

ICU Delirium

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It's hour 26 and I'm starting to drag. I can't yet tell if the hour of sleep has helped or amplified my delirium. The faint layer of sweat and grime accumulated on my skin is begging for a shower. I'm beginning to lose trust in my once faithful sensations. Nausea builds slowly and somehow competes with hunger for the dominant sensation despite hours of stress eating. Staring at the computer screen, my notes coalesce into one amorphous word cloud: "pressors," "antibiotics," "goals of care." Two hours left.

"Bed 9 is dropping their pressures and Levophed is up to 0.4; do you want to change the UF?"

"Bed 6 is having chest pain and she's tachycardic."

"Bed 3's family wants to discuss the plan with you."

The intensive care unit (ICU) is a unique combination of patient acuity and provider availability that surrounds me in a constant barrage of tasks that, at times, feels like fighting the waves just to stay afloat. I sit in a central space with a bank of computers, rolling chairs, and scattered patient records from far-flung hospitals surrounded by patient rooms, often in sight of the patients. Nurses, pharmacists, and respiratory therapists line up, sometimes 3 deep, with questions pertaining to the critically ill patients to whom I'm charged with caring. I answer each question in quick succession, returning briefly to reviewing labs and images, calling consultants, updating families, and performing invasive procedures before the next demand arrives.

"MAPs are dropping on bed 12. What would you like to do?"

"Bed 3's family has to leave in 15 minutes, and they really want to discuss the plan."

"Bed 10 is trying to rip out his ET tube. Can we go up on the propofol?"

On other services, there is space between the endless volley of small catastrophes provided by paging systems that allows triaging of various tasks. The diet order can wait, while the patient with new hypotension and confusion cannot. Team rooms are often in remote areas of the hospital, removed from the omnipresent chirps of telemetry alarms, the robotic to and fro of ventilators, and the constant parade of nurses, consultants, and families. It is in these moments that I relish a moment of thought

untainted by a new demand or concern. Control of your time and the ability to triage as a trainee while you learn medicine and all its accoutrement is a luxury. The ICU, however, affords no such luxuries, but offers a distinctly different type of education.

Working in the ICU as a trainee has taught me to react and then think. The moment I lower myself into the chair, log into the computer, take my first sip of already stale coffee, and begin a coherent thought on the 65-year-old male with undifferentiated shock, new thrombocytopenia, and renal failure, I am greeted by:

"So, the patient in room 14 hasn't made any urine in 3 hours, is febrile to 102, and now is altered."

The only way to protect yourself is to learn quickly, to adapt. Early on, I reached for UpToDate or spoke to my senior resident before acting. Through experience and countless mistakes, I have learned to react to provide enough time and space for critical thought.

"Please get a set of blood cultures, start vanc/zosyn, and LR wide open, and I'll put in for some Levophed in case we need it."

Reaction creates a moment to step back and account for all the details that precipitate hypotension, hypoxia, or bradycardia. These moments, when I have a second to think, illustrate just how far I have come. Just as often they remind me of my many limitations and how far I have yet to go. This duality, thinking while simultaneously not thinking, is the *raison d'être* for ICU training in residency. The ability to acutely stabilize a decompensating patient while simultaneously identifying the cause of their decline is a foundational competency of medical education for many specialties. This experience helps prevent "freezing" in the moment when confronted with an acutely ill patient and has bred in me a confidence and a healthy fear of complications for my patients not present before my time in the ICU. The palpable fear and anxiety I felt previously when faced with a decompensating patient has been replaced with a plan and a process. React, then think.

I hang my battered, coffee-stained white coat on the hooks adjacent to the workstation. I slowly collect my things that have scattered in an increasing radius from my workstation with the stress of the night. I try to remember if I forgot to call a consultant or place an order for a follow-up lab. I pause and remind one of my colleagues to remember to talk to vascular surgery

on bed 9 and begin to walk out of the unit. As I walk toward the parking garage bathed in the morning sun I am struck by the contrast to my mental state. How can I be so tired when the sun is only just rising?

I start my car and drive slowly with utmost caution out of the parking garage, taking care to compensate for my post-call delirium. I pull into my driveway, enter my apartment, and shed myself of all things: clothing, insecurities, research mentors with whom I need to follow up, and questions left unanswered. I slide into bed and feel the welcome warmth of the

bedsheets against my skin. In the ICU, the beds beckon with questions, alarms, and emergencies alike, but here, in my bed surrounded by darkness, silence is the dominant sound. Slowly, I fall into a deep sleep, hoping to stay only there for another 28 hours.



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