A big proportion of the acute take in less frail patients can be handled by outpatient clinics or with discharge within 48 hours if patients are admitted. Most patients who remain are then either mainstream geriatric medicine or fit more or less into one of the main organ specialities, without that much unclassified general medicine left. So the relationship between geriatrics and acute medicine is not a sideshow – it is key.

Finally, I must express disappointment that Firth feels that those doing general and geriatric medicine are regarded as 'second rate' and of lower status than those focusing on single organs or diseases. This is not a situation we can allow to continue.

As NHS doctors, we are trained and paid by the taxpayer. As such we have a duty to embrace the care of the patients who actually come through the door (generally older and medically complex) not those we might find more glamorous. Looking after these patients should be seen as a vital role to be proud of and one which is 'core business' for those of us working in general hospitals. Even tertiary referral centres like Addenbrookes Hospital (Cambridge, UK) are still the district general hospital for their local community.

I have to ask, who is giving out the message that expert generalism is a poor relation? I feel our medical schools have a big responsibility with values and curriculae not focusing nearly enough on the care of older people and those with multimorbidity.[5] Postgraduate training often reinforces this. I do not think that the Royal College of Physicians' scheme to make more doctors do medical registrar on calls will make people who are not interested in general medicine or geriatrics any more interested, nor that creating a 'chief of medicine' post, as set out in the Future Hospitals Commission Report, will shift values. We really need to send out the message that care of the unselected medical take and non-elective inpatient work is the key to solving the problems hospitals face, and therefore the most important job of all. ■

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References

1 Firth J. The future of general medicine. *Clin Med* 2014;14:354–7.
2 Oliver D. Transforming care for frail older people in hospital. Physicians must embrace the challenge. *Clin Med* 2012;12:230–4.
3 Ellis G, Whitehead MA, Langhorne P *et al.* Comprehensive geriatric assessment for older adults admitted to hospital: meta-analysis of randomised controlled trials. *BMJ* 2011;343:d6553.
4 Silvester K, Mohammad M, Harriman P, Girolami A, Downes T. Timely care for frail older people referred to hospital improves efficiency and reduces mortality without the need for extra resources. *Age Ageing* 2014;43:472–7.
5 Oakley R, Pattinson J, Goldberg S *et al.* Equipping tomorrow's doctors for the patients of today. Age Ageing 2014;43:442–7.

The history and future of intensive care units

Editor – I very much enjoyed the fascinating review on the history and future of intensive care units (ICUs) (*Clin Med* August 2014 pp 376–9) but wanted to highlight two points. Firstly, the author's comment that cooling patients to 33°C is now common. A recently published targeted temperature management trial showed no benefit from cooling to 33°C versus maintaining controlled normothermia at 36°C.[1] Indeed, the International Liaison Committee on Resuscitation put out an update statement acknowledging local ICUs may choose to aim for controlled normothermia as opposed to hypothermia.[2] This is our local practice. Secondly, the authors state the formation of a stand-alone intensive care medicine (ICM) certificate of completion of training (CCT) should make training more accessible to physicians. However, the current Faculty of ICM (FICM) guidelines only accept dual CCT with a limited number of specialties namely; respiratory, renal and acute medicine (as well as anaesthesia and emergency medicine).[3] Therefore, although the new system opens ICM registrar training to those from the core-medical training, it has shut the door on dual qualifying with varied specialities. Specifically, one cannot currently qualify in cardiology and ICM, which was stated as a possibility in the article. Furthermore, there is currently no linking of the curricular or portfolios for the dual CCTs between the FICM and Royal College of Physicians. This means undertaking this training route is associated with an enormous administrative burden merely to prove competency. ■

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References

1 Nielsen N, Wetterslev J, Cronberg T *et al.* Targeted temperature management at 33°C versus 36°C after cardiac arrest. *N Engl J Med* 2013;369:2197–206.
2 Jacobs I, Nadkarni V. Targeted temperature management following cardiac arrest. An update. Available online at www.ilcor.org/data/TTM-ILCOR-update-Dec-2013.pdf [Accessed October 8 2014].
3 The Faculty of Intensive Care Medicine. Training in intensive care medicine. Available online at www.ficm.ac.uk/sites/default/files/ICM%20Training%20Leaflet%202012.pdf [Accessed October 8 2014].

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