Getting Used to It

By Richard H. Savel, MD, and Cindy L. Munro, RN, PhD, ANP

During medical crises or the delivery of bad news, families of intensive care unit (ICU) patients sometimes look at caregivers with shock and misunderstanding. In their sadness and despair, naturally they seek professionals who know what they’re doing and who care about their loved ones, but they don’t always sense that caring in our expressions or responses during such stressful situations. It’s a paradox: as we become experienced clinicians and do this work day in and day out, we become increasingly competent and clinically adept, but we may lose the expected look of “shock” on our faces. How should families interpret this? Does it mean we lack compassion?

Although the surgeons or primary care providers (PCPs) with whom families come into contact may not have cared for a critically ill patient for some time, we in critical care may have treated such patients yesterday, even moments ago. When we make a rapid assessment that a patient has septic shock or acute respiratory distress syndrome, the fact that we make such an assessment quickly is a sign we are qualified and good at our jobs, not that we are giving the patient short shrift. On the contrary, we work this way because time is of the essence!

In effect, we want to say to these families, “Please don’t be upset with us if we don’t recoil in shock every time we must care for a critically ill patient. We care for such patients every day.” It is especially hurtful when loved ones and families imply that we do not care as much for a patient because a PCP or surgeon has known them longer. We are proud members of the international critical care community, and we care very much indeed. We have complex problems to deal with and some of our patients may have no recollection of us at all. Emotionally, some family members want to move quickly past the time they spent in the ICU, when things were on the edge, and that’s understandable.

The Problem of Misunderstanding

As we have asserted in previous editorials, being a member of the critical care team is truly a calling.1-3 Yet it’s not uncommon for those outside the circle of critical care practitioners to misunderstand and misinterpret us. In such circumstances we must rely on each other to ensure clearer communication about our clinical approach and why we do things the way we do.

Interestingly, PCPs, surgeons, and patients’ families have at least one thing in common: none want their loved ones or patients in the ICU. Because families and other caregivers can be angry, distraught, and potentially mistrustful, as an ICU team we have

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one shot to make a good first impression. Unfortunately, others occasionally misinterpret our quiet confidence as indifference or lack of caring.

Again, it can be hurtful to any hardworking, devoted, and concerned member of the ICU team when others imply we do not care, or that somehow we do not understand. Alarmed, they sometimes blurt out things like, “but my patient is critically ill!” Yes, we know. All of our patients are critically ill. Diagnosing and treating them is what we do day after day, year after year. We are not in any way diminishing the fact that this person is critically ill, but it is not a surprise to us.

Remember What Is Important

We must, as consummate ICU professionals, rise above our emotions. Our care is focused always on patients and their families. We do not have the luxury of becoming agitated or unglued. We cannot internalize others’ angst or take it personally. Patients, families, and other caregivers rely on us to be calm, cool, collected, and caring during the crisis. Remembering such a thing is one of the greatest challenges to our profession.

Reconciling such tension is important. We are highly trained, highly skilled, and highly caring professionals, but critically ill patients, their families, and their physicians often can be anxious, agitated, upset, and angry (the list of potential negative emotions is long) with us. As a profession we need to shine a bright light on this fact and deal with it head on.4 It is in everyone’s best interest that we use our emotional intelligence to handle such tensions wisely while providing the high level of technical care required to treat the modern critically ill patient.6

To ensure a brighter future in this area, we must focus on innovative ways to improve the system. We think it’s more than conflict management or dealing with moral distress, as important as those factors are: failure to deal adequately with the tensions and misunderstandings we’re talking about here can lead to burnout and loss of valuable members of the profession. One area for improvement is for us to better market our profession.

During the massive assemblies called Super-Sessions at the annual American Association of Critical-Care Nurses National Teaching Institute, the remarkable positive energy in the auditorium is electrifying and palpable. Capturing energy from whatever professional gatherings inspire us, putting it in a bottle, and bringing it back to our hospitals would be a step in the right direction. Furthermore, educating the marketing and communications departments in our hospitals about how vital what we do in critical care really is and how we contribute so significantly to the infrastructure of our hospitals is mission critical.

As a unified group of critical care specialists, we all must do our part to get the word out about what we do. We must shout from the highest rooftops that no matter what comes our way, we can handle it, we will handle it, and we will do so with composed, caring professionalism. When a family member, surgeon, or PCP comes to us with a look of discontent or a voice pitched high with distress, we can hold our heads up high and say—easily, and with great compassion—something like this:

We are very sorry this has happened. We are sorry your loved one/patient has become critically ill. We did not cause this, but we will do everything in our power to make it better. Please know that this is all we do. We do not work anywhere else. All of our patients are critically ill. Please do not misinterpret our calm, confident caring as indifference simply because we do this work all the time. Please do not imply that we do not care as much as you do because we met your loved one/patient only just now. Caring for this patient will require a tremendous amount of hard work and coordinated effort. There will be ups and downs. We will update you every day (and more often if needed). Your loved one/patient is critically ill. We can promise you this: no matter what happens, our team will be with you every step of the way. We understand and we care.

About the Authors

Richard H. Savel is coeditor in chief of the American Journal of Critical Care. He is director, surgical critical care at Maimonides Medical Center and a professor of clinical medicine at the Albert Einstein College of Medicine, both in New York City. Cindy L. Munro is coeditor in chief of the American Journal of Critical Care. She is associate dean for research and innovation at the University of South Florida, College of Nursing, Tampa, Florida.
Solutions Exist at the Local Level

Each hospital and ICU must tackle this problem at the local level. For some readers, perhaps, these issues are not significant problems. For those of you who do have this problem, however, the more resources you have to deal with it, the easier it is to manage. Having a separate team member who is devoted to interfacing with families to coordinate and facilitate their medical and nonmedical questions could make all the difference. These special members of the team might have different titles at different institutions, of course: they could be social workers, members of the patient relations or patient representative department, even members of the clergy. A simple pamphlet explaining to families how care is organized in the ICU and describing some of the basic procedures that patients might encounter can enhance the family or caregiver experience.

Another idea is to consider the creation of a family orientation video that can be viewed on a computer in the family waiting room. Such a thing could provide a more structured and understandable approach for families and could help them see that the ICU team is proud of what they do and is committed to taking a deliberate and compassionate approach to care.

There are 2 important aspects to this problem and we should tackle them both at the same time. The first is that we must help other members of the critical care team deal with the challenge of a constant presence of families and other physicians who might encounter can enhance the family or caregiver experience.

Conclusion: Finding Balance

Part of our job is to acknowledge that these stressors exist so we can nurture the best and most effective responses to them. We must use our positive energy and expertise to be there for families and other clinicians. We also must make sure we are able to find balance in our own lives to replenish our positive energy so we do not respond or get caught up in the stress-laden situations all around us. Unfortunately, there are no easy ways to find that life balance while remaining strong, caring, compassionate critical care clinicians. Seeking meaning with family and friends and in spirituality may be the best place to start.

Although we may grow accustomed to caring for the critically ill, we must reach the appropriate balance, always reminding ourselves how incredibly difficult and stressful it is for the families of our patients in intensive care while never allowing ourselves to slide down the slippery slope of pessimism, cynicism, and burnout.

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REFERENCES