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A lesson from a dying intensive care fellow! Intensive care ethics clearly exposed

'You treat a disease, you win, you lose. You treat a person, I guarantee you, you'll win, no matter what the outcome'

Hunter 'Patch' Adams

Ashraf Roshdy described how the famous theoretical physicist Stephen Hawking could survive his slow-progressing form of amyotrophic lateral sclerosis for 55 years, despite the predicted prognosis of 2 years. '*Prediction proved to be wrong but intensive care medicine never failed him*' [1]. What has intensive care medicine offered Stephen Hawking? He contracted a pneumonia in 1985 while traveling to Geneva. Admitted to an intensive care, he was placed on a ventilator and underwent a tracheotomy. After this, Hawking had 24-h nursing care, made possible by grants from several foundations and a loving wife. The overall influence of intensive care medicine was not very impressive in the life of this scientist. To state that '*palliative care*' and '*tender loving care*' never failed him instead of intensive care medicine would be, I suppose, more appropriate. However, given the high incidence of comorbidity we see in our patients at the intensive care, it seems logical that we see intensive care medicine as the most expensive form of palliative care? In this sense, yes, intensive care medicine never failed him.

Subsequently, Roshdy addressed actual ethical dilemmas such as triage for ICU admission; quality of life after ICU survival; prognostication; admission of patients with hematologic malignancies and solid tumors; the admission of many patients with severe comorbidities and low functional status and frail geriatric patients; quality adjusted life years; the paradigm shift from limits to goals-of-care and the failing of scoring systems. Additionally, he stipulates on respect, humanization and dignity as core issues for intensive care practice. And right he is as we can read in the following story:

It's 2008.33- year old intensive care fellow, Rana Awdish, was seven months pregnant when she suddenly was overwhelmed by excruciating abdominal pain. She was brought to the hospital where she practiced as a senior intensive care fellow. The reason for admission to her own hospital was, as she said: '*I trusted us*'. She was bleeding to death from a ruptured liver adenoma. She knew she entered the triad of death. Her unborn daughter died in utero, and she nearly died herself. With organ failure progressing, she was rushed to the operating theatre. She resurfaced, in fear, on her own ICU, wholly dependent on machines, understanding the magnitude of her condition. The loss of grip and awareness of her surroundings filled her with terror. She wrote her experiences in an article and in a strong and compelling book [2,3].

Professional performance of an ICU professional should be focused on 1. the intrinsic and professional drive for excellence in skills and updates in scientific knowledge; 2. working from the perspective of humanity towards patients, their relatives, colleagues and other health care professionals and 3. The willingness for critical self-reflection.

Superior professional performance does not develop naturally from extensive experience, academic education and domain-related knowledge alone. This leads to automatism in many skills and tasks, but may forego humanity and critical self-reflection. Motivated experts continue to improve their performance as a function of more experience. Burnout, boreout and compassion fatigue are not about working in a stressful environment, like and ICU, but is about lack of existential significance and professional performance [4].

An important, but much neglected, part of intensive care ethics is about respect, dignity and reciprocity which I combine in humanity as part of professional performance. Lack of awareness of humanity in daily work at the ICU is an important issue in thinking about ICU ethics. In Awdish her book this is clearly exposed. She writes about the lack of empathy, the miscommunication among hospital staff and some failures (e.g. giving Lasix for AKI). She doesn't write this in bitterness, but vowed to make a difference in how we should confront our patients. In my opinion the book is a plea for professional performance in the three mentioned domains.

One example and wise lesson from the book: "Our patients at the ICU are listening and hear. Even when they are in shock, in coma or do not react". When losing a grip on her life while in hemorrhagic shock, one of the last things Awdish was hearing, was her colleague physicians saying phrases which, she herself, without a thought, has said so many times: '*She's been trying to die on us'; 'She's circling the drain here'; 'We're losing her'*. But, patients are not actually *trying* to die on anyone, they want to live! As Awdish stipulates herself saying these words attributes intention to patients, rudely hurling themselves toward death. Implicit constructing an antagonistic relationship with the healthcare providers. Judge these sayings for yourself in reciprocity and critical self-reflection.

For healthcare providers on the ICU, this book is a must-read. I recommend the residents and fellows on our ICU to read the book, as it is proven that reading fiction and watching movies or documentaries or reading novels or ego documents on suffering can make healthcare professionals more compassionate, more understanding persons [5]. For this reason, this should be included in educational programs of ICU professionals to reduce

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dehumanization in our discussions about patients [6,7]. This trains them to take another person's perspective. To quote Rana Awdish: 'Our greatest gift is our ability to be absolutely present with suffering'.

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