

## Occasional essay

“... are you happy about that?”

Change occurs everywhere, no more so than in the intensive care unit. Technology has allowed monitoring to become unobtrusive and deceptively modest. Patients may be haemofiltered, dialysed, plasmapheresed, intra-aortic balloon counterpulsed and ventilated in any level three intensive care unit bed without causing so much as a turn of an eye. The intensive care nurse has also undergone change, although, I don't think that it would be described as unobtrusive. While they, as always, remain pivotal to the standard of care that is delivered by any intensive care unit, they are now technology wise and computer literate. Their profession has moved to improve their academic status with professors, researchers, senior lecturers and the like who are able to respond and comment on all aspects of health care. They can now tell me the causes and management of acute respiratory, cardiac, renal, hepatic or multi-organ failure.

Nevertheless, I have wondered.

With all this new found knowledge comes a sense of empowerment. If their new talents are unable to be put into practice, frustration and anger will surface. They have an opinion about all aspects concerning the standard of care for the critically ill patient. And why shouldn't they? Perhaps previously they had an opinion but kept it to themselves. Treatment concerning the circulation, ventilation, sedation, plasma biochemistry, urinary output and even systemic vascular resistance (SVR) will be questioned. For example: “Mrs. Smith's SVR is 2000 - are you happy about that?”

I once use to attempt to give a short discourse on circulatory physiology to explain why I was not necessarily “happy about that” but under the set of circumstances that the patient was encountering I would tolerate it - to find a few hours later that a nursing note would be added to state that Dr. Worthley was notified and was “happy about that”. I have also been informed after I had prescribed vecuronium for a ‘posturing’ patient, that “I'm not happy about giving this patient a relaxant unless he is also given some sedation” even though the patient was deeply unconscious with a large intracerebral haemorrhage.

Intensive care patients and their problems are complex. Normal physiological values that include a mean arterial pressure of 80 mmHg, PaO<sub>2</sub> of 90 mmHg and

urine output of 50 mL/hr are sometimes not normal for various pathological conditions. A PaO<sub>2</sub> of 60 mmHg, urine output of 10 mL/hr, and arterial pressure of 60 mmHg or 120 mmHg may be acceptable as an alternative to large doses of vasoactive agents, intubation and ventilation or extensive use of diuretics. Furthermore, sedation and opiates may be inappropriate for those who are in a coma. To simply change a number that we measure, or add an agent to suppress consciousness that is already suppressed, is not necessarily associated with improved patient outcome.

Moreover, while intensive care nurses have become more informed, I have often wondered if this aspect of their training has received more attention than the various practical aspects of their vocation. For example, securing endotracheal tubes, underwater seal drains or central venous lines (which occasionally appear to just ‘fall out’), zeroing pressure transducers, checking the endotracheal cuff, ensuring vasoactive infusions are administered in separate lines and the nasogastric suction is working, administering intravenous antibiotics without delay, managing pressure areas and attending to eye and mouth hygiene.

Nonetheless, any sense of medical paternalism or arrogance is no longer accepted by nurses, physiotherapists, junior medical staff or hospital cleaners. Nor should it have been. All wish to be an active partner in the decision-making process relating to the patient's management. However, and more so now, if these expectations are unfulfilled the nurse, junior medical staff or physiotherapist (or hospital cleaner) is likely to consult their supervisor, administrator, lawyer or local newspaper reporter, as they are no longer frightened of confrontation. To be fair though, all believe that they act with the understanding that whatever they do will be in the patient's best interest – an interest that is clearly paramount. However, sometimes having a committee that decrees treatment produces much the same result as having a committee drive a car. Rather than having one coordinated team, two or more teams exist with all hands tugging at the wheel to produce the erratic results that nobody takes responsibility for.

I guess as a ‘baby boomer’ wishing to judge the change in those who are largely ‘generation X's’ I risk being pilloried as just another dinosaur who has outlived his hope and who should be relegated to the retirement ‘condo’. Yet to live through the gestation of the discipline I know as Intensive Care Medicine and see its maturation may allow a useful perspective.

With all these random thoughts circling about concerning the change in the relationship between the intensive care specialist and nurse, I felt somewhat repentant following a recent incident. A patient was admitted to our intensive care unit following coronary artery bypass surgery. In this group of patients we often

use intravenous sodium nitroprusside (SNP) to keep the mean arterial pressure ranging between 60 to 90 mmHg. In one such patient I found the mean arterial pressure had increased to 100 mmHg and asked the nurse "how is Mr. Jones".

"OK" she replied "the pressure is up a bit so I have turned the SNP off". I looked at the pump and sure enough it was off. I leaned over, reset it and turned it on again. Just then Jan (the intensive care charge nurse) appeared.

"I think nurse might have a few questions to ask you Jan" I said and left.

The next day I received a letter from the nurse that said "Thank you for your patience yesterday. I was so nervous and anxious about making sure that I was organised and did everything correctly, that I ended up making stupid errors. Unfortunately anxiety gains its own momentum which does not dissipate easily. I will

never repeat that error again and will keep trying to deliver the best patient care I can".

Intensive care units are stressful places and I guess I tend to forget how stressful they are to junior staff. I reflected a little and felt that perhaps when making judgements about the various changes in intensive care I should remember my early days better.

Lately I think I have listened a little more.

*"When doctors listen to nurses, patients recover more quickly"*

Reg Evans

L. I. G. WORTHLEY

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