Increased collaboration between aid agencies, national health services, universities and accrediting bodies (such as the UK Royal Colleges) would enable entrants to develop field skills, to study best practice, and to understand the importance of academic critique, with the rigors of service training. Furthermore, donors, as purchasers of aid, must ensure rigorous assessment and accreditation of the implementing agencies, with emphasis on the quality and appropriateness of programme design. The agencies themselves need strong commitment to improving the quality of work they undertake—internal audit and evaluation is essential.

Governments and international policymakers would do better to direct their resources and efforts in support of those agencies providing expertise in emergency medical aid. Another international bureaucracy is not needed.

Nicholas Banatvala, John T Howarth, Alison J Roger, Christopher P Besse
Medical Emergency Relief International (MERLIN), London W1M 1HW, UK

1 Editorial. Emergency medical aid is not for amateurs. *Lancet* 1996; **348:** 1393.

SIR—You suggest,[1] to our surprise, that medical relief activities in the Eastern Zaire crisis were handled by amateurs. Some confusion might have risen because of the fact that since early November, aid workers and journalists have been denied access to the eastern Zaire region where huge refugee camps had been turned into military targets. Impotence seems a better description than amateurism for the humanitarians at the border.

On Nov 14, 1996, thousands of Rwandan refugees started crossing the border at Gisenyi, at a rate ten times higher than estimated by the contingency plans. As Brown and colleagues report in this issue,[3] the MSF health project in the Gysenyi area took immediate responsibility for the water supply and first-aid posts along the road. By day 3, 30 members of the MSF emergency team had arrived in the area. By day 4, ten first aid posts, four hospitals, and 20 oral-rehydration points were in operation. Water delivery capacity was 210 m^3 a day.These facilities were possible only because MSF had prepared for such an emergency and had stocks in place in Rwanda and in Europe. In emergency situations, relief professionals speak in terms of life and death. Confronted with the huge crowd of returnees, the priority was to avoid a Goma 1994 scenario. In 1994, an estimated 50 000 people died because of overcrowding and lack of water, compounded by outbreaks of cholera and shigellosis,[2] which is in striking contrast to the rate in Rwanda between Nov 16–24, 1996.

Indeed, we agree with you that this kind of work cannot be left to amateurs. However, we strongly contest the suggestion that a new international body should be created to cope with medical emergency aid. It would result in a UN-like organisation, wherever it is located. We fear that, like the UN, it will be highly skilled in co-ordination meetings and liaison but less flexible in adapting to a changing field situation. You in fact raise all the arguments against the establishment of yet another centralised international co-ordination body, which would lack the flexibility to rapidly respond to emergencies and to adapt to situations as they evolve on the ground. Better co-ordination is necessary, but you hardly pay attention to the central role the Rwandan government had in this repatriation process. The efforts of the home and host governments should never be underestimated when talking about refugees crises.

We do not want to deter criticism of the performance of emergency non-governmental organisations. On the contrary, a continuing process of evaluation is the best guarantee of quality improvement. However, sound evaluation of this type of work cannot be left to journalists. If the international community has any lesson to draw from the massive, yet hardly spontaneous, return of the Rwandese, it is that a more genuine, more morally courageous, and more effective international political commitment to the weakest and the poorest on this planet is needed. It might not only address the consequences but also the roots of the problems.

*Marleen Boelaert, *Myriam Henkens*
Médecins Sans Frontières, International Office, Rue de la Tourelle 39, B-1040 Brussels, Belgium

1 Editorial. Emergency medical aid is not for amateurs. *Lancet* 1996; **348:** 1393.
2 Goma Epidemiology Group. Public health impact of Rwandan refugee crisis: what happened in Goma, Zaire, in July, 1994? *Lancet* 1995; **345:** 339–44.
3 Brown V, Reilley B, Ferir M-C, Gabaldon J, Manoncourt S. Cholera outbreak during massive influx of Rwandan returnees in November, 1996. *Lancet* 1997; **349:** 212.

Physician staffing in intensive care units

SIR—In their Nov 30 commentary Cunnion and Masur[1] discuss the increasing use of clinicians with special training and experience in managing acute life-threatening conditions within the intensive care setting. We believe that the evidence accruing that intensive care units improve outcome in selected disease categories is compelling. We endorse the evidence cited that intensive care units can achieve better outcomes when individuals trained in this discipline direct patient management. The commentary was, however, based on the practice of intensive care medicine in the USA and has limited relevance to the UK.

In the UK, the recent establishment of an intercollegiate board of intensive care medicine represents a most encouraging commitment to this issue by the parent colleges. The board has established recommendations for training, approval of units for training, and procedures for assessment and accreditation of training programmes. The multidisciplinary nature of the clinical practice is recognised in the composition of the board, the terms of reference for which, in part, involve gaining recognition for this clinical discipline as a specialty within its own right. It is hoped that 1-year training programmes for individuals seeking a certificate of completion of specialist training in another clinical area will be possible from 1997. The report of the working group on guidelines on admission to and discharge from intensive care and high dependency units recommended that Royal Colleges address the designation of intensive care as a specialty as soon as possible in view of the potential benefits including improved quality of care.

We maintain that a commentary devoted to debating the benefits accruing from any form of organisation of practice within this field over another (open versus closed units) is premature, at least in the UK. In this country the medical community must first be made aware of the importance of developing highly trained individuals practising within this clinically and academically exciting area, before embarking on a debate about the best way in which they might be deployed.

T W Evans, S M Willatts
Intercollegiate Board on Training in Intensive Care Medicine, 48–49 Russell Square, London WC1B 4JY, UK

1 Cunnion RE, Masur H. Physician staffing in intensive-care units. *Lancet* 1996; **348:** 1464–65.
2 NHSE Report of the Working Group on guidelines on Admission to and Discharge from Intensive Care and High Dependency Units. Department of Health. March 1996.

What has happened to the surgical intensivist?

SIR—Discussing the staffing of intensive care units, Cunnion and Masur (Nov 30, p 1464)[1] do not mention the words surgeon and surgical