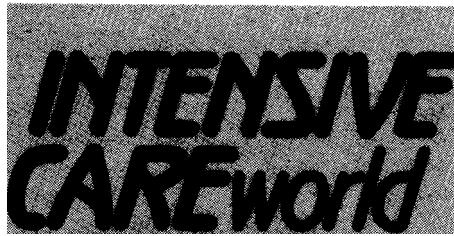


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## Intensive Care - Sub- or Supra-speciality?

The question whether intensive care medicine should become a speciality in its own right has led to a sometimes heated discussion about the future of this discipline. Those in favour of an independent development quote the experience gained in Australia or Spain where teams of intensivists run intensive care units (ICUs) and provide specialist services for the critically ill patient. These intensivists come from various backgrounds but have accomplished specific training programmes which enable them to cope with the increasing amount of special knowledge and technology necessary to practise intensive care medicine to its full extent. This concept has obvious advantages in many respects such as the concentration of knowledge and highly expensive equipment. The handling of complicated procedures becomes routine. There is a continuous care from experienced medical staff when the patient is at his or her worst. Instantaneous correction of therapy according to the ongoing screening and monitoring can be initiated at any time. In addition, experience and knowledge can be passed on in formalised training session.

In other countries intensive care has developed as a subspeciality of anaesthesia, general medicine or surgery. This in turn has led to a subdivision of intensive care. In some places surgical and medical ICUs or neurosurgical and cardiothoracic ICUs live together in the same hospital not taking into account the common-nature of diagnosis and treatment of vital organ malfunction.

The assumption that only the specialist

## Comment:

involved with the primary or underlying disease and its treatment can deal with acute emergencies in his field can nowadays only be seen as part of the historical evolution of intensive care when high dependency areas were formed within surgical or medical wards. Some of those concerned with intensive care from its very beginning who have contributed to its development still believe that referring a patient to an intensive care specialist would deprive them of their medical responsibility. The same doctor, however, would refer the patient quite happily to another specialist such as the renal physician or gastroenterologist. Yet another argument against the intensive care specialist is his lack of understanding of the underlying disease, since the aim of the intensive care should be to restore vital organ function to normal in order to win time for treatment of the primary disease. Only the causal treatment could provide cure and hence an appropriate quality of life for the future.

What then is the role of the intensivist and who should play this role? The role of the intensivist is manifold and that of a director of a play. All the strings of those participating in the care of the critically ill patient should come together in his hands. He or she is responsible for the outline of intensive care policies, for the training of junior medical staff and teaching of nursing staff. He or she is responsible for the facilities provided and the correct use of equipment. He or she should be in charge of an independent budget and the allocation of this budget. However, they should not only be administrators and teachers but also intensive care physicians with full medical responsibility, including the assessment of patients before coming to ICU. In many

cases, admission to ICU can be avoided when an intensive care expert opinion has been given. And finally, the intensivist should be the only arbiter of admission to and discharge from ICU. In an area where facilities are rare and costly, decisions can only be made with the special knowledge of the possibilities and limitations of intensive care. Who then is the most appropriate person to run these units? One of the main virtues of an intensivist is obviously diplomacy and a certain amount of flexibility. It has recently been claimed that anaesthetists would be the most appropriate specialists to fulfill these criteria since they are trained to deal with many surgical firms and are flexible enough to move out of intensive care when the so called "burning out syndrome" of intensivists sets in. Of course, anaesthetists have proven to be good intensivists, but so have physicians and surgeons.

In conclusion, intensive care has become an increasingly complex subject and special training is therefore required not just for six months but for at least a period of three to four years. Intensive care is, therefore, neither a subspeciality of anaesthesia nor medicine nor surgery. It is applied physiology and pharmacology and a certain degree of technical understanding is essential. Psychological and ethical implications are often much greater in intensive care than in any other medical field, and the curriculum should take this into account. Emerging as a new entity intensive care could become the supraspeciality of anaesthesia, medicine and surgery, and the training of the intensive care specialist should include parts of all these disciplines. It would then appear that amidst the innumerable single organ doctors (specialists) a new brand of multiorgan doctors (supraspecialists) would emerge.

**LETTER TO THE EDITOR**

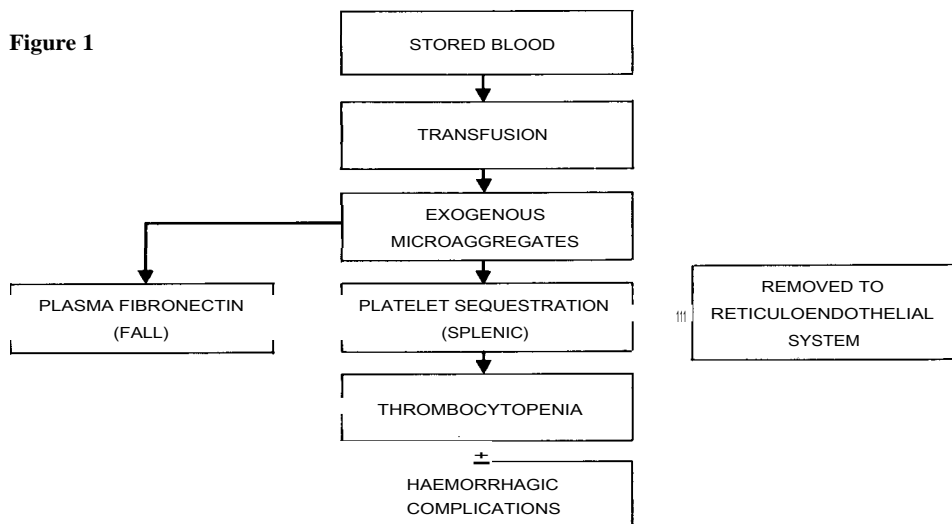
Dear Sir, May we refer to the article "Blood Microaggregates, Their Role in Transfusion Reactions", published in Intensive Care World, Vol. 3, No.4, December 1986, by Lloyd and Marshall et al. This paper rightly extols the virtues of blood microfiltration and identifies four main roles in which a microfilter can be used to remove microaggregates debris and assist in tipping the complicated multifactorial balance after transfusion in the patient's favour.

New and novel research was presented in January 1987 at the Royal College of Physicians, London, during the Society of Haematology meeting, by Dr D. Bareford from Queen Elizabeth Medical Centre, Birmingham. The main paper has been accepted for publication in the British Journal of Haematology.

The review article published in your journal would be incomplete without considering the addition of this other vital role of the degenerate microaggregate; Vis :-

The development of thrombocytopenia following transfusion of 10 units of whole blood or packed cells was identified (Miller et al 1971). Later Mannucci et al (1982) reported a fall in platelet count in patients transfused with 5 - 9 units of stored blood. Presently Bareford et al (1987, yet to be published) has indicated by the use of Indium-labelled platelets, a fall in platelet count in patients receiving less than 5 units of blood with some cases demonstrating a post-transfusion thrombocytopenia severe

**Figure 1**



enough to cause or exacerbate haemorrhage. In using a microaggregate filter to remove blood debris the platelet sequestration in the spleen was reduced significantly. Bareford goes on to suggest that the fall in plasma fibronectin (Snyder et al 1981) was most likely caused by the same microaggregate debris and proposes that like fibronectin, platelets also adhere to the

surface of the microaggregate debris causing their premature removal from the circulation by the reticuloendothelial system (fig. 1). Patients who receive red cell transfusion for anaemia should therefore receive blood products depleted of microaggregates.

R.B. Baker  
 (Managing Director)  
 G.B. Biomedical Products Ltd

**References**

1. Miller R D, Robbins T O, Tong M J, Barton S L (1971) *Annals of Surgery* 174: 794-801
2. Mannucci PM, Federici A B, Sirchia G (1982) Haemostasis testing during massive blood replacement. A study of 172 cases. *Vox Sanguinis* 42: 113-123.
3. Bareford D, Chandler S T, Harker R J, Jackson N, Smith M, Boughton B J Departments of Haematology, Nuclear Medicine and Surgery, Q E Hospital Birmingham. accepted for publication *British Journal of Haematology*.
4. Snyder EL, Mosher DF, Hezzy A, Golenwsky G (1981) Effect of blood transfusion on in vivo levels of plasma fibronectin. *Journal of Laboratory Clinical Medicine*, 98: 336-341.

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