

## Anaesthetist or intensivist: continued debate

*Sir,*

What's in a name? Quite a lot, to judge by the editorial by Parry-Jones (vol 65(9), 2004, p. 516). The issue of who cares for the severely ill is important, not least because in the past clinical care in this arena has been suboptimal. However, developments over the past 5 years suggest that a multidisciplinary focus on the care of the severely ill is emerging in the UK. Initiatives including the formation of an Intercollegiate Board for Training in Intensive Care Medicine (IBTICM), specialty recognition and the emergence of a Certificate of Completion of Specialty Training, UK and European diplomas in intensive care medicine and a series of influential reports from the government (Department of Health, 2000) and Royal colleges underline this change.

Intensive care medicine gained specialty status primarily because the severely ill are a physiologically homogeneous group, whose outcome can be improved by prompt and rapid treatment (Rivers et al, 2001). Second, the provision of effective intensive care involves complex decision making and leadership skills unique to the discipline. These include the selection of appropriate and complex therapy, the ability to progress patient care, and the skills needed to reach a consensus across multiple disciplines. Third, intensive care is expensive. An ageing population is likely to draw increasingly upon its services (Sparkes et al, 2004). Those who fully understand the issues involved will be best placed to make future decisions concerning resource allocation.

So where does this leave the anaesthesia vs critical care debate? Hopefully, redundant. The 'hospital at night' project points to real, patient-based needs (NHS Modernisation Agency, 2004) that will produce multidisciplinary care teams in all acute trusts. Their expertise will be based on shared, modular training programmes that are competency-

based and which will cut across old professional boundaries. They may call themselves by different names, but their core skills will be in delivering effective support and treatment to the severely ill. In the end perhaps all who work in acute medical disciplines will consider themselves to be intensivists.

**Simon Baudouin**

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*Sir,*

While recognizing some issues that Dr Parry-Jones alludes to, it is important to remember that intensive care in the UK is taking its future in its own hands.

Largely through the efforts of the Intensive Care Society's members and our nursing colleagues, intensive care is now recognized as a multidisciplinary specialty in its own right. Standards for training future intensivists have been defined by the IBTICM. Several centres have developed accredited training schemes based on these standards, and there are now national and European exams that document the quality of such training.

The importance of intensive care as a clinical specialty is recognized within hospitals by expansion of resources, and nationally through the Modernisation Agency. Members of the UK intensive care community have been pathfinders in clinical audit; and the past and continuing achievements of the Intensive Care National Audit and Research Centre are a testament to how rigorous and meticulous audit can help improve patient care. The society is now the largest funder of critical care research in the UK, and will help develop best practice through rigorous multicentre clinical trials.

There continue to be issues that we need to address, but future opportuni-

ties for critical care are great. While the maintenance and development of professional identity is a consideration, it is important to keep this in perspective. There is a need to continue to educate our colleagues about our role in patient care and education of trainees. Labels are important, but this is more likely to be achieved by recognizing and publicizing our successes.

**Saxon Ridley**

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*Sir,*

Dr Parry-Jones makes an impassioned and cogent plea for a clear distinction to be made between anaesthesia and the nascent speciality of intensive care. It was not that long ago that anaesthetists strove for greater autonomy from the Royal College of Surgeons (under whose auspices they fell as a faculty) in order to achieve more credibility, influence and an enhanced status.

Despite being one of the minority of intensivists from a physician background, I can empathize with his desire to differentiate intensivists from anaesthetists. However, we have to merit the appellation rather than expecting it by right. By displaying the correct attitude and appropriate erudition, the referring clinician will be confident that his/her patient will receive high-quality and holistic care within intensive care.

The perception that the intensive care unit will only take patients who require mechanical ventilation, and whose management then consists of twiddling a few knobs on the ventilator, is a disappearing stereotype that needs to be erased totally. Any referring doctor should not be given short shrift, even if it is the last available bed or the patient is deemed to be either too well or beyond hope. They may hold opinions with which we may fervently disagree; a tactful presentation of the relevant literature or a calmly negotiated compromise should ensure that honour and tempers remain intact on all sides. We have to make certain that trainees are properly trained in all facets of critical care, and that the established consultants maintain their

skills and a bang-up-to-date knowledge base. With professionalism comes trust and respect, and the specialist tag.

**Mervyn Singer**

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**Sir,**

Dr Wallace appears to have misunderstood the purpose of my article. It was not a reflection on how I see intensive care developing over the next 150 years, which I hope will be under the guidance of those with similar understanding and perception as Drs Heneghan and Nightingale.

I know that intensive care is already established as a speciality even if I haven't been doing it as long as Dr Wallace. My 'personal insecurities' which he so perceptively alludes to, do mean that I only practice in intensive care although I have postgraduate qualifications in medicine, anaesthesia and intensive care. My point is simple: physicians and surgeons outside of intensive care, who refer those requiring critical care to us, need to perceive us as intensivists not anaesthetists if they are going to refer patients appropriately and in good time for therapies to achieve their maximum benefit. This is not an insult to them. They know their speciality practice, and I hopefully know mine. I would hope that we can work together, with mutual recognition, in the patient's best interests.

I also know that anaesthetists are essential to the current good practice of intensive care in this country and will continue to be so in the immediate future. I believe, however, that it is in our patients' best interests, that when we are doing intensive care we think of ourselves as intensivists, and that colleagues in other specialities do as well. If you are also an anaesthetist then when you are giving an anaesthetic you are an anaesthetist. I am sorry that the only time Dr Wallace gets to feel that he is an intensivist is when he is in a strop.

**AJD Parry-Jones**

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## Copying letters to patients

**Sir,**

I was interested to read Dr Vaidya's editorial on copying letters to patients (Vol 65(8), 2004, p. 454). My concern is not that we as doctors need more training in the process but rather letters must still convey useful and needed information to colleagues in primary care.

In my cancer clinic on a Friday morning I will see 15 patients with lung cancer, some of whom will be entering the terminal phase of their illness. Colleagues in primary care need to be alerted to this problem and often patient's relatives as well as primary care clinicians may have been informed that the patient's life expectancy is only a few weeks at best. It is important that primary care colleagues have this information but it is not always appropriate for the patient to be aware because of the unnecessary distress this may cause.

If one is selective in which letters are sent to patients this will maintain a feeling that we are deliberately hiding or have the potential to hide information from all patients.

**Roger J Wolstenholme**

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## Swollen and cyanotic arm: a new cause?

**Sir,**

During admission to a rehabilitation centre for low back pain a 27-year-old man presented with cyanosis and swelling of the right arm following right shoulder manipulation. It resolved spontaneously. He was readmitted. Limited shoulder movement was a significant problem. His right arm became cyanosed, oedematous and numb during resisted internal rotation exercises in adduction. Peripheral pulses and systolic blood pressure were symmetrical and normal. Capillary refill was 4 seconds. Neurology was normal.

Symptoms resolved spontaneously and rapidly. A further episode occurred. He was referred for investigation.

Clotting and thrombophilia screens were normal. A right arm venogram showed extrinsic soft tissue compression of the axillary vein with the arm in neutral, removed with arm abduction. The axillary vein appeared normal. Venography showed compression and decompression of the axillary vein with shoulder adduction and abduction. Ultrasound excluded a mass within a hypertrophied latissimus dorsi.

Abnormal tissue may cause venous compression. The axillary vein can be compressed by lymphadenopathy, haematomas, cysts, abscesses, subluxation of the shoulder (Freidman et al, 1992), hypertrophy and intramuscular oedema of subscapularis (Holtzhausen et al, 1995) or in this case latissimus dorsi hypertrophy. Individual muscle fibres increase in size in response to exercise. An increase in the number (hyperplasia) is more debatable. Venous compression syndromes exist, e.g. iliac vein compression (May-Thurner or Cockett's syndrome) is well characterized (Cockett and Thomas, 1965).

To the authors' knowledge this is the first case reported of axillary vein compression secondary to latissimus dorsi hypertrophy. Owing to the intermittent obstruction complications of venous compression should be less. A conservative approach was adopted, including passive physiotherapy of the shoulder and refraining from symptomatic movements, allowing disuse atrophy of the latissimus dorsi to resolve the problem.

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