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Correspondence

Letters to the Editor should not exceed 500 words.

Intensive Care and the Anaesthetist

SIR,—Professor W. W. Mushin and Dr. J. N. Lunn (14 June, p. 683) seem overconcerned that many young anaesthetists are spending too much of their time in intensive care. I find it difficult to accept their reasoning, as although a considerable number of units are administered by anaesthetists few claim more than one or two sessions for their efforts. The number of anaesthetists devoting more than five sessions to intensive care must be very small, and these are likely to remain limited to undergraduate or postgraduate teaching hospitals with the full range of surgical and medical specialties. There are anaesthetists, both young and old, who prefer not to become involved in this type of work, but there is no doubt that many young doctors with good academic backgrounds are attracted into anaesthesia by the prospect of working in intensive care as well as the operating-theatre.

I agree that intensive care involves no new disease processes, but it does involve new methods of treatment, and, much more important, new attitudes to clinical and administrative management. If it is accepted that the experience, skill, and knowledge of anaesthetists qualify them to fill vital roles in intensive care more than any other single specialty, the next logical step is for an anaesthetist with a special interest to manage the intensive care unit. Some of us are enthusiasts and quite prepared to accept this burden without neglecting our other duties, nor do we believe the responsibility for individual patients should be removed from the consultant under whom they were admitted.—I am, etc.,

R. D. MARSHALL.

General Hospital, Northampton.

SIR,—I was interested to see that Professor W. W. Mushin and Dr. J. N. Lunn (14 June, p. 683) express the view that anaesthetists should not be in administrative and clinical charge of intensive care units but should be called upon to use their expertise when a particular problem requires their help..

I have shown that in an intensive care unit taking all types of cases needing life-supporting nursing and the machines of modern medical technology, 41% of the cases come into the province of general medicine.[1] While medicine becomes more departmentalized the general physician should remain at least *au fait* with current knowledge of supportive therapy in the dangerously ill, and should not need to be advised on basic matters of fluid balance by an anaesthetist or respiratory failure by a chest physician. To have to hand over the care of the patient to others when they become seriously ill must surely lead one to ask what the proper function of the physician is.

A small intensive care unit such as there has been at Kettering for the past six and a half years functions well with a physician in administrative charge, the clinical control of patients remaining in the hands of those consultants who admit patients to the unit. The nurses are clear who is in clinical charge of patients, and have the benefit of working under more than one consultant. They can turn to the physician in charge for any help in matters of equipment, organization, nursing shortage, and, in particular, training.

Larger units may need to be under the control both clinically and administratively of one person and his team. The French, with their sense of realism, entitle him *physicien réanimateur*; meanwhile physicians of today may need to reanimate themselves in order to remain in clinical control of their patients.—I am, etc.,

G. S. CROCKETT.

Kettering General Hospital, Kettering, Northants.

REFERENCE

1 Crockett, G. S., and Barr, A., *British Medical Journal*, 1965, **2**, 1173.

Simplified Scoring System for Newborn

SIR,—Routine Apgar scoring has become current practice in many obstetrical units.[1] While the one-minute score is valuable in determining those infants which need immediate attention, the five-minute score is better in deciding which infants may be in danger of developing neurological complications or of dying in the neonatal period. The association between Apgar scoring and neonatal mortality becomes stronger when birth weight is taken into consideration, as Drage and Berendes have shown.[2]

We wish to suggest an alternative scoring system, to be called the ABC System. Interest is concerned with three vital functions of the newborn infant: A—Activity, B—Breathing, and C—Circulation. Scoring on a 0, 1, 2 basis, 0 indicates complete absence of activity, breathing, and circulation, while 2 indicates full satisfactory function. The intermediate grade is designated 1. The face is preferred as the site for observation of colour, as many babies who are otherwise normal have some persistence of peripheral cyanosis.

In a limited number of babies examined, Apgar and ABC total scores have been compared and a close correlation exists between the two methods, both at 1 minute ($r=0.3963$,