Anaesthetist or intensivist?

Pain may be defined as a sensory and emotional experience to an unpleasant stimulus. The birth of a new speciality can be painful. In the quest for independence there may be separation issues from the parent speciality, individual and collective egos may be bruised, and fights over disputed territory may leave bloody wounds.

In the birth of surgery as a speciality, separate from hair cutting, this pain may have been experienced not only by other barbers but also by their patients. For some of us whose major practice is in intensive care, being persistently called and thought of as an anaesthetist is an unpleasant stimulus for an unnecessary pain that should be easily avoidable. More importantly, it betrays a lack of understanding that is affecting the recognition, prompt appropriate referral and treatment of the critically ill.

AT WHAT POINT DOES A SPECIALITY EXIST?

To those that are practising it, it is when they see themselves and their colleagues as having their own separate identity. New societies are formed with their own specialist journals. Courses are run, and national, European and worldwide meetings are held to unite and bind together colleagues. These developments, however, are likely to precede the time when those outside this new speciality consider them to have a new separate identity. This interval between the speciality's self perception and general recognition may be a source of friction.

The time that it takes to close this interval is likely to be governed by the usual suspects: money, power and kudos. In the case of medicine in the UK this is reflected by private practice potential, a Royal college and a good role played by a sexy lead in a popular medical soap. Intensive care has little to no private practice, no Royal college of its own and no sexy lead actors or actresses. Those practising intensive care see it as separate from anaesthesia, even if they are doing both, in much the same manner in which physicians doing general medicine see it as separate from their sub-speciality outpatient clinics. Unfortunately many outside intensive care continue to see anaesthesia and intensive care as one and the same.

ANAESTHESIA IS THE PARENT SPECIALITY OF INTENSIVE CARE

Anaesthesia's own fight for recognition as a speciality has been slow and at times painful. It does of course have its own Royal college, but private practice is paid at a third of the surgeon's fee, and it is barely recognized in medical soaps. You only have to watch a documentary on the development of cardiac surgery, for instance, to realize the position that anaesthesia continues to hold in the public's perception. The very fact that a National Anaesthesia Day is required at all 150 years after the first anaesthetic was given in this country is testimony to this.

Is it going to take 150 years for intensive care to be recognized as a separate speciality? I hope and believe that this will not be the case, but if both surgeons and physicians fail to recognize the distinction between anaesthetist and intensivist, what hope is there that the general public will?

TRAINED INTENSIVISTS IMPROVE CARE OF THE CRITICALLY ILL

Should intensivists concern themselves with being called anaesthetists and does it make a difference to the patients? In short, yes; they are different after all and this difference is increasing. The similarity between an intensive care patient and a patient having surgery performed under anaesthesia may start and end with them both looking asleep – not, I might add, a prerequisite for either.

Leaving an intensive care patient under anaesthesia for days without a diagnosis and appropriate treatment is unlikely to make them better, and conversely, sedation on intensive care is not going to provide the operative conditions that surgery now often requires. Some technical skills between the specialities are obviously shared but the required mind set is very different.

From the patient's and their relatives' perspective there is now good evidence from Provonost et al (2002) and the Leapfrog Group (2004) that care of the critically ill by trained intensivists improves their outcome, reduces the cost of their care, and shortens the length of their hospital stay. This improvement is likely to become more marked as the management of sepsis, the common denominator of the critically ill, becomes more complicated, as demonstrated by Dellinger et al (2004).

The point at which the complexity of care necessary for the critically ill requires a separate identifiable speciality has long since been reached. This needs to be recognized outside the speciality. Intensive care societies have been established for decades and yet in this country many outside the speciality still persist in seeing the intensivist as an anaesthetist outside the operating theatre.

TRAINING IS MORE IMPORTANT THAN BACKGROUND

There will still be those who might argue 'why be so touchy' – after all most intensivists are Fellows of the Royal College of Anaesthetists, and it is only a name. Therein lies the problem. The wrong use of a name betrays a basic lack of understanding of intensive care and hinders the prompt recognition, timely referral and treatment of the critically ill by an intensivist. Recognition of the critically ill and the input of a trained intensivist applying evidence-based medicine in an appropriately staffed environment will, if delayed, adversely affect the patient's outcome.

There is also a side issue that despite most intensivists also being anaesthetists, some are physicians, some are surgeons and others have mixed backgrounds. Of far more importance than

their background speciality, however, is that they have all received an appropriate training in intensive care medicine. It is now well recognized by the appropriate colleges that training in anaesthesia alone is not enough to become an intensivist. This is despite trainee anaesthetists being essential to the running of intensive care units in this country and spending considerable periods of their training time managing the critically ill.

THE WRONG NAME BETRAYS A LACK OF UNDERSTANDING OF INTENSIVE CARE

Looking at it from another perspective, all physicians are members of the Royal College of Physicians but if I want a neurology opinion I don't ask a cardiologist, despite them sharing the same postgraduate exam qualifications. There are postgraduate examinations in critical care, but these by themselves will not create recognition outside the speciality, and postgraduate examinations have not in the past proven themselves necessary for other medical specialities to be recognized as such. If you want a surgeon to operate on you or your patient you no longer call him/her a barber and if you want a physician you do not call him/her a quack. So please, when it's an intensivist that you want for a critically ill patient, demonstrate your understanding of critical care, and ask for an intensivist. **HM**

KEY POINTS

- There is no easily definable point after which a speciality can be said to exist.
- Many outside intensive care continue to see anaesthesia and intensive care as one and the same.
- Anaesthesia's own fight for recognition as a speciality has been slow and at times painful.
- Care by trained intensivists improves the outcome, reduces the cost and shortens the hospital stay of the critically ill.
- The complexity of care of the critically ill has necessitated a separate speciality.
- The wrong name betrays a lack of understanding of intensive care.
- Appropriate training is more important than background speciality.

AJD Parry-Jones
Locum Consultant Intensivist
University Hospital of Wales
Cardiff CF14 4XW

Dellinger RP, Carlet JM, Masur H et al (2004) Surviving Sepsis Campaign guidelines for management of severe sepsis and septic shock. *Crit Care Med* **32**(3): 858–73

Leapfrog Group (2004) *Factsheet: ICU Physician Staffing*. The Leapfrog Group, Washington, USA http://www.leapfroggroup.org/FactSheets/ICU_FactSheet.pdf

Provonost PJ, Angus DC, Dorman T et al (2002) Physician staffing patterns and clinical outcomes in critically ill patients : a systematic review. *JAMA* **288:** 2151–62

COMMENTARIES

Association with anaesthesia must be maintained

In response to this editorial, on behalf of the Royal College of Anaesthetists, we would comment as follows:

- The foundation of the Intercollegiate Board recognized and meets the unique training needs of intensivists
- The Council of the Royal College of Anaesthetists and the Intercollegiate Board are on good terms, working closely together
- Many intensivists share Dr Parry-Jones's disquiet with the way continued reference to intensivists as anaesthetists bespeaks a lack of recognition of the genuine separation that is appearing between anaesthesia and intensive care medicine, although most would not wish to lose the strength that comes from the continued close association between intensive care and anaesthesia
- While the Colleges will probably devolve more to the Intercollegiate Board, which may become an Intercollegiate Faculty in the fullness of time, there is a definite wish within the Royal College of Anaesthetists for continued close connection between the lead College and the developing sub-speciality
- The specialty of acute medicine is likely to become a major player in tomorrow's hospitals, when much elective practice has been relocated to independent sector treatment centres. There will need to be close liaison between acute medicine and critical care, overlapping responsibilities being handled sensitively, without turf wars
- The Royal College of Anaesthetists is planning a multidisciplinary education and research centre which will house the Intensive Care Society and the Pain Society, and other like-minded bodies will be welcomed
- The reasons for the resurgence in popularity of critical care as a career include:
  Consultant expansion, sessional allocation and humane on-call rotas
  Increased independence and improved status of critical care practitioners.

Overall, it cannot be seriously doubted that intensive care or critical care will separate more from mainstream anaesthesia, and it would be to everyone's advantage if the special skills of intensivists were better recognized and understood. The development of rotations that include trainees from medical and surgical specialties, and involvement of foundation year trainees in critical care, can only help to spread understanding of the speciality and what it has to offer, although it might

be some time before this greater understanding brings real improvement to the workings of the general hospital.

Chris Heneghan
Consultant in Anaesthesia and Intensive Care
Nevill Hall Hospital
Abergavenny NP7 7EG
Pete Nightingale
Consultant in Anaesthesia and Intensive Care
Wythenshawe Hospital
South Manchester University Hospital NHS Trust
Manchester M23 9LT

What's in a name?

No-one would disagree that all doctors practising intensive care should be appropriately trained, patients should be referred as early as possible and should be looked after in a properly resourced and managed intensive care unit (ICU).

Dr Parry-Jones' other points betray more of his personal insecurities than a true reflection of how intensive care medicine is developing in the UK. It will not take 150 years; there has been enormous progress in the last decade. Intensive care medicine is now an established specialty (all be it with a joint certificate of completion of specialist training), has an Intercollegiate Board supervising standards and training, an active regional postgraduate education structure with up to 100 dedicated training posts in the UK plus a flexible multidisciplinary entry programme. Despite limited facilities and resources, outcomes compare well with international comparitors.

I can see the point of being sensitive about the title 'intensivist' if one is only practicing in intensive care, similar to those quoted who have sole activity in one branch of medicine such as gastroenterology or psychiatry. Full-time intensivists, however, although increasing in number, are few and far between in the UK and will not become common for some time until units are larger. The typical 6–8-bed UK unit cannot support fully dedicated intensivists, as 24-hour 365-day cover depends on a number of consultants who will also practice in another specialty, most commonly anaesthesia, for a proportion of the week.

I would not insult our referring clinicians by suggesting that the base specialty title of the intensive care doctor from whom they seek assistance will bother them or, more importantly, delay timely referral as long as they know that they will get good advice and skilled support.

Like 90% of those providing intensive care in the UK, some days I am an anaesthetist, sometimes I'm an anaesthetist 'doing' ICU, sometimes I'm a consultant in anaesthesia and intensive care, and some days when I am feeling stroppy or undervalued, I elevate myself to being an intensivist. I don't think the patients notice the difference.

Peter Wallace
Consultant in Anaesthesia (and Intensive Care)
Western Infirmary
Glasgow G11 6NT