



## Editorial

### The border territories of the specialty<sup>☆</sup>

### Los territorios fronterizos de la especialidad



All medical specialties have their disputed territories, that is to say, areas, diseases or processes where 2 or more branches of medicine argue about who is responsible for the care of patients. One of the most common conflict zones in a good number of hospitals is the department of internal medicine. Indeed, in many cases, respiratory medicine exists as a section of internal medicine and not as a department in its own right, with all the consequences that entails. However, friction over responsibilities for certain patients is more common among specialties that are perfectly well recognized as independent units. There are often clashes when determining the medical department responsible for respiratory infectious diseases, pulmonary hypertension, pulmonary thromboembolism, pleural disease, asthma, lung cancer, and a long list of other diagnoses. The coronavirus pandemic, with its severe acute respiratory failure and the acute demand for admission to intensive care units (ICU), has created a new frontline.

Respiratory medicine has had much success in recent years in implementing intermediate respiratory care units (IRCU), where the number of specifically trained experts, the ratio of nurses to beds, and the available medical equipment have introduced several advances and allowed the solid foundations of respiratory physiology that were previously confined to lung function laboratories to be applied as never before. ICU colleagues were quickly welcomed to our ranks, and a good example of this change of course was when the American Review of Respiratory Disease (ARRD) was renamed the American Journal of Respiratory and Critical Care Medicine (AJRCCM). In fact, in a magnificent article<sup>1</sup>, Chicago-based Irish physician Professor Martin J. Tobin – one of the most respected editors of the AJRCCM in recent years (1999–2004) – provides a reminder of the importance of appropriately applying an understanding of physiology to the treatment of patients with SARS-CoV-2 infection. This paper should be compulsory reading for all pulmonologists, particularly those who are still in training.

Professor Tobin's article discusses several issues that are applicable to this pandemic: the practical application of the ideal alveolar gas equation, taking into account the effects of physiological shunt in pneumonia and dead space in pulmonary thromboembolism that were so well described years ago; the need to observe patient signs and know how to ask about symptoms; how to interpret this information, which is often missed in a cursory examination, and apply the corresponding laws of physics;

and, in particular, the awareness that the 3 most important things in clinical medicine are diagnosis, diagnosis, and diagnosis.

The issue of the best place and the best time to admit these patients revives the border conflict between 2 old combatants, the pulmonologist and the intensivist. No one questions the enormous importance or the outstanding role played by the ICUs in this pandemic year 2020, and their heroic efforts will live on in memory. But let us wage a battle for respiratory medicine and for our IRCUs, which have cost us so much effort to implement. Other colleagues in Spain<sup>2</sup> and elsewhere<sup>3,4</sup> have already taken it upon themselves to point out their benefits, especially in the field of non-invasive ventilation therapies, once the appropriate considerations have been made. We believe that it is time to demand that these units be incorporated in the respiratory medicine departments of large and medium-sized hospitals, given the enormous advantages they offer and the progress in quality and costs they can bring<sup>5</sup>. We believe the following could be a recipe for success: (1) be prepared, both theoretical and practically. We need knowledge and equipment, sufficient medical personnel, and an appropriate nurse-bed ratio. This will involve a considerable struggle, much greater than the usual effort invested in conventional departments, hospitalization areas, and outpatient clinics. Duty rosters will be needed, and substitutions for vacation or rest days must be well planned. A unit of this kind cannot be improvised, nor can it depend solely on voluntary action. It is and will continue to be hard work; (2) gain the support of our medical directors and the acceptance of management. To do this, healthcare cadres must be convinced of the enormous importance of these units, given the improvement they represent for patients, both in terms of quality and survival. Economic feasibility and efficacy studies must also be conducted to justify the human teams and the necessary equipment; and finally, (3) convince the UCI chiefs that this is not an area of confrontation, but of collaboration. Everyone, starting with the patients, will benefit from the distribution of work and cooperation in treating critical patients, who can be offered an intermediate place of care before being referred to rehabilitation or to a conventional ward.

It is time to reflect and act. The bulwarks of respiratory medicine must be reinforced post-Covid-19, and one way of doing so is to demand that hospitals create units dedicated to semi-critical patients, given the important outpatient and domiciliary support that can and must be implemented. We refer to neuromuscular diseases, ventilation in COPD and other processes where the role of pulmonologists, with their practical understanding of respiratory physiology, and especially of ventilatory mechanics, has been consolidated. We are living through times of change, and from

<sup>☆</sup> Please cite this article as: Casan Clarà P, Rodríguez Jerez F, Martínez González C. Los territorios fronterizos de la especialidad. Arch Bronconeumol. 2021;57:565–566.

these changes a new type of pulmonologist for the next era must be born. Our ongoing challenges are interventional pulmonology, sleep-disordered breathing, chest ultrasound, pulmonary vascular disease and, of course, IRCUs for the treatment of severe acute respiratory failure, caused either by the current virus or by the next.

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