Intensive care and compassion

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When I was invited to do the presentation in this symposium few months ago, I asked myself. Why me? There is no answer. Maybe the reason is that I am an anaesthesiologist –reanimatologist and I have been working in Intensive care clinic as the head of clinic and as an anaesthesiologist in operating room for more than twenty years. But before choosing this speciality, I tried to get to know the medical field by working as an assistant nurse in an ambulance and also as an assistant of physician in a small regional hospital. At the end of the studies, I chose my speciality.

Once I asked my teacher. Why did he choose anaesthesiology-reanimatology? And an old doctor told me about an event that happened 55 years ago at our university hospital. I remember the year well since I was also born 55 years ago. In the main auditorium of our university hospital there was a discussion on “whether the ICU is needed at all”? Some very respectable professors were of the opinion that if patient's condition requires maintenance of life through external devices and the continuous administration of drugs into the bloodstream, then is it really worth to support the patient's vital functions. After all, everything is already determined. Maybe it is even inhumane? But there was another part of the audience that told the success stories when people returned to normal life after successful treatment of a critical condition, or even clinical death. We can understand how this discussion ended and how attractive it sounded: "to pull someone out of death’s clutches." The professional path of my teacher was already decided. As well as mine. But let’s look at it from an earlier perspective.

What led to the development of intensive care and anaesthesiology? I think it was DEATH, and fear of death. I‘m visiting Italy for the second time in my life and I know that here in Italy, in old cemetery located in Camposanto in Pisa there is a great fresco "The Triumph of Death" painted by Bonamiko Bufolmako. The way this fresco speaks is impressive. We can feel the human reaction to death. Death from plaque. The PLAQUE claimed many lives. But at the same time, these deaths have forced us to look for solutions on how to protect ourselves and what can be done to survive. Don’t get me wrong. It is clear that the plague in Europe has not created an intensive care unit. But infectious diseases, and the conditions that they cause, such as sepsis, are one of the leading causes of death in modern ICU. Another cause of massive death, especially among young and healthy people, is WAR. This form of madness is still present in modern society. Once again, massive deaths from injuries have pushed forward progress of medical science.

One more impulse for the development of intensive care as a field of medicine was the outbreak of polio in the middle of twentieth-century. Polio is an acute infectious disease caused by a virus, which causes death of neurones and leads to muscle weakness or complete paralysis. The weakness of respiratory muscles causes respiratory failure even though the lungs are intact. Medical response to this was the “iron lungs”. The device was huge. Patient was in this cylinder. The negative pressure on the inside of the vessel, helped the patient to draw in air from the environment. “Full metal jacket”. Seeing the imperfections of such treatment, Danish doctor Bjorn Ibsen proposed a solution: positive-pressure lung ventilation by blowing air with a bag into the patient. And it became the standard of care. Indeed, the first “ventilators” of lungs were medical students. They alternately visited the sick and literally held the lives of patients in their hands. Technologies that changed manual work came soon after and mechanical inflation and exhalation was transferred to mechanical electrical devices.

I don't want to focus too much on the history of ICU, but It is impossible not to mention that twentieth-century surgery progressed along with anaesthesiology. Artificial blood circulation, MV, an oxygenation, have enabled even heart surgery. Moreover, transplantation of heart, kidneys and liver were introduced thanks to these great man Murray, Bernard and Starzl.

Let's go back to ICU. Who are the people treated in modern ICU? Patients with life-threatening conditions, including: COMA, circulatory insufficiency – SHOCK, acute respiratory insufficiency and life-threatening disorders of HOMEOSTASIS. And they need a support to survive. Of course, patients whose body is connected to external devices will feel uncomfortable. To avoid the resistance, commonly patients are sedated and receive narcotic analgesics to relief pain. Currently the mortality rate in ICU is 30/40 % depending on the pathology. In very rare cases patients who survive a critical condition visit the ICU after recovery. I always give them one question. *"What do you remember from our department?"* The most common answer is *"Nothing"*. They look at the environment of ICU with surprise; and ask us to show them the bed where they were laying. They look to their family members with the silent question *"Was I really here?"*

The modern healthcare involves various stakeholders, including patients, doctors, nurses, government, insurance companies, and even journalists and politicians. Sometimes it is difficult to find the patient among them, as well as among our devices. But I want to focus on other things. Considering that patients in ICU are often physically unable to communicate, communication with ICU patient's family members also lays on the shoulders of ICU physicians. To talk about compassion without mentioning them would be wrong. There is a proverb, saying that the theatre starts in the changing room. I would like to rephrase it by saying that ICU starts in the waiting room. That room is filled with pain, anxiety, suffering and waiting.

We can all admit to the benefits of protocol medicine. Standardised medicine facilitates the diagnostic and treatment process. These are the advantages. But there is other side to the coin. The biological laws of nature do not always obey the rules of protocols. There is no single factor determining the course of the process in nature. There is a combination of factors and none of them is the main one. Therefore, it is important to evaluate the specific characteristics of each patient. Individualize the treatment. There is also a standard for compassion. The rule of 3 T's. Technically it is: TALK, TAKE the TIME, TOUCH. Like at Bjorn's Ibsen's time. But is that the case in real life? Intensivists are facing a huge responsibly and losses every day and it has become a routine. Currently we are hearing about burnout and fatigue of physicians. It is a dangerous trend leading to disappointment, self-pity and even suicide. As a result, there are problems in our families as well. For life satisfaction and relaxation some of physicians turn to addiction. Some become cynical. These are the barriers to compassion.

When I talk to patient 's family I often hear a question „Why did this happen to us? "In response I try to explain that nobody gave us a promise that there would be no suffering, no pain, no sadness. To understand their expectations, I ask what do they expect from intensive care? A new life? Return home? Death? I also would like ask what do the audience expect from intensive care? Professionalism, compassion?

I like art. It helps me to find the answers to many questions. Here you can see the painting of Peter Bruegel the elder - *The Procession to Calvary.* There is a lot of action in the painting. We see the suffering Christ carrying the cross. And many people, who are involved in this. Some of them are in sorrow, some are trying to help. Some just came to look at the event. Someone is doing the daily job. The painting is about us. The artist allows us to know the nature of human. We can find ourselves in this picture and it is up to us to decide what is our role.