HOPE AND CHANGE IN CRITICAL CARE

By Cindy L. Munro, RN, PhD, ANP

I am pleased to follow in Dr Kathleen Dracup's footsteps as the new nurse coeditor of the American Journal of Critical Care. The founding editors of this journal, Dr Dracup and Dr Christopher Bryan-Brown, have provided a wonderful legacy of interdisciplinary excellence, and I am looking forward to working with Dr Peter Morris as we continue to facilitate the dissemination of research and practice information to improve patient outcomes.

I began my journey in critical care nursing in 1976, when, as a new RN diploma graduate, I was responsible for all 4 of the "monitored" beds in our small rural hospital. I have also worked in large critical care units and taught critical care nursing to undergraduate students after earning my master's degree in cardiopulmonary nursing. A desire to participate in research led me to a doctoral program focused in microbiology/immunology, which strengthened both my laboratory skills and my appreciation for interdisciplinary work. I am now a professor at Virginia Commonwealth University, where the quality and enthusiasm of our students gives me great hope for the future of nursing.

Much of my time is spent performing research in critical care units and in basic science laboratories, and I highly value both my nursing colleagues and my interdisciplinary collaborators. Over the past 15 years, my scholarship has focused on improving outcomes for critically ill adults through evidence-based nursing practice and implementation of best practices to reduce the risk of ventilator-associated pneumonia—one of the most significant complications associated with critical illness and an important patient safety issue. I maintain my skills as a nurse practitioner on a volunteer basis at Petersburg Health Care Alliance in Virginia, where the staff and my patients keep me firmly grounded in clinical practice.

Two themes, hope and change, have been prevalent in recent American discourse. Both of these themes have been of interest to the nursing discipline since I became a nurse in the 1970s, and these themes remain timely and particularly relevant to critical care practice.
Hope Defined

To hope is "to desire with expectation of obtainment" or "to expect with confidence." Verhaeghe et al. recently defined hope as "keeping a possible positive outcome in mind in an uncertain situation, even if one knows that this outcome is unlikely to happen."

In the 2004 speech at the Democratic National Convention that propelled him into the national spotlight, Barack Obama introduced the concept of a politics of hope. He said:

I'm not talking about blind optimism here—the almost willful ignorance that thinks unemployment will go away if we just don’t talk about it, or the health care crisis will solve itself if we just ignore it. No, I'm talking about something more substantial. It’s the hope of slaves sitting around a fire singing freedom songs; the hope of immigrants setting out for distant shores; the hope of a young naval lieutenant bravely patrolling the Mekong Delta; the hope of a millworker’s son who dares to defy the odds; the hope of a skinny kid with a funny name who believes that America has a place for him, too. Hope in the face of difficulty. Hope in the face of uncertainty. The audacity of hope.

I would add to these exemplars of hope that of a nurse at the bedside of a critically ill patient. Hope is a central concept in health care, and critical care practitioners are well acquainted with the audacity of hope in the face of difficulty and uncertainty. We have sustained our professional lives with a belief that many, if not all, of those in our care will survive their critical illness and later thrive. We have been on the front lines as families coped with devastating situations and helped them as they parsed hope from the sometimes bleak information we were obligated to impart. Every day, we persevere with hope for our patients in situations that may seem hopeless.

The Importance of Hope in Family Members of Critically Ill Patients

Shakespeare wrote, “The miserable have no other medicine but only hope.” In the critical care setting, even though advanced treatments are available, supporting hope becomes an essential part of the patient’s care. Much of the focus regarding hope in critical care has been on the role of the provider in assisting patients and families. In 1979, Molter published the “Critical Care Family Needs Inventory,” a landmark tool that has been widely used and well tested over the past 30 years. The recognition of a need for hope was one of the original items (“To feel there is hope”), and subsequent research has continued to support the critical role of hope for family members of critically ill patients.

Recently, attention has focused on end-of-life and palliative care situations, where we seek a careful balance between maintaining hope and avoiding false hope. In a qualitative study of 24 families of patients with traumatic coma, Verhaeghe et al. reported that hope was a central theme of their experiences. They found that accurate, complete, understandable information was intricately entwined with maintaining realistic hope. Incomplete or incorrect information led to false hope, where family members hoped for something impossible. The quality of information from providers can thus either support or undermine family hope.

The Importance of Hope for Care Providers

But what of our own hope? Our own hope in caring for our patients permeates our practice in every patient encounter. In addition to addressing family need for hope, it is necessary to recognize what desires and expectations providers themselves bring to the bedside. The maintenance of hope in a context of full recognition of the patient’s clinical situation is difficult but necessary. Depending on the patient and the situation, we cherish a hope of healing, or a hope for recovery, or a hope for preserving function, or a hope for a peaceful death.

About the Author
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The Importance of Hope in Critical Care Research

Hope also drives research. Nowhere is hope more evident than in critical care research. Researchers develop hypotheses, design studies, collect data, analyze and seek publication of study results, all in the hope that their work will improve outcomes for critically ill patients. This is hope that moves beyond the individual patient to larger groups or whole populations. Researchers do not randomly select interventions to be tested—rather, they test those interventions that they expect will have the most benefit for patients. The current emphasis on translational research, and concomitant pressure that findings from the research setting quickly move to inform clinical practice, is an expression of society’s hope that research can indeed make a positive difference in patients’ outcomes.

Given the investment of hope that researchers must make in developing and testing research interventions, it is not surprising that many investigators are reluctant to believe data that challenge their expectations about the outcomes of a study’s interventions when those data contradict a fond hope. Courage is required to act on the evidence rather than on our preconceived notions of the world. Hope for improving outcomes for patients is required to maintain our focus.

Change and Its Relationship to Hope

Change is central to practice, and it is particularly characteristic of critical care practice. Practice today is different from yesterday, and it will be different tomorrow. We should welcome change when that change is in a direction that honors our hopes for patients. Publication of research and translation of research into practice are central to this change. What is shown to work is added to practice; what doesn’t work is removed.

There have been recent changes in the American Journal of Critical Care as well—changes in the look of the journal, in the format of articles, changes in coeditors. These changes have honored the hope that is the central mission of the journal, to “provide its readers with clinically relevant content in every issue and to serve as a vehicle for the American Association of Critical-Care Nurses to achieve its mission of improving the care of critically ill patients and their families.”

This is an exciting time for critical care and for the journal, and I am certain that more changes will occur. As the journal moves forward, finding innovative and cost-effective strategies to disseminate the knowledge necessary for critical care practice will be both challenging and rewarding. I believe that there are exciting opportunities ahead, and I am grateful to contribute to improving the care of critically ill patients and their families by serving as nurse coeditor of the American Journal of Critical Care.

The statements and opinions contained in this editorial are solely those of the coeditor.

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FINANCIAL DISCLOSURES

None reported.

REFERENCES

4. Shakespeare W. Measure for Measure, Act III, scene 1, line 2.

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