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Providing Compassionate Care in the ICU

After a combined 60 years of working as intensivists, we write this editorial to reflect on our experiences caring for critically ill patients and their families, as well as caring for the interdisciplinary teams with whom we worked. In addition to our time working in the ICUs of teaching hospitals, we have also had the privilege of serving as presidents of two of the leading professional societies in critical care medicine: the American Thoracic Society (J.R.C.) and the Society of Critical Care Medicine (M.L.L.)—coincidentally in the same year. Therefore, we have insight into the strengths and limitations of educational institutions and professional societies for educating and supporting critical care clinicians in providing compassionate care in the ICU; we believe that both our educational institutions and our professional societies can do more.

Over the course of our careers, we have witnessed many advances in the understanding of critical illness pathophysiology, the technologies we use to support patients' failing organ systems, and improvements in communication and shared decision making with patients and families. Although these changes have been important, our goal now is to reflect on the foundational role of critical care clinicians' compassion and openness in our efforts to support critically ill patients, their families, and our interdisciplinary ICU colleagues, especially when facing death or life-threatening critical illness.

Being with critically ill patients at the bedside, being present and supportive with grieving and suffering family members, and at the same time being able to care for all the other critically ill patients under our care in the frenetic and complex ICU environment require a unique skill set. We believe this skill set does not receive the attention it should in the training of critical care clinicians. In this editorial, we describe five interrelated principles underlying this skill set and highlight some examples of putting these principles into practice.

The first principle is that to be compassionate to others, we must be kind to and trust ourselves. Being calm and compassionate when confronted by an angry family member upset with our care, when we are working hard to do our best, can test the patience of even the most compassionate ICU clinician. We have found that when we are kind to and trust ourselves, that compassion arises naturally. Being kind to ourselves also means practicing self-care while in the ICU and, just as important, when we are not in the ICU. There is a rising epidemic of burnout among critical care clinicians, which was present before the coronavirus disease pandemic and has been dramatically exacerbated by the pandemic (1, 2). Being able to be compassionate in our clinical work while ensuring time for self-care both in and outside of work is an essential skill for longevity as critical care clinicians. Self-care may include sleep, exercise, cultivating interests outside of medicine, and time for reflection. This important practice can be modeled for others and should become part of the culture of the ICU.

Originally Published in Press as DOI: 10.1164/rccm.202112-2787ED on February 7, 2022

The second principle is being willing to be vulnerable. Effective empathy involves allowing ourselves to be vulnerable to the grief and tragedy experienced by a patient or family member while also recognizing that we have an important job to do. This vulnerability allows empathy to be genuine, and it must be balanced with an ability to move on to the next patient or the next task effectively when needed. During a period with multiple deaths, the entire team can experience cumulative grief, and maintaining this balance requires intention and practice. Formalizing opportunities to debrief and reflect on our experiences caring for patients and their families can be extremely helpful (3). In our experience, it helps when such reflection is an integral part of the culture of the ICU.

The third principle is being willing to be present and steady in the face of grief and emotional pain rather than avoiding these strong emotions. Being willing to walk into a room to comfort a family after a patient has died and to be fully present and supportive in the face of their grief is a skill that can only be learned through practice. This ability to "rest" in the face of the family members' intense grief requires patience and willingness not to resort to avoidant behavior because of our personal discomfort. This ability requires practice, incorporating compassion and vulnerability, and is aided by the belief that we can make an important difference in how families experience grief and loss.

The fourth principle is being able to live with uncertainty. In the ICU, prognosis, cause of illness, and timing of death are often characterized by uncertainty. As clinicians, we are often asked by our patients and their loved ones: Why was there such deterioration? How certain are you that they are dying? When will my loved one die? Our discomfort with uncertainty can lead us to avoidant behavior. We often see colleagues avoid difficult conversations rather than accept discomfort and embrace uncertainty. Learning to accept the discomfort of uncertainty is a key element in delivering high-quality care in the ICU.

The final principle is a willingness to be wrong. Our professional world is marked too often by a reluctance to admit we are wrong or to receive constructive feedback. For example, setting a tone of inclusiveness on ICU rounds and modeling a willingness to be wrong can empower members of the interdisciplinary ICU team to voice disagreement with the supervising physician or one another in a respectful and supportive way. This willingness to be wrong can be modeled and learned through respectful and supportive interactions.

In our careers, we have strived to use research to identify ways to implement these principles and their associated practices in the ICU. Even though we believe that identifying evidence-based approaches is critically important for improving compassionate care (4, 5), we have come to believe in the importance of these principles mostly through our experiences working in the ICU. Our field needs to continue to develop the evidence base for enhancing the delivery of compassionate care in the ICU so that we know when and how to apply scarce resources to improve clinical care. However, we must also enhance our ability to support and teach each other to provide compassionate care in the difficult and often tragic ICU environment, independent of and parallel to efforts to enhance the evidence base. We must do this as individuals, institutions, and professional societies for our patients, our patients' families, our colleagues, and ourselves. ■

Author disclosures are available with the text of this article at www.atsjournals.org.

Acknowledgment: The authors thank Drs. Başak Çoruh, Ruth Engelberg, and Erin Kross for their thoughtful input on this editorial.

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