Middle Articles

HOSPITAL TOPICS

The Anaesthetist and Intensive Care

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Summary: Intensive care and its development is part of an evolutionary process in the general organization of hospital medical practice. No new disease process is involved, and this alone should be sufficient to support our view that intensive care does not call for the creation of a new specialty. The experience, skill, and knowledge of anaesthetists qualify them to fill vital roles in intensive care, but it is of paramount importance that in doing so they should neither neglect nor abdicate from their own special field of medical work from which their unique expertise derives.

Introduction

In every country where progressive patient care is developing anaesthetists play an important part in the intensive care unit. In view of the shortage of anaesthetists it is important to examine very carefully every new demand for their services, and to determine to what extent anaesthetists are specially suitable and to what extent their involvement can be limited to their particular skills. It is also necessary to examine the motives behind what seems to be the ready acceptance by anaesthetists of this new commitment.

Intensive Care Units

Clinical Management

It is not difficult to see the connexion between anaesthetists and intensive care. By the nature of their work anaesthetists are familiar with problems of "moribundity." The maintenance of proper respiratory and cardiovascular function is as important in the intensive care unit as it is in the operating-theatre, and the tools which aid the anaesthetist in this task are identical with those needed in the intensive care unit. The *clinical* relevance of the anaesthetist to intensive care thus becomes understandable. The extent to which the anaesthetist's involvement in the *administrative* management of intensive care units is desirable or justified is less clear.

Administrative Management

There are several possible administrative arrangements for the running of these units; some have been tried, and the results of at least two are slowly becoming apparent. In the first, one of the hospital consultants is "in charge" of the unit and bears the clinical responsibility for all the patients in it, though it is expected that he will, and he usually does,

consult other specialists, particularly the one under whose care the patient was originally admitted, when he thinks appropriate. In such an arrangement medical, nursing, and other routines of care can be established and there is no confusion in the minds of the nurses and other paramedical staff, to say nothing of other clinicians, regarding who is in clinical charge of the patients and to whom they should turn for help.

In another arrangement the consultant who is in administrative charge of the unit is not necessarily in clinical charge of the patients, and each patient is looked after by his own consultant. Although there are notable examples of hospitals where the scheme works, there are others where it has failed, and we doubt the usefulness of such a division of responsibility. In our experience an administrative decision usually involves, at the same time, a clinical decision. In this arrangement the advantages of single management are lost. Routines are difficult or impossible to establish, and the nursing staff becomes confused and dispirited in the absence of a clear chain of command, particularly when acute clinical problems arise. Difficulties may arise over the admission of patients to the unit as well as over their discharge, and tensions easily develop between colleagues over the priorities of usage of the beds and facilities.

There are undoubted advantages in this system of management. The heavy burden of responsibility of caring for extremely ill patients with complex problems is not borne by one person but is spread over many. Individual consultants maintain "control" over the management of their own patients and do not feel unhappy because their patients appear to be under another's temporary care.

The anaesthetist may fit into either of these two arrangements. He may be in both administrative and clinical charge or he may be in administrative charge alone, though this is difficult to define, and he then participates in clinical care only when particular problems arise, in the solution of which it is thought he could be helpful. We have had some experience of both arrangements. The former undeniably leads to a smooth-running efficient intensive care unit in which the morale of the nursing staff is high, specialist colleagues are given full opportunities for consultation and collaboration, a high bed usage of suitable cases is maintained, and both medical staff and hospital administrators are satisfied. The choice of an anaesthetist as manager has the added advantage that he does not usually have the responsibility of beds elsewhere in the hospital, and so cannot be accused of a vested interest in the admission or discharge of particular patients.

In spite of all these advantages we have misgivings about the desirability of such an arrangement as a general pattern for the future in this country.

Limitations of Anaesthetists as Managers

There is a widely held view in hospital circles that anaesthetists are the most suitable specialists to be in charge of

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an intensive care unit. We have already discussed the clinical reasons justifying this view. We also recognize clearly that anaesthetists have other virtues which make them successful managers of these units. By the nature of their work they have learnt to collaborate harmoniously with others, and they are fully aware of the need to seek advice from other experts and do so readily when the need arises.

Nevertheless, our experience leads us to the view that it is neither advantageous for the individual anaesthetist, nor for the specialty of anaesthesia, nor for the community at large for anaesthetists to give up being anaesthetists in order to become intensive care doctors.

However wide any individual specialist's experience may be, there are bound to be occasions when he must consult other specialists to seek advice. No specialist's training fits him for the *total* care of patients suffering from the wide range of complex conditions found in an intensive care unit. This applies to the anaesthetist as it does to any other specialist. Any specialist who undertakes the total clinical responsibility of intensive care patients soon finds himself in the position of a co-ordinator who, valuable though he may be, does little more, from a clinical point of view, than implement the advice of others. It is open to question that the performance of this function needs an anaesthetist.

The practical difference between the anaesthetist and other specialists in this connexion is the crucial one that, if the main concern of an anaesthetist is anaesthetics, including all that that means, then he is not physically available often enough for the heavy demands of intensive care unless he gives up a great deal of his anaesthetic work. Other specialists whose physical activities are based on wards could more easily include intensive care in their circuit, and could more easily be called to the unit without so much disruption of their routine activities. Even if the initial involvement of an anaesthetist is only part-time there is a high probability that, because of the constant and insistent demands on his time by intensive care, this will soon become virtually whole-time.

Intensivism—A New Specialty?

On the basis of our experience we are unable to accept the notion that the care of patients in intensive care units constitutes a new specialty in medicine to which some have already given the name of "intensivism." Its ideas and practices belong to the whole corpus of medicine, and there is no piece of knowledge or skill which the intensivist can claim to be unique to him that cannot equally well be so claimed by other doctors as well. Since the intensivist's experience of any one part of medicine is necessarily limited to the acutely ill he cannot be regarded as a specialist in that entire section of medicine. His knowledge, though it may be broad in extent, is inevitably limited in depth. This is not a satisfactory basis for the appellation of specialist. The adoption of "intensivism" as a total career is likely to be indicative of a somewhat narrow field of interest which is not based on any clear scientific or clinical demarcation, such as that which obtains between other branches of medicine. Though the element of drama, throughout the day and night, inherent in intensive care may be attractive to younger specialists, it is unlikely that this will

still be so in later life. We are apprehensive whether intensivism can maintain a lifelong interest. It is therefore difficult to see a career based on this work alone.

Involvement of Anaesthetists in Intensive Care

In examining the reasons which underlie the ready acceptance of heavy involvement in the management of intensive care units by some anaesthetists—particularly younger ones—we see a number of possible factors. Many anaesthetists have little or no bedside contact with patients and tend to become entirely technical in their work. They find themselves restricted to the environs of the operating-theatre, probably because they have never been taught to see their duties embracing the whole patient from the preoperative to the postoperative points. They may be seeking, subconsciously, more opportunities to practise bedside medicine. Many anaesthetists develop an increasing frustration and tension at the way the organization of their daily work slips out of their hands into those of colleagues in another specialty. Some of these anaesthetists may seek opportunities for work in which they feel they are their own managers, and they find it in the intensive care unit. Another reason might be that some anaesthetists are unable to develop collaboration on a mutual basis of respect with their surgical colleagues, and they look for opportunities in which their not inconsiderable knowledge of medicine and other sciences, and their own practical skills, can be put to fruitful use. They find the intensive care unit is such a place.

A retreat from the field of anaesthesia by those trained as anaesthetists will be a serious loss to the community, because the development of the specialty will inevitably be slowed down. The anaesthetist himself will also lose heavily, since he will very quickly no longer be able to claim a range of knowledge and skill which is unique to him.

Nevertheless, if an anaesthetist is involved in an intensive care unit, and seeks to maintain his anaesthetic competence, then from our experience he should not devote more than half his time to such a unit or his anaesthetic work is likely to suffer. A practical arrangement might be a rotational scheme of work in the intensive care unit shared among a group of anaesthetists.

In case our remarks above may be misinterpreted, we wish to emphasize that in our view anaesthetists have, and will always have, a very important part to play in the care of acutely ill patients, wherever they may be in the hospital, and we hope that anaesthetists will continue to be called into consultation in connexion with these cases on every possible occasion. Their wide and specialized knowledge is invaluable in these cases, and the fact that their subject cuts across almost every other branch of medicine and extends into neighbouring sciences as well is sure to have a powerful and beneficial influence on both the diagnosis and the treatment of acutely ill patients.

It is in this consultative manner rather than as a manager that we feel the anaesthetist should be involved in intensive care. Before accepting the role of manager he must examine carefully both his own motives and those of his colleagues who invite him. He must assess the likely results, both to himself and to the community at large, of his withdrawal from the practice of anaesthesia, from which he derived that skill so much desired in the intensive care unit.