Editorial

Rites of Passage

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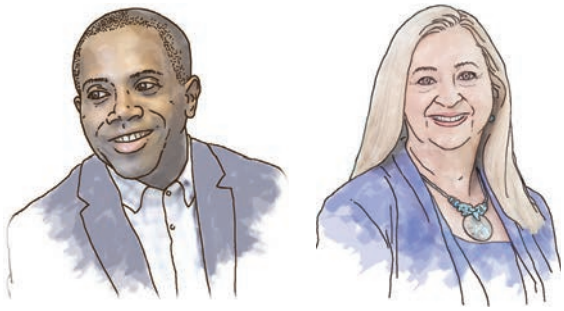

The truth is that we meet most of our patients in the middle of things. Their acute illnesses are rarely stories of brief disruptions, with death or restoration at the end. More often, their acute illnesses are complications of cancer, frailty, dementia, or chronic diseases like asthma or congestive heart failure. Their acute illnesses are stories of exile; stories with shifting identities; stories with crossings into sacred and secular borderlands brimming with mystery, apprehension, and isolation.

How do we best care for patients during moments of transition? Transitional care is care that is designed to ensure the coordination and continuity of care as patients transfer between different locations or different levels of care within the same location.[1] Transitional care may mean caring for a patient as they leave the intensive care unit (ICU) for the hospital ward; it may mean caring for a patient as they transition from the hospital to a rehabilitation facility; it may mean caring for a patient as they arrive home after hospital discharge or in the months after discharge from the hospital as they struggle with the slow pace of recovery.

Clear conceptual frameworks for thinking about transitional care are only now emerging.[2] Ethnographer Arnold van Gennep's classic work on the systematic study of ritual ceremonies describes the passing from one age to another as "rites of passage" marked by 3 phases: separation, transition, and incorporation.[3] Transitional care would represent the second liminal phase of caring for patients. Transitional care is situated in the existential space after the ill person has been separated from their fixed stable "pre-ill" social structure and before they have fully integrated their repairing body back into their life. Transitional care would seem to invite a different set of ethical principles than the ethics of rescue. When our care is focused on rescue, too often we clinicians place ourselves as the hero or heroine at the center of the action; we lapse into thinking ourselves capable of turning the sea of our patients' illness into dry land. Transitional care would seem to humble us into a kind of solidarity with our patients: we are not the hero or the heroine at the center of our patients' rescue. Transitions invite us to share with our patients the dizzying recognition that time is irrevocable, that the next thing to happen will take the place of what has already gone. We become aware that nothing is bound to repeat itself.[4]

As we thought together about some key principles of good interdisciplinary transitional care, 4 tentative principles emerged that we present here for discussion and feedback: First, transitional care is context specific; second, transitional care attends to the importance of emotions and affect; third, transitional care recognizes the importance of patients' values; and fourth, transitional care empowers the patient and their family.

To acknowledge that transitional care is contextual is simply to acknowledge that illness is occurring in a specific person at a specific time. The ill person

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has a specific social location defined by any number of factors including such things as their race, national identity, gender, ethnicity, geography, or political ideology. The ill person enters the current illness with previous conditions, comorbidities, or risk factors that may inform such things as their response to treatment or their prognosis for full recovery. Context also means that the ill person is being cared for in a specific health care system and within a specific community setting.

Clinicians providing good interdisciplinary transitional care will not be afraid to acknowledge that humans are emotional beings. We know that strong emotions can impact how we process information and how we reason[5]; therefore, we must practice recognizing our patients' emotional cues and have skills to attend explicitly to these emotions when we see them. Transitional care is often happening during a time when our patients' bodies are posing new challenges. Their bodies may not be recognizable to them; their bodies may not be able to do what they want their bodies to do. Their thoughts or feelings may not be recognizable to them, whether it is the surprising anger over their failing body or the unwelcome sadness over their loss of social connection. Our patients may experience aspects of our care as triggers for their traumatic memories, and these traumatic memories can affect not just their emotions but how their bodies appear to us. Good transitional care will be trauma-informed care.[6] Thus we may need not only to actively listen to what our patients say, but to develop routines of care that include opportunities for listening to their bodies so that our patients can feel emotionally and psychologically safe during the care we provide them.

Good transitional care is patient centered and involves trying to help patients to make authentic decisions that reflect their best communal values. Too often we think of our patients' health care values as fixed, divorced from diagnosis and prognosis. In fact, our patients' values are specific to their diagnoses and their prognosis and must be facilitated by skillful communication. In the face of illness, the question of what is most important, the question of how you want to be treated, and the question of who you want to speak for you are all weighty questions filled with the potential for misunderstandings, emotional wails, and moral imagination. Too often, we think of our patients as rational atomistic beings, divorced from their social context. We would hope that good transitional care will be bold enough to respect our patients as social beings, thereby inviting the voices and perspectives of our patients' loved ones during the care process.

Clinicians practicing good transitional care seek to help patients and their families be the leaders of their own disease management. Such care can include support services that allow our patients and their families to better adjust their lives to accommodate and manage their symptoms and limitations stemming from their illness.[7] Empowering our patients will mean that our information sharing needs to be structured to allow patients to ask questions, have conversations with themselves and with other patients, and allow patients the chance to try and fail and try again.

What might these proposed principles of good transitional care mean for research and scholarship in this area? Perhaps these principles will invite more focus on the social and biological conditions that are involved in acute illness.[8] The importance of emotions, affect, and the communal nature of patients' values invites more interdisciplinary collaboration so that all the causal mechanisms of disease and outcomes can be appropriately explored. These principles may invite more innovation in how clinical care is structured, more interventions with the potential to improve patients' skills in self-management.

Those of us who care for patients as they go through moments of transition are called to be effective witnesses. We are called to help our patients pass through the turbulent sea of illness without knowing how the storm will end, without knowing how this, too, shall pass.

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

FINANCIAL DISCLOSURES
None reported.

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