Editorial

Principles of Narrative Critical Care

By Aluko A. Hope, MD, MSCE

I am humbled and excited to have recently been named the new physician coeditor of the *American Journal of Critical Care* (*AJCC*). I am grateful for the trust and support afforded me by the leaders of the American Association of Critical-Care Nurses (AACN), and I am lucky to be able to learn from my new colleague and coeditor, Dr Cindy Munro, with whom I share a passion for clinical research and critical appraisal. In this inaugural issue of the new calendar year, I have been given the space to introduce myself to the *AJCC* community. I thought it best to tell you a bit about myself, my perspective on critical care, and how I see journal communities like ours fitting into that vision.

Walt Whitman, in his poem "Song of Myself" wrote, "You shall listen to all sides and filter them from your self." My very desire to be a physician grew out of whispered family stories about my grandfather's illness: stories of treatments not received; sad, funny stories of how his strokes had transformed him from a gentle bon vivant to an irritable wandering lunatic. After medical school at the University of Pennsylvania, I studied primary care internal medicine at Columbia University Medical Center with the goal of mastering the incremental art of caring for older adults in the outpatient setting. Critical care medicine was not on my short list of possible specialties. Nevertheless, during my first rotations in the intensive care unit (ICU), I encountered seriously ill patients whose stories inspired a change in plans.

One of these patients was Mr X, who was awaiting a liver transplant in the ICU with complications from a portal vein thrombosis. One night, Mr X started bleeding from a central venous catheter site, and I was asked to attend to the bleeding. First, I tried a cross-stitch at the bleeding site. The bleeding continued. I then resolved to hold pressure at the site for a few minutes. As I stood over him for those few minutes, my hand pressing on his neck, Mr X spoke to me about his life. He spoke of the fact that he was a new father, that he and his wife had recently adopted children, that becoming a father had been his greatest achievement. He spoke of how hard it had been to come to terms with his vulnerable body, of his illness requiring of him a kind of "vigilant patience," by which he meant that he was both waiting for the possibility of rescue (the transplant), and yet was always ready for the possibility of a disruption (the bleeding or clotting body).[1]

Although as a young physician, I always enjoyed channeling my understanding of pathophysiology into the rescue of patients; it was stories like Mr X's that sparked my excitement about the possibility of a career in critical care medicine. After my training in internal medicine, I spent years training in pulmonary and critical care medicine along with training in bioethics, medical humanities, and palliative medicine—all with an eye toward practicing what I call "narrative critical care."

doi:https://doi.org/10.4037/ajcc2019164

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Narrative Critical Care

Narrative critical care, as I envision it, is a subspecialty branch within narrative medicine: an approach to medical care that orients itself toward careful attention to the skills of recognizing, absorbing, and interpreting stories as a means of improving the care of our critically ill patients.[2]

Often the hallmark of critical illness is that our patients cannot speak for themselves and highly technologic rescue is required urgently. In the face of these challenges, narrative critical care dares to practice a radical curiosity toward the critically ill patient's story. Each communication encounter with a patient or family member is titrated and dosed as if it were a medicine: carefully measured and paced in an effort to maximize its beneficial effects. Early in the ICU course, practitioners of narrative critical care might invite the family to speak broadly of the patient. Such an invitation might begin with a statement like, "We want to get to know your mother as a person, please tell us . . . about her." What follows such an invitation is a skillful attention to the story's structure and form, the kind of attention that presumes that each story is complex, that each story has layers of meaning.

Practitioners of narrative critical care pay close attention to the flow of each conversation with a patient or family member, not simply as a vehicle for shared decision-making, but as an intervention in and of itself. Such close attention means tracking both verbal and nonverbal communication; it means tracking informational as well as emotional cues. In the presence of emotions, the practitioner of narrative critical care sees opportunities to be an effective witness. Rather than trying to terminate or fix emotions, narrative critical care comes equipped with specific skills that allow for explicit attention to these emotions as they are expressed.[3] Such an inquiry into the affective domain might be a simple statement of recognition—"I can tell how frustrating this is for you"—or it can be a statement of respect or praise—"I am so impressed that you are here despite how hard it has been for you"—or it can be a willingness to silently nod or a willingness to hear more with an exploratory statement like "Tell me more."[4]

Narrative critical care accepts that stories are provisional, that stories can be contradictory. In trying to facilitate or extract the values of the sick patient, we become cartographers, aiming to match the patient's values with his or her diagnoses and prognosis.[5] Such map-making may begin with a question like, "Given where we are with your father's illness, what do you think would be important to him?" The first tentative response is gently probed for its meaning with phrases like "It sounds like . . ." or "I wonder . . . ." Practitioners of narrative critical care learn to develop a willingness to keep probing for more possibilities, for more of the patient's possible concerns, with questions like "and what else?"

Narrative critical care aspires to pay close attention to the words we use. One narrative practitioner may be inspired by the anecdotal evidence from cognitive psychology that the word "but" carries the risk of the listener missing all of what was said before it; such a practitioner may try to reconstruct sentences to substitute "and yet" for "but." Another may read a perspective on the use of "I am sorry" after the giving of bad news and decide to say instead "I wish things were different."[6] With such careful attention to the words we choose, we hope that what results is a clearer representation of what we mean.

Narrative critical care, as a multidisciplinary specialty, aims to mediate the multiple approaches that the various practitioners who work in the ICU bring to the clinical encounter. Each stakeholder comes with his or her own specific skills in attention and representation. Surgeons in the ICU may come armed with testimony from their knowledge of patients from the preoperative setting.[7,8] The nurse may come armed with testimony from seeing the family for hours at the bedside. The narrative impulse means that no one stakeholder is subordinated for another. The nurses' testimonies can be listened to alongside those of the physicians or the respiratory therapists. This demolition of hierarchy has the potential to attenuate the moral distress and burnout that can so often wreak havoc among our ICU staff.[9]

The practitioner of narrative critical care must also be aware that stories are socially constructed. This recognition insists that we acknowledge that our societal and organizational structures perpetuate implicit bias that marginalizes some stories more

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than others.[10,11] To say that stories are socially constructed also is to acknowledge that gaps in our social vocabulary may marginalize some kinds of stories over others.[12] If a patient's syndrome has not yet been named, we may struggle to distinguish the patient's story of a troubled body from his or her anxiety or mood. A commitment to a narrative approach becomes then a commitment to expanding one's moral sensitivity with deliberate reflection, humility, and mindfulness during each communication encounter.

After each communication encounter, the story is reviewed and presented with an eye toward expanding our moral imagination. Whether we are alone or with a group of learners, narrative critical care involves spending some time debriefing the encounter with questions such as, "What went well?" or "What could I have done or said differently?" Sometimes the probing is for symbolism or significance: "What did s/he mean when this or that was said?"; "What do you think it suggests that he/she did not answer this or that question?" This kind of after-action review allows us to return to our future encounter with more tools for careful attention to and interpretation of stories.

A Vision for *AJCC*

The goal of good narrative critical care is to allow for the continued revolution of high-tech care while also creating a space of respect for a type of high-touch care. Good science of the kind that we can present in these pages will be crucial to this goal. As critical care research moves beyond the walls of the ICU to grapple with such things as the role of our patients' premorbid function on outcomes, measuring and defining the struggles of ICU survivorship for our patients and their caregivers, and the role of organizational structure and process in patient care and outcomes, *AJCC* is uniquely positioned to forge a space in which all types of researchers and clinicians can come to our pages for science that can motivate their research or clinical care. *AJCC* can continue to sustain a forum in which our readers and peer reviewers can interact with the leading scientists in our field to create a dynamic community.

Conclusions

I am heartened by the large community of readers who are a part of this *AJCC* community. To this new endeavor, I will bring my passion for critical care medicine, my love for the critical appraisal of the medical literature, my willingness to read the submissions carefully, and my desire to keep improving at all aspects of the job. I promise that I will respect the tradition from which the journal has emerged even as I promise to look for innovative ways to keep us growing and developing. With the guidance and support from my coeditor, as well as the leadership and membership of AACN, I look forward to working together to sustain *AJCC* as one of the flagship research journals in critical care medicine.

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

FINANCIAL DISCLOSURES
None reported.

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