

FROM THE INSIDE



# Knock, knock, knockin'... on critical care's door

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I do not understand why we could not stay with my father as now I stay with my son here. While he was in critical care we could only see him for a couple of hours per day, and no more than two people at a time. When my father was there, he said he felt completely empty, with nobody to share it with or to really talk to. He also said that maybe some procedures could have been performed under more analgesia, or maybe, at least with one of us there just holding his hand. He missed being asked, “how are you doing?” by physicians and nurses; he missed his radio programs, his new e-reader and his music. During those days, he also had questions to ask about his condition, but with no words or courage to address the doctors he remained silent. He used to say not only that he missed being healthy but also that staying in such [an] unfamiliar place made him feel completely lost...

These words were said by a father whose child was admitted to our paediatric critical care unit (PICU). As paediatricians we are usually taught to treat not only children's medical needs. It is logical for us to think that if they require their caregivers at home, when they are well, they need them even more at the hospital or in the critical care unit.

Nowadays, from the paediatric point of view, we observe how the paradigm of how to “take care” of adults in critical units is changing. Some people call it “humanizing intensive care” and we see as external viewers that many of these proposed changes are yet to be included as elemental parts of children's critical therapy.

In the PICU, our patients are usually unable to talk or express their feelings or needs, and this is not only because of their critical condition but because they are too young to do it. As paediatric intensivists we are

usually “surrounded” by parents and caregivers because we need them to fully understand our patients. They become fundamental partners for their management and we constantly try to include them in our focus. We request them not only to normalize, if it is at all possible, their children's state (“to bring home to PICU”) but also to initiate or optimize critical therapies. As an example, they know how to calm them down better than any of us prior to the initiation of a non-invasive ventilation procedure caused by a respiratory distress. They always explain to us how and what their children usually eat or help us to achieve better analgesia, especially in a postsurgical situation, through coadjuvant therapies such as their favourite TV shows, music or just with them breathing near. We frequently observe that respiratory weaning is much more effective and safe when a child sees that their caregiver is near as a “shield” from those strange people dressed in white or blue with unfamiliar voices.

It is usually said that paediatricians adapt therapies from those used in adults and, in some cases, even “copy and paste” our colleagues' knowledge to adapt the methods to children. Now we encourage you to “copy us just a little” in order to find the key to open the door we unlocked years ago. This is not a new technique or an incredible inotropic drug but it will probably improve your therapies. Certainly it will not be easy and the adjustment period would be a difficult challenge; but without any doubt, in this case, adults deserve to be treated as children.

**Compliance with ethical standards**

**Conflicts of interest**  
None.

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