsibilities are shared by the critical care service and the attending of record, concurrent care is provided. Under concurrent care, the intensivist provides a service by implementing and coordinating a patient care plan jointly created with the admitting physician. Each institution must define the roles of the intensivist and primary care physician when concurrent care is chosen as the management mode.

When the majority of care is provided by physicians other than the critical care service, then the services of the intensivist may be considered consultative.

There is clearly overlap among these models of patient care practice.

When primary or concurrent care is provided, the intensivist is uniquely qualified by educational background (including training), procedural skills, time commitment, experience, and has the institutional support to serve as the team leader. An intensivist takes a total care approach to critically ill patients, orchestrating opinions from many different consultants, thus preventing fractionation of care and providing a coordinated approach to the patient and family.

In some situations, transfer to the critical care service may be mandated by hospital policy (i.e., the "closed" unit). In other "open" units, concurrent or consultative care may be required.

2. Unit Administration

An inherent responsibility of the critical care service is to ensure an environment for the delivery of safe, timely, and effective care. To achieve this goal will require participation by the intensivist in daily unit management activities, as well as other activities, including the formulation of unit policies and procedures, development and administration of a budget, inservice-training activities, and interfacing with other hospital departments, such as administration, nursing, respiratory care, nutrition, and others. The intensivists of the critical care service must participate in, and usually will co-direct, in collaboration with nursing, quality improvement activities.

3. Education

The critical care service is responsible for the education of physicians of various levels, and participates in educational programs for nurses and other health-care providers as related to the critically ill. In collaboration with relevant hospital departments, the quality of the institution's training programs is continually approved.
4. Research

Research is an important responsibility of the critical care service. Depending on the size and type of hospital and the level of its intensive care units, the type of research may range from a review of quality of care to physiologic studies.

In summary, the purpose of a critical care service is to provide continuous titrated medical care, and to avoid fragmentation among various consultants and health care providers.

These guidelines have been developed by the Guidelines Committee of the Society of Critical Care Medicine, and thereafter reviewed and revised by the Society's Council. These guidelines reflect the official opinion of the Society of Critical Care Medicine and do not necessarily reflect, and should not be construed to reflect, the view of certification bodies, regulatory agencies or other medical review organizations.

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