Personal Paper

Reflections on an intensive therapy unit

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The clinical diagnosis had been confirmed: I had myasthenia gravis. Fortunately I responded well to medication, and a baseline dose of pyridostigmine had been determined. After stabilisation, however, I was advised that thymectomy would probably be valuable as part of the long-term management of my condition.

The thoracic surgeon discussed the operation with me, outlining the procedure and its sequelae. When he had emphasised the (to him) simplicity of the operation, he added, "We shall have you in the ITU for a few days—just as a matter of routine." My immediate reaction was one of almost panic: Was I really more seriously ill than my colleagues had told me? But the surgeon answered my questions and fears fully. The anaesthetist in charge of the intensive therapy unit (ITU) later suggested that the view of a patient with some medical knowledge would be interesting and reassuring to others and might help staff in their understanding of patients' attitudes to intensive care.

The condition

My problem had started less than two months earlier, with persistent laryngitis, indistinct speech, and difficulty in eating and swallowing. At the same time I developed diplopia and the muscles of my neck and arms became progressively weaker. This was all very alarming and suggested, even to me, that myasthenia gravis might be the problem. After a careful history and examination the neurologist's diagnosis was that this was the case and he admitted me to hospital, using his own phrase, "to challenge the diagnosis" and to investigate any related problems.

Investigations included comprehensive blood and urine analysis, assessment by physiotherapists, electrocardiography and electromyography radiographs, and an EMI scan of the mediastinum—none of them unpleasant. Then followed two very significant days: the first when the Tensilon test proved positive and the second when intramuscular neostigmine gave a very satisfactory response, so confirming the way ahead.

Before the operation

Shortly before I underwent thymectomy an understanding ward sister suggested that a visit to the unit to see the gadgetary

and surroundings would be very reassuring before actually waking there after the operation. This was an excellent idea since it was not only reassuring but also educational; I was also able to meet some of the staff who would be looking after me. Clearly this ideal is not always possible, but it was made possible for me and I was grateful.

Education is important, not only for the patient but also for his colleagues and family. Since rumour is always rife in a large institution such as a teaching hospital, I warned my colleagues, as well as my family, that I should be going straight from theatre to the ITU, so that when they heard I was there not to assume that there was trouble.

The main problem of postoperative care for a patient with myasthenia gravis is maintaining the function of the intercostal muscles and lungs: before the advent of ITUs tracheostomy was routine for patients such as myself in many centres. Because of the weakness of the muscles, premedication with drugs such as diazepam may be contraindicated, as are muscle relaxants in association with the anaesthetic. The anaesthetist explained that the anaesthetic procedures would be designed to reduce medication to a minimum, with the object of ensuring good respiratory function as soon as possible and so enabling the endotracheal tube to be removed early. In discussing this (and I was grateful for the way my colleagues included me in the discussion) I suggested that since I was being operated on first on the list I should not be premedicated, so that all those concerned would have the best conditions for doing their job. As it turned out, I needed relatively little medication in the ITU either so that, in some respects, I was not typical of most patients being cared for in the units. My memory of the two days there is therefore clearer than that of many patients.

In the ITU

On the morning of the operation anaesthesia seemed to be induced very smoothly and my next memories are of waking, surprisingly peacefully, in the ITU.

What was it like to be there? The predictions were pretty accurate. My earliest memory is of waking somewhat befuddled but not feeling so bad as I had expected and without any sense of nausea or major discomfort. But thymectomy is, after all, relatively simple.

I must have dozed and drifted intermittently but it seemed a very short time before my wife was at my bedside, not only encouraging me but clearly delighted with the fact that the operation was over and that I looked much better than she had expected so soon after surgery. Being attached to the monitor was reassuring and, apart from occluding my arterial pressure recording from time to time (with a consequently swift investigation from sister), it caused no real problems apart from restricting my movements. Certainly my wife was impressed at being able to watch the smooth and even functions being recorded on the screen.

ENDOTRACHEAL TUBE

Several recollections stand out, mainly the endotracheal tube and the constant light. I had been warned that the tube would be unpleasant but that proved to be an understatement. A constant feeling of choking and gagging is my main memory, even though the tube was not left in place for more than a few hours. Moving, whether head or body, was grim, and the stern exhortations from the nursing staff to relax and not fight the tube were impossible to comply with. I listened subsequently to the same exhortations to other patients, including those who were fairly deeply sedated. Intubation was the one feature that most people really disliked, and is the only thing that would prevent me from welcoming a return to an ITU should the need arise.

While the tube was in place it had to be sucked out from time to time. I was surprised that this was not a disturbing procedure and it was quite interesting to listen to the gurglings coming from deep within one's chest without being distressed. Thankfully, it was only a few hours before I was extubated. My relief was almost unbelievable. I had also been warned to expect a very sore throat but I was lucky that there was little soreness and I was soon able to talk, which certainly caused me satisfaction, though it probably gave the nurses less peace.

Compared with many patients in the unit, who had undergone cardiac surgery, I was much less surrounded by the paraphernalia of drips and drainage tubes. Nevertheless, I was pleased when I parted with my single thoracic drainage tube, partly because of the restriction on movement that this caused but mainly because of the discomfort produced by the regular "milking" of the tube to keep it clear and drainage active. This produced a very strange sensation, not really painful, but distinctly unpleasant. To my surprise, removing the tube was not uncomfortable. I was told to breathe deeply and then the quickness of the hand deceived the eye as the lengthy tube was produced.

LIGHT AND NOISE

I had also been warned that the constant light might be trying, and full overhead illumination 24 hours a day, when you cannot turn over to avoid it, can be uncomfortable. The second night, when I had been disconnected from the monitors and felt much better, was, in this respect, the more difficult of my two in the unit. I did eventually drop off to sleep, only to be woken by sister gently shaking my shoulder to see if I was still breathing since I was lying in bed so peacefully.

By contrast, the noise came as a surprise. I had expected a quiet atmosphere rather like that in a coronary care unit and that the patients in intensive care must be pretty ill to warrant this form of nursing. But I had, of course, overlooked several factors. Firstly, most patients were fairly heavily sedated and not receptive to ambient noise, so there was a lot of chatter and the radio was on for much of the day. Because of the sedation, staff had to speak to the patients loudly, often, and with apparent severity to communicate with them. This difficulty in communication is two way, since a sedated and intubated patient, feeling in imminent danger of choking, finds it very hard to make his thoughts known. Frustration is inevitable. I listened to several attempts at conversation between nurses and other patients who clearly wanted to say or do something. Each time it seemed to be a variation of "Twenty Questions," which often ended without the objective being discovered, after a final query "Is it important?" and then, "Well if not, try to forget it and relax."

TREATMENT

Another major factor, I realised, was that this form of nursing really is intensive. Before admission I had wondered about the implications of the gradual change in the title of these units from "intensive care" to "intensive therapy." In the light of my stay

there I realise that active treatment, rather than passive care, is just what patients receive. There seemed to be very few minutes when some form of treatment by nurses or a physiotherapist was not being administered.

This form of nursing requires constant hard work of a particular sort. Each nurse's patient needs constant watching and frequent attention, yet the nurse must also be ready to help others with their patients, either for simple things such as turning them or for some aspects of their treatment. Because of the sedation there is also less response from the patient to the nurse and less encouragement, so the nurses must be largely self-sufficient and able to maintain their own morale at a high level. Nurses seem either to enjoy this form of work thoroughly or to actively dislike it. It must be difficult to be indifferent to it.

There were regular visits from the physiotherapist and radiographer. I had been warned about the physiotherapist by her colleagues on my ward: to be prepared for rigorous treatment to ensure the best start to my postoperative recovery. This turned out to be quite true, and her regular and insistent demand was for really deep breathing and active coughing to clear my lungs. The former was reasonable, particularly with her support and help, but the latter made me feel that everything would come apart at any moment. Thanks largely to the physiotherapist's ministrations, however, and, probably aided by my being a non-smoker, I soon had no residual problems with my lungs.

BEDS AND VISITORS

One source of discomfort I was not really expecting was the bed. Hospital beds are not renowned for their comfort, but my bed in the unit seemed even more uncomfortable than most. It may have been suitable for a patient of 5 feet 8 inches, but one of 6 feet 1 inch just did not fit. Apart from overall size this was partly due to the function of the back rest, and when the foot board was eventually removed and pillows used to extend the bed, it became more comfortable. On return to the ward a standard hospital bed seemed almost luxurious.

Visitors were much less restricted than I had expected. The staff first made sure that my wife understood the surroundings and my condition and attachments, since some visitors may be upset by the environment and by the patients. My wife was a regular visitor and she commented on the helpfulness of the nurses. They went to great trouble to manage as much of their work as possible around visitors.

My second day in the unit, which was also my birthday, was largely precautionary and I was well enough to be out of bed for part of the time. Certainly this was one birthday I am never likely to forget. The next day I was on my way back to the ward—feeling almost well enough to walk but at sister's insistence conveyed by wheelchair, although I was soon able to be up and around for considerable periods.

Postscript

Two months later I look back on the time between becoming ill and being first admitted to hospital as a short bad interlude in an otherwise healthy life. I am now virtually back to my old self, on a low dosage of pyridostigmine, with all muscle groups functioning well and with very little diminution of activity. My chest healed swiftly and the sternum is coming along well, although coughing—and especially sneezing—is still far from enjoyable. I can look forward to my condition improving still further and I am very grateful to all who have been concerned in my care—the medical, surgical, and nursing staff who have looked after me so well. I am especially grateful to the nurses, both in the ITU and on the ward, for their constant encouragement and excellent standard of nursing, treatment, and care, despite all the difficulties and problems that attend work in our hospitals today.

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