

# Optimal Role of the Nephrologist in the Intensive Care Unit: An Intensivist's Opinion

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Dear Editor

It is with intrigue I read the article by Askenazi and colleagues in *Blood Purification* 2017;43:68–77. Notwithstanding the variations in practices across different countries and health systems and that nephrologists are highly skillful doctors, I could not help but feel this article reads like a position statement posturing for greater control within the intensive care environment rather than a concerted document defining realistic mechanisms for improved outcomes. This manuscript has a generic template, is Americo-centric and has foregone meaningful clinical content for an overabundance of corporate governance style verbiage like “quality” (24 times), “multidisciplinary” (9 times) and “collaboration” (5 times). The apparent absence of intensive care authorship in a document belies the acclaimed multidiscipline approach, while the espoused roles of leadership, education and being a clinician are qualities that apply to all disciplines. None of the qualities listed in this document are specific to nephrologists and the authors fail to segregate the skill set unique to their specialty that obligates an increased role in intensive care. Similarly, the claim that critical care nephrology is an established specialty is both unfounded and self-promoting. At best, critical care nephrology is a niche area of expertise where decisive clinical advances in the past decade have been limited.

The intensivists' role in acute kidney injury and renal replacement therapies has been born out of 2 harsh realities of modern medicine. First, patients with multi-organ failure are best looked after by intensive care doctors and nurses. So successful has the critical care model been that our medical and surgical colleagues have relinquished all but the most stable of ward patients to our care. Intensivists, by our very namesake, are trained to manage multi-system failures more often than any other specialty and thus have the greatest understanding of multisystem interdependency, pathophysiology and prioritisation. Given that the vast majority of acute kidney injury is secondary to multiple organ failure, it is the intensivist who is best placed to manage this syndrome. However, probably the most pertinent observation is that sick patients get better when senior, experienced clinicians and nurses review them on a regular basis – not just once or twice a day, after clinic, or at the end of a ward round. The PROMOTE, PROMISE and the ARISE trials all demonstrated that “prescription” medicine does not absolve the clinician of reviewing their patients [1–3]. The intensivist's expertise has grown to not only include renal replacement therapies but also include performing echocardiography, inserting ECMO cannulas and heading medical emergency response teams. All these have evolved out of the lack of provision of these services by their traditional stakeholders during crucial

out-of-hour time periods. The ATN and RENAL Trials provide some interesting insights to this point. In Australasia where the intensivist oversees the renal replacement therapy, patients were enrolled into the RENAL Study, on average, within 18–20 h of ICU admission with a 44.7% 90-day mortality [4]. In America, where nephrologists are far more influential, on average, it was 6.4–6.9 days before patients were randomised into the ATN Trial with a 52.3% 60-day mortality [5].

I have been fortunate enough to work alongside, and be taught by, many outstanding nephrologists. They have a crucial role to play in patient care but until the discipline is prepared to provide 24/7 senior bedside reviews and assume out-of-hours responsibility, then intensivists must remain the driving clinicians behind time-sensitive acute kidney injury management in the intensive care unit.

## Disclosure Statement

I declare that I have no ethical or pecuniary interests that would conflict with the production of this manuscript.

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