VIEW POINT

"Compassion Cannot Choose:" A Call for Family-centered Critical Care during the COVID-19 Pandemic

Midhun Mohan[1], Lloyd F Joy[2], Arun Sivasankar[3], Shoukath Ali[4], Biju Vareed Meckattuparamban[5]

Abstract

Compassion has been one of the greatest virtues of healthcare professionals. In the early phase of the pandemic, a lot of caution was essential, and restrictions were imposed on the hospital visitation of the COVID-19 patients by their family members. The healthcare system was overburdened, and the healthcare workers were apprehensive about the new virus and the rising mortality. Compassion and family-centered care took a step back as survival of the pandemic became the ultimate goal of mankind. "COVID-19 patients admitted to the critical care units, their loved ones and the healthcare professionals caring for these patients took the brunt of the emotional and psychological impacts of the pandemic." However, as we have moved more than a year into the pandemic, knowledge and resources we gained may be leveraged to provide family-centered critical care for COVID-19 patients. Family presence in intensive care units (ICUs) has been associated with higher satisfaction with care, collaboration with the medical team, shared decision-making, reduced delirium, and optimized end-of-life care of COVID-19 patients. The policymakers should review the restrictions, consider a holistic approach, and take appropriate actions to provide safe family-centered critical care for COVID-19 patients.

Keywords: Compassion, COVID-19, Family presence, Family-centered critical care, Intensive care unit.

Indian Journal of Critical Care Medicine (2021): 10.5005/jp-journals-10071-23957

The fear of suffering has been the greatest impediment to all the possibilities in human life. When COVID-19 unleashed its death spree, survival became the greatest concern for mankind. The healthcare systems around the world have been looked upon to be the savior of humankind. However, the challenges posed by the virus have brought down the healthcare systems in even the most affluent nations to its knees. The physical stress of the personnel protective equipment (PPE) and long shifts; the fear of disease contraction and transmission; the social stigma around the disease; inadequate resources; and a feeling of helplessness has been plaguing the minds of healthcare workers since the beginning of this pandemic.[1,2] All this has incapacitated the healthcare workers of one of the most valued qualities that are associated with this profession, compassion.

Compassion is built on inclusiveness and involvement. Many gestures that were considered valuable for humanity and a sign of empathy became a concern of virus transmission and unsafe during patient care. This includes the time spent near patients; the human touch of doctors and nurses; many aspects of nursing care; the direct debriefing with patient relatives; and providing the essential psychosocial support. The restrictions were apparent at all levels of healthcare. However, the effect of these restrictions has been most tangible in the intensive care units (ICUs) for COVID-19 patients. The pandemic has been unrelenting for those requiring critical care in India.[1–4] Along with the uncertainty of hospital beds, oxygen, and ventilator availability, the need for prolonged ventilator support, ICU stay, and the high mortality associated with the severe disease has been causing substantial emotional turmoil for the patients and their loved ones. The rigorous isolation of COVID-19 patients and the strict quarantine recommendations for their contacts prevented the family from visiting the patients once they get admitted to the hospitals. Even the practice of restricted visiting hours that had prevailed in most of the ICUs in the country had to be done away with, making the healthcare crisis into a humanity crisis.[1–4]

[1]Department of Emergency Medicine, Kozhikode District Cooperative Hospital, Kozhikode, Kerala, India

[2]Department of Critical Care Medicine, Kozhikode District Cooperative Hospital, Kozhikode, Kerala, India

[3]Department of General Medicine, Kozhikode District Cooperative Hospital, Kozhikode, Kerala, India

[4]Department of Anesthesiology, Kozhikode District Cooperative Hospital, Kozhikode, Kerala, India

[5]Department of Nephrology, Kozhikode District Cooperative Hospital, Kozhikode, Kerala, India

Corresponding Author: Midhun Mohan, Department of Emergency Medicine, Kozhikode District Cooperative Hospital, Kozhikode, Kerala, India, Phone: +91 9567522186, e-mail: midhun6486@gmail.com

How to cite this article: Mohan M, Joy LF, Sivasankar A, Ali S, Meckattuparamban BV. "Compassion Cannot Choose:" A Call for Family-centered Critical Care during the COVID-19 Pandemic. Indian J Crit Care Med 2021;25(9):1049–1050.

Source of support: Nil

Conflict of interest: None

The majority of the COVID-19 patients admitted to the ICUs are elderly, with multiple comorbidities, requiring some form of oxygen and/or ventilator support for many days compared to other diseases. These patients are dependent on their healthcare providers, even to meet their basic needs. Noninvasive ventilation and awake proning have been shown to improve the outcome in these patients. However, these treatment strategies require enduring cooperation from the patients and persistent motivation for them. Prolonged ICU stay, hypoxia, the use of steroids, the fear of death, and being contactless with the loved ones may precipitate delirium, noncooperation, agitation, and violent behavior among the patients. This may worsen the patient's physiological condition, leading to the

© Jaypee Brothers Medical Publishers. 2021 Open Access This article is distributed under the terms of the Creative Commons Attribution 4.0 International License (https://creativecommons.org/licenses/by-nc/4.0/), which permits unrestricted use, distribution, and non-commercial reproduction in any medium, provided you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license, and indicate if changes were made. The Creative Commons Public Domain Dedication waiver (http://creativecommons.org/publicdomain/zero/1.0/) applies to the data made available in this article, unless otherwise stated.

usage of sedative drugs or invasive ventilation. Delirium is associated with longer ICU and hospital stays, reintubations, ICU readmissions, and higher workloads for nursing staff.[1,2,5]

In a country where the healthcare workforce is much less than what is required, all the hospitals in India were enforced to accommodate COVID-19 patients beyond their capability, utilize the existing ICUs, makeshift, or improvised ICUs.[6] Many of these ICUs were understaffed and run by staff inexperienced in critical care. This has been more so evident in government hospitals where the workforce is much less concentrated compared to the private hospitals. Adverse events can occur in an ICU when the physiological condition of the patients is not recognized or acted upon. The inadequate nurse-to-patient ratio, the utilization of inexperienced doctors and nurses in the existing and makeshift ICUs, the physical and mental stress imposed by the infection control practices, and the overwhelming needs of these patients are dangerous combinations threatening patient safety that can lead to poor outcomes.[5] Even essential end-of-life care for patients and grieving for family members may be deprived of compassion under these appalling circumstances.[1,3,4]

Families of ICU patients have an active role in care. Opening ICUs to families and friends has been shown to provide reassurance to the patients, reduce their stress levels, and provide stability and orientation in the unfamiliar, overstimulated ICU environment. The presence of friends and family was often perceived by ICU doctors and nurses as an impediment to care and an additional stress to the patient. Evidence from the growing body of literature indicates that the problems regarding open visitation are generally overstated and manageable.[7] Visitation of COVID-19 patients in hospitals was restricted with a desire to prevent the contraction and transmission of the disease by the visitors within the hospital as well as to the community.[1,2,8] Even though the number of cases has been rising, there is no existing evidence that visitors of admitted patients are a significant contributor to the nosocomial spread of the virus, or that complete restriction of visitations to patients with COVID-19 protects against viral transmission to the visitors, patients, or staff.[1,9,10] In the early phase of the pandemic, PPEs were also scarce and had to be reserved for the healthcare workers.[1] PPEs are now more readily available and have been proven to be effective in reducing virus transmission. Public has been largely sensitized through education and by mandating the importance of hand hygiene and wearing a mask to prevent virus transmission. The knowledge we gained over the last 1 year of the pandemic should be leveraged to facilitate family-centered critical care for COVID-19 patients.[1,11]

The physical presence of family members has been shown to reduce delirium that is common among COVID-19 patients.[1,2] The family presence is associated with higher satisfaction with care; collaboration with the medical team; shared decision-making; and optimizing end-of-life care and grief experiences for patients, families, and physicians.[1,2,7,11] In hospitals with inadequate workforce, family presence may help to reduce the workload for nurses and may even improve patient safety.[5] Video conferencing, routinized tele-counseling, and other communication strategies have many limitations and have only partially filled the gaps left by prohibiting family presence.[12] As the cases overwhelmed, many hospitals with limited manpower were permitting informed family members and sometimes volunteers to help in the care of COVID-19 patients in wards and rooms. Parents of children admitted with COVID-19 are permitted to stay with them for better care and support. COVID-19 is likely to continue as a public health threat for many more months or even years. Critically ill COVID-19 patients should also be permitted to exercise their right to see their family members, if they desire to. It is time the government and hospital administrators consider creating policies to safely open up the ICUs caring for adult COVID-19 patients to the family members who wish to visit their loved ones, knowing the risk of virus transmission. Compassion is a choice, but compassion cannot choose; be it adult or child; ICU or ward; COVID-19 or not.

Orcid

Midhun Mohan https://orcid.org/0000-0002-4813-1195

Lloyd F Joy https://orcid.org/0000-0002-3322-5850

Arun Sivasankar https://orcid.org/0000-0002-4813-1195

Shoukath Ali https://orcid.org/0000-0002-4813-1195

Biju Vareed Meckattuparamban https://orcid.org/0000-0003-3775-444X

References

1. Hart JL, Taylor SP. Family presence for critically ill patients during a pandemic. Chest 2021:S0012-3692(21)00890-4. DOI: 10.1016/j.chest.2021.05.003. PMID: 33971149; PMCID: PMC8105126.
2. Andrist E, Clarke RG, Harding M. Paved with good intentions: hospital visitation restrictions in the age of coronavirus disease 2019. Pediatr Crit Care Med 2020;21(10):e924–e926. DOI: 10.1097/PCC.0000000000002506.
3. Siddiqi H. To suffer alone: hospital visitation policies during COVID-19. J Hosp Med 2020;15(11):694–695. DOI: 10.12788/jhm.3494. PMID: 32853145.
4. Guessoum SB, Moro MR, Mallet J. The COVID-19 pandemic: do not turn the health crisis into a humanity crisis. Prim Care Companion CNS Disord 2020;22(4):20com02709. DOI: 10.4088/PCC.20com02709. PMID: 32678524.
5. Navathe A, Liao J. Barring visitors from hospitals can worsen patient care during COVID. The Philadelphia inquirer. 2020. Available from: https://www.inquirer.com/opinion/commentary/hospital-visits-coronavirus-philadelphia-pennsylvania-regulations-20200727.html.
6. World Health Organization. The health workforce in India. 2016. Available from: www.who.int/hrh/resources/16058health_workforce_India.pdf.
7. Berwick DM, Kotagal M. Restricted visiting hours in ICUs: time to change. JAMA 2004;292(6):736–737. DOI: 10.1001/jama.292.6.736.
8. Valley TS, Schutz A, Nagle MT, Miles LJ, Lipman K, Ketcham SW, et al. Changes to visitation policies and communication practices in Michigan ICUs during the COVID-19 pandemic. Am J Respir Crit Care Med 2020;202(6):883–885. DOI: 10.1164/rccm.202005-1706LE. PMID: 32687720; PMCID: PMC7491388.
9. Zhou Q, Gao Y, Wang X, Liu R, Du P, Wang X, et al. Nosocomial infections among patients with COVID-19, SARS and MERS: a rapid review and meta-analysis. Ann Transl Med 2020;8(10):629. DOI: 10.21037/atm-20-3324.
10. Bergman C, Stall NM, Haimowitz D, Aronson L, Lynn J, Steinberg K, et al. Recommendations for welcoming back nursing home visitors during the COVID-19 pandemic: results of a Delphi panel. J Am Med Dir Assoc 2020;21(12):1759–1766. DOI: 10.1016/j.jamda.2020.09.036.
11. Hart JL, Turnbull AE, Oppenheim IM, Courtright KR. Family-cented care during the COVID-19 era. J Pain Symptom Manage 2020;60(2):e93–e97. DOI: 10.1016/j.jpainsymman.2020.04.017. PMID: 32333961; PMCID: PMC7175858.
12. Sutherland AE, Stickland J, Wee B. Can video consultations replace face-to-face interviews? Palliative medicine and the Covid-19 pandemic: rapid review. BMJ Support Palliat Care 2020;10(3):271–275. DOI: 10.1136/bmjspcare-2020-002326. PMID: 32457086; PMCID: PMC7295858.