Occasional essay

"If you knew 20 years ago what ICU medicine would be like today, do you think that you would still choose to be an intensivist?"

It was a balmy evening with not a breath of wind. The setting was made even more celestial by the last rays of the setting sun filtering through the vine on my back fence and flickering a kaleidoscope of red, yellow and gold on the rendered wall behind us. David and I were resting after a long day of teaching at a short course on intensive care medicine and were attempting to unwind while sipping a light ale. We had been talking about the various trainees - their weaknesses - their strengths when suddenly he said.

"Tub, why did your lads do cardiology?"

"I guess because they liked it" I replied.

"Yeah... but why did they *not* do intensive care medicine. I mean did you actively discourage them?"

As both David and I have had difficulties with hospital administration, I began by saying,

"I don't think that I actively discouraged or encouraged them - although I probably was happier that they chose a discipline that would not lock them into requiring a hospital appointment to practice their specialty"

He drank his last mouthful of ale and leaned back. His eyes glazed a little as he looked at his empty bottle and then dismissed my remarks with,

"Yeah but all specialists usually try to get a hospital appointment and probably have as much trouble as we do with administration."

He sucked the few remaining drips from his bottle and put it down next to the foot of his chair. He then lent forward and looked at me and said,

"If you knew 20 years ago what ICU medicine would be like today, do you think that you would still choose to be an intensivist?"

He paused, but not long enough for me to give an answer, and added,

"You know, I'm not so sure that I would."

David is about 10 to 15 years my junior. I last worked with him about 12 years ago when I knew him as a bright and enthusiastic intensivist who was a dedicated clinician, committed teacher and probing researcher. He continued with,

"Oh, I still get a kick every time I deal with a young critically ill patient who gets better and I still get a kick out of teaching, but I find that more and more of my time is being spent talking to relatives and taking them through the process of withdrawal of treatment for their dear old demented mother."

"Do you want another light beer?" I asked, and stood as if preparing for my errand.

"I've got stacks of it left in my fridge. My lads only leave the light beer as they reckon its poison" I added, trying to lighten the conversation.

David smiled a little but was not going to be moved.

"What do you think Tub?" he repeated slowly "If you knew 20 years ago what ICU medicine would be like today, do you think that you would still choose to be an intensivist?"

I sat down again and began to peel the label from my bottle.

"Well…I know what you are saying and I guess that I am glad that I'm getting close to retirement, but I still think that I would."

We didn't continue the conversation much further. My wife had prepared the evening meal, the sun had set and it was now becoming a little chilly so we went inside to eat. We spent the rest of the evening talking about other things. However, I could not forget our earlier conversation.

Intensive care is changing. I can remember when starting more than 30 years ago I worked in an 11 bed intensive care unit which serviced a major teaching hospital with approximately 1000 beds (i.e. 1 ICU bed per 100 general hospital beds). We very rarely, if ever, admitted anybody over the age of 70. Withdrawal of therapy was an unusual event. The approach was simple, we treated patients actively until they survived or died.

Now, intensive care units vary from 20 - 40 beds in 400 - 800 bed hospitals (i.e. 1 ICU bed per 20 general hospital beds). The high dependency beds appear to have been incorporated into the ICU, patients are often more than 80 years of age and intensivists are often required to withdraw therapy when there appears to be no hope of recovery. Withdrawal of therapy is now an important part of our practice.

I talked about this aspect of our vocation with two of our senior fellows, one of whom stated that during his training he had spent some time managing patients in a palliative care unit. He found, to his surprise, that palliation was a part of medicine that could be most rewarding, and that his time in that unit had prepared him well for this aspect of ICU medicine.

In the intensive care unit we do spend a lot of time talking to relatives. In the frail elderly patient who is unconscious or deeply sedated and unable to effectively communicate his or her wishes, where continued

therapy may be in question, we ask the relatives to articulate, as best they can, the patient's wishes after explaining to them the circumstances and likely prognosis. The discussions are involved, as there may be an almost limitless number of contingencies in which supportive therapy (e.g. cardiopulmonary resuscitation dialysis, ventilation, artificial feeding, life sustaining drugs) may, or may not, be considered appropriate.

If withdrawal of therapy is considered desirable, the process is complex. It is not an abandonment of the patient or relatives. Perceptive management of both the patient's and relatives physical and psychological needs throughout the ordeal, although at times delicate and demanding, is essential.

"In the sufferer let me see only the human being"

Maimonides 1135 - 1204

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