Editorial

The pleasure of being an anesthesiologist-intensivist

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"When a human being has a why, he can go through any how"

Viktor Frankl

Editorial

The academic life of a medical professional is full of goals, it is a long journey to walk in search of each one of our objectives, enjoying the successes and remedying the failures until the moment of retirement. As a teenager, my life goal was to be a doctor and once this intermediate goal was reached, I decided to become an internist. A few months before the end of 4 years as an internal medicine resident, I was at the precise moment in my life when I had the pressing need to modify, to complete my medical training, to find myself as a subspecialty medicine professional. At that time, I wondered if internal medicine fulfilled my aspirations to serve and heal people? If it would be my modus vivendi throughout my professional life? I realized that I wanted a more dynamic, more powerful spark. Something that would combine medical knowledge with manual skills at critical moments. That something that causes us to leave the comfort of an achieved goal, that induces us to overcome some dissatisfaction to go further, to emerge into another dimension, is a factor that varies in each person throughout our existence. Something related to a certain moment, to consummated achievements, to the search for happiness. I had not finished reading that huge and complex textbook known as *"The Harrison"* when I became interested in critically ill patients, which led me to seek formal training in intensive care medine.

Luckily for me, at that time the residency in critical medicine also included simultaneous training in anesthesiology, with a dressing in pain management. I must say that during the first two months of this mixed residency, I didn't really understand why this program was as complex and difficult. *"What a combination I thought back then"*. I had no idea where I was going, what I was getting myself into, and above all, I had no idea of my professional future. However, I was glad to experience a new change in my intellectual formation. There were my mentors with their teachings, their continuous demands and example who took us step by step in this new specialty. I learned that my critically ill and non-severely ill patients were in the operating room, in the postoperative recovery room or in the Intensive Care Unit under the effect of anesthetic drugs and anesthesia adjuvants, sepsis, with or without multiple organic failure and other acute pathologies, required the solid training that the residents of this dual program received, characterized by a combination of knowledge and skills, which did not guarantee success in all cases, but did satisfactorily solve most of the challenges.

The change of scenery was not easy. The new environment was arduous, demanding, inflexible, overwhelming. That type of training that does not admit mistakes, that gives little time to act, that seeks excellence as a symbol of the brand. I had to get on an academic train that was going at high speed, a vehicle that would take me to a happy academic life where I completely found myself with that professional exercise that I desired for from the most intimate of my love for being a doctor; to become an anesthesiologist-intensive care provider.

Without losing the importance of being an internist, the new challenge of critical medicine and anesthesiology suddenly changed my life, my professional approach. A positive adjustment, with permanent challenge, with continuous scientific advances, full of successes and failures where death lurks moment by moment, in which victories were only part of an obligatory defy. Having made a decision to change caused me uncertainty; hesitation that I resolved without losing the meaning of my elementary preparation, but including that knowledge with the certainty of seeking pleasure in a novel context related to the seriously ill, the perioperative patient who needs to quickly resolve their health through one or more surgeries where anesthesiological care is vital, as is perioperative care and pain management.

Undoubtedly, any change gives rise to regrets, disagreements, confusion, suffering, ruptures that can generate crises. However, when you have the how, you just have to find a way that leads to full professional happiness that makes it easier to care for the health problems of your patients.

On the other hand, this way of practicing medicine entails the need to teach the new generations, to be an integral part of their professional training, as well as to establish clinical research projects, to publish, to give lectures and other academic activities that keep us updated. Being Born in 1946, I am privileged to be an aging baby boomer doctor, one who has been fortunate enough to enjoy living in two extremely different centuries; 20th century medicine received an ancestral legacy of knowledge full of illusions, of professional ethics, of love for our profession. A time when the Hippocratic Oath was part of each of our medical actions, a time when we used a manual cuff to measure the blood pressure, a mercury thermometer, a monitor with a screen so small and pale that it was difficult for us to see more than four PQRS complexes. Arterial blood gases were mandatory to determine perioperative oxygenation and acid-base status. We learned regional anesthesia guided by our mentors through anatomical references, and if we were lucky, using neurostimulation devices.

The end of the last century and the beginning of the 21st century was accompanied by enormous changes; new drugs, technological advances unimagined in the post-war period that saw us born. Pulse oximetry, capnography, monitoring equipment integrated into compact and intelligent anesthesia machines that almost whisper in our ears the hemodynamic and metabolic changes of our patients, thus facilitating the modifications of our anesthetic plan. Ultrasound-guided regional anesthesia has been gaining by leaps and bounds a very special place in our specialty, as has the use of new local anesthetics and adjuvant drugs. Airway management was modified with video laryngoscopes

and the advent of the laryngeal mask, leaving difficult airway problems in the past. Artificial intelligence is another recent topic in our professional practice, with very high expectations and surely already having a high impact on our specialty.

Despite these advances, clinical medicine continues to occupy a prominent place in the comprehensive management of each of our patients. Old, not so old, and new generations of anesthesiologists-intensivists must observe the elementary principle *primum non nocere.*

Being an anesthesiologist-intensivist is an activity very close to professional perfection in relation to the care and safety of each patient in the perioperative period. Separately, each of these specialties has earned the respect of patients and surgeons, recognition that grows when both specialties are combined in a single person as the range of safety is extended in this critical time frame. The extensive knowledge of physiology, pathology, pharmacology and, of course, the clinic that an intensivist has, together with the wisdom and manual skills of a good anesthesiologist, are the ideal couple both in the operating room, in post-surgical recovery, and in the intensive care unit.[1-6]

Having simultaneously practiced anesthesiology and critical medicine during four decades has been a unique professional pleasure of its kind, a complete satisfaction that I enjoyed every moment of my professional life, and that as a very special achievement led me to be the chief editor of the Journal of Anesthesia and Critical Care:Open Access, which has given me the unique opportunity to read ahead of time the unpublished ideas of colleagues from diverse regions of our planet; from sites with unlimited resources to places where the available technology is scarce.

Recognition

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Conflicts of interest

None.

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