

Preface



Peter E. Morris, MD, FACP
Guest Editor

Dedication

To our patients that we continue to work to relieve their suffering and that we may slow and prevent the effects of disease whenever possible.

A special dedication to Dr. Kathy Stiller, whose work has focused numerous critical care practitioners on the importance of early ICU mobility. Through her direct contribution and the effect of her work stimulating others to contribute to critical care, numerous patients have had, and will have, their suffering and their morbidity reduced.

A few people have asked how one develops an interest in ICU mobility. It typically is not something first envisioned on a black board or developed hypothetically. The concern usually grows out of direct patient care and discussions on daily ICU rounds. What drives this search for improvement comes from examining critically ill patients and witnessing the devastating ICU-related physical changes, even in the previously normal person, following their time and treatment in the ICU. For many in the critical care field, early ICU mobility therapy provides an opportunity to do more for our ICU patients. Waiting until a person is assigned a floor bed to address the issues of mobilization seems too long a wait, particularly for those who have profound weakness and skin breakdown.

In developing this *Critical Care Clinics* issue, my discussions with other intensive care providers first tried to establish what was known about ICU mobility. I came away with a sense that critical care medicine's approach to early mobility was certainly not as developed as other areas of critical care medicine.

When I went to the literature, I was elated to find a special work from Dr. Kathy Stiller. I found Dr. Stiller's article in *Chest*, "Physiotherapy in Intensive Care: Towards an Evidence-Based Practice," that pointed out the vast deficiencies of knowledge but was written in a way to be inspiring [1]. In her review, Dr. Stiller comments, "Although there is unequivocal evidence that prolonged bed rest results in deconditioning, to my knowledge, there are no published data involving intubated patients receiving mechanical ventilation that investigate the effect of mobilization on pulmonary function, the resolution of pulmonary disease, weaning from mechanical ventilation, or the length of ICU stay." Initially reading that passage, I thought, "this can't be true; there must be those types of data out there—certainly someone has studied this topic sufficiently?" Unfortunately, Dr. Stiller was right.

A growing number of intensive care practitioners have been in search of such data for several years now. Such data will be vitally important and will help shape a culture of critical care practitioners (including hospital, government, and insurance administrators) to view early ICU mobility therapy as a necessary aspect of care. Mobility therapy will not be inexpensive, so data are required to help administrators decide where to spend shrinking health care budgets. Although movement and mobility in ICU patients seems intuitive to most of us who work in the critical care area, it is striking that not more study has centered upon this important subject. Luckily, attention to this important area of critical care is increasing, and it is increasing rapidly.

In this issue, a multidisciplinary group of intensive care practitioners from Australia, Europe, and North America have contributed their insight on the topic of early ICU mobility therapy. Their writings hopefully will provide meaningful contributions of thought regarding early ICU mobility. These authors have covered many of the current problems concerning

barriers to early ICU mobility. The various articles review work that provides the reader with a familiarity of the diverse areas of scientific study contributing to early ICU mobility concepts. Many of the authors have pointed out the barriers inherent in our current care models to the administration of early ICU mobility therapies. Possibly the most meaningful characteristic of these articles is their ability to serve as a “roadmap” for more study so that the most effective and efficient ICU mobility care may be provided.

Peter E. Morris, MD, FACP
*Section on Pulmonary, Critical Care
Allergy and Immunologic Diseases
Wake Forest University School of Medicine
Room 3141, 3rd Floor Gray Building
Winston Salem, NC 27157, USA*
E-mail address: pemorris@wfubmc.edu

Reference

- [1] Stiller K. Physiotherapy in the ICU: toward evidence based practice. *Chest* 2000;118:1801–13.