The value of the intensivist in the intensive care unit

El valor del intensivista en la unidad de cuidados intensivos

Dear Editor:

We had read with great interest the editorial published by Maurizio Cecconi et al: ''Diversity and inclusivity: the way to multidisciplinary intensive care medicine in Europe''.[1] This need has come to the forefront during the current SARS-CoV-2 pandemic as an imperative need to increase the number of ICU beds per 100,000 inhabitants in Europe. Notwithstanding, as important as the ability to open these beds, is the specific training of the competent, skilled professionals that will integrally manage critically ill patients.

This document highlights a need that is known but not prioritized in the plans of the health authorities. Greater hospital response capacity at all levels including the most severe and complex clinical scenarios is a fundamental pillar in society. Furthermore, in the current days where panic and uncertainty have taken over the lives of citizens, it gives safeness to the population and allows the normal functioning of society. The care of the critically ill patients must be following rigorous scientific methods and performed by professional fully dedicated to this kind of patients. For this reason, we share with the authors the need for specific training in intensive care medicine, with recognized competences in all member countries of the European Union.

In Spain, there is a specific training program of five years for intensive care medicine. Currently, Spanish critical care units are run by professionals (Intensivist) dedicated exclusively to the management of critically ill patients. However, the current situation has also shown that more staff is still needed.

In our Intensive Care Department at Ramón y Cajal University Hospital, we have a staff of 23 Intensivist. During the last year, more than 300 critically ill patients with severe SARS-CoV-2 pneumonia and ARDS have been admitted. Among these, 90% required invasive mechanical ventilation. The average age was 60 (±12.57) years, predominantly male population (68.9%), with an average severity of: SOFA 7 (±3.13). APACHEII 18.21 (±8.43). SAPS II 41.36 (±16), and despite this, we have had an ICU mortality of 19.5%. In our opinion, these results are influenced by the training received. Despite a priori ignorance of this pathology, the results reflect better results than other training models.

Any loss of human life through acute illness is a disgrace. However, we want to add to the published editorial that the specific training of doctors, nurses and health personnel in charge of critically ill patients can not only attend more patients, but also can do that with greater capacity and skills, reducing mortality.

Part of the management of the critical patient is the information to the families. This very sensitive information, especially in patients who before admission to the ICU did not have a serious medical condition and present a high risk of dying, must be careful and also requires training. The management and follow-up of the critically ill patient after leaving the ICU can also be optimized by the intensive care physician in a global and optimal way.

For all these reasons, we consider and are firm in believing that a specialty dedicated to the management of critical patients in Europe and in the world, should be a main goal for our intensive medicine society.

Reference

1. Cecconi M, Kesecioglu J, Azoulay E. European Society of Intensive Care Medicine. Diversity and inclusivity: the way to multidisciplinary intensive care medicine in Europe. Intensive Care Med. 2021;29(April):1–4, http://dx.doi.org/10.1007/s00134-021-06384-4. PMID: 33914111; PMCID: PMC8082476 [Epub ahead of print].

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