SOAPBOX

The missed art of care?

They are standing around my bed talking about my heart rate and blood pressure, concerned because it is so high. I know why it is high.
The alarms are going off.
I can feel my heart pumping.
They don't know I can't breathe when I am flat.
They have not asked me if I am ok.
They say I am anxious.
I have pain and can't breathe.
My hands are tied to the bed.
I can't move.
I can't breathe.
Please lift me up so I can breathe.
Someone … please … ask me what is wrong.
(Adult critically ill patient with multiple rib fractures)

The intensive care unit offers lifesaving interventions, but these interventions are often accompanied by loss of patient autonomy and, at times, even dignity.[1] Loss of control over one's body, inability to communicate needs, fear, and loss of identity, to name just a few, contribute to patients' vulnerability, suffering and dehumanisation in the ICU.[1-4] Unless we specifically and intentionally attend to these, how are autonomy, non-maleficence and beneficence applied in our care?[5] The harm that may arise is from the neglect of adequate respect and in turn the erosion of one's dignity.[2,6] Perhaps one of the biggest dangers of dehumanisation is that it can occur slowly and silently over time and is perpetuated by a lack of respect of persons – patients, families and staff alike.[1]

The negative effects of such 'care' may be significant and last well beyond the ICU.[3,7,8]

There is growing evidence that measuring survival is not sufficient to determine the effectiveness of our ICU *care* – is it about the quality of the life saved or the death died?[9] While there many unpreventable risk factors for morbidity following an ICU stay, many are preventable and are care/culture-induced risk factors. A recent systematic review looking at risk factors for increased morbidity following an ICU stay found that a negative patient experience is one of these preventable risk factors.[10] Surely we can all play a role in rehumanising the ICU and returning dignity to the people entrusted to our *care*?[2]

Communication, and where possible dialogue, is probably the simplest tool we can use to return some dignity, autonomy and identity to the person.[2-4,11] This communication enables health*care* providers to see Bed 5 as more than the polytrauma patient, as *someone* with a past, present and future; and this communication is essential to person-centred care and to mitigate many of the negative experiences in the ICU.[2,12] When engaging in such communication, we as health*care* providers need to be cognisant of the inevitable power relationship that occurs when one member in the conversation is limited.[13] It is not, however, merely speaking to and listening to the person, but speaking and listening with empathy – engaging with them with compassion from and between all members of the interdisciplinary team.[4,14]

Admittedly ICU environments are not the most personal environments, and as Francis Peabody asked, how one can be more personal (person centred) in an impersonal environment?[15] Perhaps the first port of call is to stand back and look at ourselves. What are we as healthcare providers bringing to our interactions? What are our biases, attitudes and assumptions that we carry with us?[4] How are these impacting on our behaviour?[4] Are we reflective in our practice – aware of our assumptions and behaviours, and able to acknowledge and remedy these?[4] What are our contributions to the environment and the culture in which we work? However, in the same breath, we also need to acknowledge how the environment and culture impact on us as health*care* providers.

As much as the ICU is a stressful environment for patients and family members, its toll on health*care* providers is increasingly being recognised.[16] In our post-pandemic world today, a pandemic during which health*care* providers had little time to breathe, the effects of the ICU environment on staff are likely to be amplified. Disengagement as a result of self-preservation or emotional fatigue may contribute to a decline in empathy, and consequently to the dehumanisation one may experience in the ICU.[2,14] Increasing cynicism around one's job related to systemic culture, process and infrastructure may further perpetuate the healthcare provider's approach to patient care.[1-3,14] To what degree do we feel seen, heard and respected in our environments?[1] The aforementioned factors are likely to be symptoms and/or contributors to staff burnout, which further impacts on the *care* we provide.[3,16,17] As health*care* workers we need to recognise that we too are human, and part of humanising the ICU is humanising it for us also.[2] Improving *care* to patients may start with improving *care* for staff, and calls for leaders and advocates to sound the alarm, and calls for change at systems level as well as with us as individuals.[1,2,4]

How are we embodying *care* to ourselves, our colleagues and, most importantly, those entrusted to our *care*?

One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is caring for the patient.
(Francis Peabody,[15] 1927)

Alison Lupton-Smith, PhD, BSc (Physiotherapy)
Division of Physiotherapy, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa
aluptonsmith@sun.ac.za

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