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FROM THE INSIDE

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On being an intensivist

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What is it that motivates those who practice acute care medicine to want to do so in the intensive care unit, a place most other doctors and nurses tend to avoid out of fear and trepidation? Is it the challenge of confronting complex pathophysiological processes head on using diagnostic and therapeutic options not readably available in the rest of the hospital? Is it the feeling of fulfillment when one can be a significant part of one human's life during a very delicate balance between life and death? I have thought of these questions many times before. In fact, as a boy I wrote the following poem to address my quandary in considering going into medicine as a profession:

Of all the live
  All will die
So to this world
What use am I?

The answer is, of course, that saving lives is not our goal, nor should it be. As I say often and in a slightly flippant manner to young students and medical professionals that I teach: "Life is a sexually transmitted terminal disease." We can all agree that it is sexually transmitted and also that everyone will die. Thus, our goal as health care professionals is never to prevent death at any cost, but to maximize the quality of life of our patients within the context of health. And, importantly, it is not our definition of quality of life that matters, it is theirs. I initially chose to become an intensivist because of my fascination with physiology, homeostasis and the processes that disrupt it in disease. But at a very early stage I too was reminded that it was not my disease or problem, it was my patient's disease and problem, and that the consequences of both were also felt by their loved ones.

In my last 35 years as an intensivist, I have been honored to be allowed to study human physiology in the laboratory and at the bedside, to teach in the classroom and at the bedside and to be an intensivist. Occasionally when asked to help understand a difficult patient's condition I usually can reach a reasonable and accurate diagnosis easily when other well-meaning and thoughtful physicians have not, because I was able to return to the first principles of physiology in exploring the determinants of a given patient's condition. I recall that in my early years of research, research that was always matched with large animal models and human validation studies, we explored and discovered many of the underlying principles presently accepted driving heart–lung interactions. Those findings were realized by doing very thoughtful and clear studies and rigorously accepting that the data, and not our hypothesis, were real and then trying to understand what was going through the mind of God when nature thus created these processes. I was reminded several times during those years that I was standing on the shoulders of giants, men and women who years before and using less advanced instruments still found the way to understand the underlying principles of these processes. Those detractors were right, but to those just starting out, let me say, though you are truly standing on the shoulders of giants, you are still standing. You are there and you are

pushing knowledge forward and caring for the sick. It is that dedication, respectfully balanced to an understanding of our past that both keeps us humble and optimistic at the same time.

And yet, sometimes, often times, it is not practical medical acumen that serves my patients well, but rather a pure and simple compassion for their mental and physical state and how it impacts those they loved. We are often reminded that death does not only hurt those going through the dying process, but lingers in their surviving loved ones. We need to be willing on the one hand to do everything possible to stop a pathological process and minimize tissue injury, prevent further harm and allow the body to recover, but also remember that in the end this will be a losing process and that we need to understand when health or an acceptable substitute for health within the mind of the patient cannot be achieved and allow them to have a good respectful and even joyous death, celebrating their life's achievements rather than fearing the pain of death and the void that may follow.

I recall many patient care conferences with families during which these issues were discussed, and though often different family members disagreed on the wishes and intents of their loved ones, I never felt that we were at odds as to these final therapeutic goals. We were all wanderers in the wilderness of disease hoping to find a path to peace that if it could not mean recovery at least would not mean pain and distress. Indeed, my most difficult conversations about the goals of therapy were not with families but with other physicians who saw limiting care as abandonment. But that should not be the case if such decisions are made openly and thoughtfully. I am always reminded of why I originally went into medicine—because I wanted to help people within the context of health. I will leave you with this one last poem I wrote one night while thinking of a wonderful person I had seen and help treat as a medical student and who had recently passed after a long and well-fought battle against disease:

And through the window came
  Like a soft and gentle rain
  The hope, that was despair
Came through the tear-dropped air
  And landed on his mind
  And being of similar kind
  Too refuge in this home
  A tired and wrinkled dome
  To sleep, to sleep, to sleep

Conflicts of interest None.