

FROM THE INSIDE



Critical but stable—critical care communication in the COVID-19 pandemic**

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“Stable”, from the Latin “stabilis”, from the based word “stare”, meaning “to stand”.

In the early stages of the coronavirus disease 2019 (COVID-19) pandemic (and even now), many intensive care units (ICUs) severely restricted visitors. The reason was to minimise human contact to control transmission of infection. As a result, many patient updates which would normally have been carried out by the bedside or during a physical visit needed to be done over the telephone. Our patients are all unstable and critically ill. Why then did many telephone updates contain the word “stable”? Why did we struggle to describe the precarious situations our patients found themselves in? Why were we unable to balance the need to provide hope and convey severity to already distressed relatives?

Before COVID-19, I thought little about using the word “stable” in critically ill patient updates. Phrases such as “your [insert chronic disease] is well under control”, or “your [biomarker or clinical measurement] is stable with the medications” pervade medical lingo. Stability is thus associated with longevity and health. Likewise, physiological stability is associated with homeostasis and normal bodily regulatory mechanisms. With such weight placed on a single word, and the control it portrays, it is little wonder intensivists are known to use phrases such as “critical but stable” [1]. Yet, such ambiguous phrases have been the source of interdisciplinary misunderstandings, as noticed even before COVID-19 [2]. More importantly, when used in patient conversations, they

can be far more problematic. The term “stable” acknowledges neither the long and arduous journey of critically ill COVID-19 patients, nor the various levels of support they require to maintain survival. Over the telephone, families lose the usual visual and environmental input with which to frame such conversations. They would normally have seen the numerous lines and tubes, heard the multiple monitoring alarms, and felt the tepid, diaphoretic skin of near-death on their loved one. In other words, non-verbal cues convey far more information than speech can [3].

Anushua Gupta is a General Practitioner (GP) and survivor of COVID-19. When she was critically ill, she was put on extra-corporeal membrane oxygenation (ECMO) [4]. She tethered on the brink of death for many weeks. I spoke to her and her husband about the communication they had when she was in ICU [5]. The word “stable” was indeed frequently used during update conversations. However, without visits, her husband struggled to imagine her progress, or lack thereof. He read extensively about ECMO, but as we all know, physiological variables and biomarkers can only convey a limited amount about a patient’s condition. This is particularly the case in ICU, where the active manipulation of physiology through machines and infusions may provide a false sense of security. If Anushua’s husband, himself a GP, felt unable to comprehend the severity of critical illness based on the terminology used, then what hope does the non-medical public have? Such dissonance prompted me to reflect upon the false assumptions associated with the word “stable” and to expose the unseen turmoil healthcare professionals shared with patients in a short piece last year entitled *Telephone Lament for Coronavirus* [6].

The absence of family during a critical care stay can further destabilise the entire healthcare journey. For the critically ill patients themselves, the presence of family has been shown to contribute to both physiological

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and psychological well-being and recovery [7, 8]. Such human connection is even more important with the depersonalisation associated with the use of Personal Protective Equipment (PPE). The anonymity, ambiguity, and androgyny associated with full PPE further limit the humanisation of provider-patient relationships [9]; reversing the many years, it has taken to move away from a rigidly paternalistic system. Attempts such as the PPE portrait project may help to mitigate depersonalisation [10], but the resultant feeling of ostracisation and uncleanness continues to plague COVID-19 survivors long after their encounter with healthcare [11]. This wobble is not confined to the psychological domain, but includes physical, functional, and cognitive impairments [12]. Unsurprisingly, the ripples of instability reach far beyond the individual and exacerbate the already problematic “post-intensive care syndrome” suffered by families [13].

Therefore, if “stable” is insufficient a word to describe our patients, how can we better navigate such conversations? Clearly, face-to-face encounters are best [14], but in their absence, video-based telecommunications may mitigate the lack of visual and environmental input needed for families to comprehend the severity of illness [15]. The use of guides such as the Serious Illness Conversation (SIC) guide can help address the expectations of families and aid clinicians in explaining and exploring complexities. It has been shown to increase understanding of families and encourage shared decision-making, and even provides satisfaction to clinicians [16]. A key part of this is the use of contrasting statements such as “wish...sorry” or “hope...worry”. These frame the ongoing tension and resolution as two sides of the same coin of critical illness. By doing this, we attempt to strike a balance between providing hope and guarding against false reassurance. In addition, we can make use of the rich imagery already described in patient literature, such as sinewaves, roller-coasters, or vortices [17, 18]. The condition of a patient may be thought of as a single point in such dynamic processes; while we can view this point with reference to the journey hitherto, we cannot fully predict the future trajectory. Thus, an acknowledgement of uncertainty replaces an otherwise static adjective. Such strategies may thus help to avoid the misleadingly manicured term “stable” and instead acknowledges our own fragilities and humanness, thereby facilitating authentic communication and compassionate care.

In the end, perhaps, the most striking rebuttal of the stability narrative in COVID-19 critical illness comes from the etymology of the word “stable”. The fact that intensive-care units globally are filled with prone or supine patients, suffering from a multi-systemic disease, reliant on machines to maintain basic physiology, clearly

indicates their inability “to stand”. The numerous waves and variants which continue to overwhelm global health-care systems have brought our profession to their knees. The countless lives lost seems to have run the human spirit into the ground. The COVID-19 pandemic is anything but stable, and our communications must reflect that. The absence of family does not only produce a null deflection, but negatively skews the illness journey. We must bear that in mind when imposing restrictions on hospital visits. Therefore, I will ditch the “stable” rhetoric in critical care and embrace the fragility that this pandemic has exposed. For it is through our fragility that we continue to hope. Through humility that we practice selflessness. Through instability that the human spirit clambers, climbs, and conquers, just like a patient’s recovery trajectory, until humanity stands once again.

“where there is love for man there is also love for the art of medicine” – Hippocrates

Declarations

Conflicts of interest

The author declares that he does not have any competing interests.

Informed consent

The author confirms that consent has been obtained by relevant parties mentioned within the text.

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