critical care training. So it would seem that the total number of critical care beds at his institution has been increased to fill a need. However, I was interested in why the existing critical care unit (CCU) was not just expanded. One interpretation follows from the patient flow pattern: any patient staying >24 h is sent to the CCU but patients are not allowed to overflow from CCU to the OIR, and no medical patients are admitted. Is this not just ‘ring fencing’ beds for elective surgery, with all the inefficiencies and ethical problems that such a policy involves?

If the overall provision is sufficient to accommodate all demand, then the system works. However, when the CCU is full and a medical patient needs level 3 care what happens? Is a bed used in the OIR or is that patient transferred to another hospital so that an elective case can be done in the morning?

With any ‘safety net’ service such as critical care there are few steps that can be taken to regulate demand. As we all know, it is the peaks of demand that cause interhospital transfers with their associated morbidity and mortality. The only aspects of our demand that we can regulate are elective surgery and transfers into the hospital. Nobody defers elective surgery lightly and the frequency with which this happens is directly related to the adequacy of critical care provision. However, surely our first duty of care is to those patients that are already critically ill, even if this is at the expense of elective surgery? I believe that the national problem is the lack of critical care provision, which is not helped by ‘ring fencing’ beds for elective surgery.

C. J. Day
Exeter, UK

Editor—Thank you for the opportunity to reply to Dr Day’s letter in which he makes some interesting and useful points. He is, of course, correct in his statement that ‘the national problem is the lack of critical care provision’. However, I disagree with his conclusion that the development of an OIR ‘ring fences’ beds for elective surgery to the detriment of critical care provision as a whole.

The OIR concept is about finite skills and location. It is a mistake to attribute its capabilities to be those of a formal ICU. Whilst it is true to say that the OIR is providing surgical critical care, the majority of that care, albeit falling under the ICS definitions of levels 2–3, is relatively straightforward, largely limited to cardiopulmonary support and of shorter duration than the spectrum of care that an ICU offers. It also occurs in a recovery unit and not a general CCU that has much wider responsibilities.

The competences of an OIR lend themselves well to the management of postoperative surgical patients, the majority elective, but with an emergency element too. Proper use of an OIR therefore precludes the admission of the very sick who may need long-term ICU care. Similarly, such competencies also preclude the admission of critically ill medical patients, because we do not have the optimal skills to deal with them. Such patients should go to the ICU.

Consequently, the main advantages of OIR activity are to relieve the ICU of a workload that we have demonstrated to be more appropriately managed in a developed postoperative facility. This will mean that the ICU is better able to respond to the medical emergencies that Dr Day alludes to. In the 16 yr experience of formally developing and managing the OIR at St Thomas’ Hospital, there has been no instance of exporting a patient from the ICU to another hospital as a result of our operational policy.

The throughput of an OIR usually allows next-day discharge and frees up beds for that day’s surgical activity (which is all it is designed to do), which superficially may seem to be ‘ring fencing’. In contrast, such elective OIR critical care provision,

Surgical critical care—a rose by any other name…

Editor—Many of us have worked with inadequate provision of level 2 and 3 beds, which leads to cancelled elective surgery and substandard care of patients on general wards or in an inadequately staffed recovery area. Dr Aps has been able to fill a gap in patient care by developing an overnight intensive recovery (OIR) area.1 The unit that he has established would be recognized by many as an intensive care unit: bed spaces equipped to level 3 standard; 1:1 patient:nurse ratio and 40% of nurses with...
unlike ‘ring fencing’ in an ICU, has only a beneficial impact on
the ability of the main pluripotential critical care providers in the
organization to admit sick patients, by freeing up their beds from
elective surgical pressures. So, in effect, the OIR concept will also
contribute to the total critical care resource.

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