care unit directed by a pulmonary internist, I can assure Coppe1 that his statement is incorrect regarding participation by pulmonary specialists in resuscitation and long-term mechanical ventilatory assistance as "purely a United States phenomenon." I also doubt that Coppe1 can substantiate his claim that massive gastric distention can be completely avoided during cardiac resuscitation with mask breathing, even in skilled hands. Gastric distention can usually be avoided during mechanical ventilation by placement of a nasogastric tube; however, one may cause development of a tracheoesophageal fistula by long-term placement of a nasogastric tube in the tracheally intubated patient.3 No one would disagree with Coppe1 that we must avoid the avoidable, but to stridently imply that we should have reached a utopian state devoid of complications is folly.

Zwillich and Petty's editorial rebuttal of Coppe's commentary is important in showing that there is further room for improvement in prevention of well-known avoidable complications of respiratory therapy. As they correctly imply, there are few things as distressing as trying to place quickly a large tube in the trachea of an agitated, combative, wheezing, hypertensive, cyanotic hypercapnic patient. I wonder whether earlier placement under more controlled circumstances could possibly have been accomplished. Since the exact circumstances under which complications of tracheal intubation occurred were not documented, one can only guess.

During the past five years, we have successfully utilized predictive indices for weaning (recently publicized by the Denver group4 as indices to predict the need for assisted mechanical ventilation). In most instances, the need for emergency intubation in uncontrolled circumstances has been avoided. After reading Zwillich and Petty's reply to Coppe,2 it is unclear as to whether there is a person with expert ability immediately available in their respiratory care unit to intubate the trachea quickly. Clearly, an anesthesiologist is likely to possess this skill. I would hope that one lesson learned from the original study is the value of such a person.

I and members of our respiratory care group have been observers in many of the intensive care units in academic centers in the United States. As Zwillich and Petty state, expertise doesn't seem to depend upon the medical specialty of the director of the intensive care facility, but it remains true that few units are multidisciplinary. Most are run and controlled by one medical specialty or another. Zwillich et al.,1 Coppe,2 and Zwillich and Petty have focused on a very important point; seldom does the expertise of one medical specialty become so all encompassing as to prevent all of the avoidable complications of respiratory failure. As long as strident rebuttals continue between specialties, we will be unable to provide the level of critical care medicine of which we are now capable.

Ralph T. Geer, M.D.
Director of Respiratory Care
Surgical Intensive Care Unit
Hospital of the University of Pennsylvania
Philadelphia

To the Editor:

Dr. Geer raises several important issues in his letter. We agree that the multidisciplinary approach to these extremely ill patients is needed. We currently have a resident in anesthesiology rotating on our service throughout the year. We have found this to be rewarding because these residents have contributed to our understanding of postanesthetic problems. Furthermore, the resident in anesthesiology, who is an expert in techniques of intubation, has assisted us in instructing our residents and fellows in the skills of intubation. The importance of skillful endotracheal intubation was emphasized by our study.1 All residents have benefited from having firsthand experience on the intensive care units while being on the team that helps manage both the medical and surgical patients with severe respiratory problems. We have also found it very informative to frequently make rounds (twice per week) with a thoracic surgeon. This is also aimed at increasing the multidisciplinary approach to these complex patients.

A question was raised by Dr. Geer regarding methods of decreasing the need for emergency intubations. We often find it difficult to anticipate the need for intubation because many of the patients are called to our attention only after prolonged nonmechanical respiratory therapy has been unsuccessful. These exhausted, commonly hypoxemic and hypercapnic patients frequently require emergency intubation and represent those at greatest risk for complications of intubation. Increased awareness of this problem on the part of physicians is certainly required.

Clifford W. Zwillich, M.D.
Assistant Professor of Medicine
and Thomas L. Petty, M.D., F.C.C.P.
Professor of Medicine and Chief
Division of Pulmonary Sciences
University of Colorado Medical Center, Denver

Reference