Letter

Journal of the Intensive Care Society

A resilient death: Gross oxymoron or realistic Utopia?

Journal of the Intensive Care Society
2023, Vol. 24(3) Supplement 63–64

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DOI: 10.1177/17511437221142252
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Keywords
Resilience, palliative care, death and dying, medical humanities, integrated care

Queen Elizabeth II's death on 8 September 2022 was a powerful catalyst for increased public understanding about natural dying, but contrasts with many of the deaths witnessed in intensive care. Dr Rajagopal, a member of the Lancet's commission into the value of death, wrote about a harrowing experience. The lack of whole family involvement in end-of-life decisions resulted in a picture scathing to ICU care; one of unnecessary invasive interventions and a disregard for the relational experiences of death.[1] Like palliative care doctors who chaired the Lancet Commission,[1] intensivists share in countless processes of death, albeit from very different and sometimes loggerhead perspectives. The widespread medicalisation of death in critical care and our occasional inadvertent forgetfulness of the relational and ritualistic aspects of the dying process make us contributors to gross over-treatment, medical futility and insustainability.

There are lessons from healthcare resilience literature which may speak to how we should approach dying on ICU. A prominent thinker in resilience engineering, Erik Hollnagel,[2] describes four resilience potentials to anticipate, monitor, respond and learn from crises. But can death and dying really demonstrate these potentials?

The COVID19 pandemic highlighted the importance of social determinants of health, and by extension, death. The critical care community highlighted disproportionate outcomes for ethnic minorities and those from underprivileged socioeconomical settings. It provided compelling evidence for the need to tackle health inequalities head-on, to better anticipate the next shock. And with the ongoing climate crisis, shocks will indeed become more frequent, disproportionately affecting the poor.[3] We have been canaries in the coal mine and must continue to take active roles in addressing health inequalities.

Yet how short-sighted we have been by framing COVID19 deaths as 'failures'. The international medical community monitored mortality rates as if only life itself held value, but not death. Intensivists have likewise struggled with the suitability of death as an outcome measure for decades.[4] As this metric overshadowed all others during the pandemic, many ICUs recognised the detrimental effects of visiting restrictions and responded with rapid adoption of telecommunication technologies. By doing so, they re-focused the critical illness journey and process of dying as relational and spiritual ones.[1,5]

As the world recovers from the pandemic, and ponders the natural death of the Queen, we seek to learn from our experiences. There is increased recognition of the need for interdisciplinary, cross-sectoral and multi-level approaches to health. Like the Lancet commission, the current push towards Integrated Care Systems within the NHS prioritises collaboration between organisations. Expanding our involvement into these arenas, beyond the walls of the ICU and the confines of the hospital, through inter-organisational collaboration, may perhaps be the best way to achieve honest communication about death, and avoid over-medicalisation in ICU. By doing so, we may begin to come to grips with the ouroboric (a circular symbol depicting a snake eating its own tail) cycle of life and death.

So, is a resilient death really that utopian?

Declaration of conflicting interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The author does not receive any funding to cover research costs. He is an academic clinical fellow undertaking research in the field of healthcare resilience. The academic clinical fellowship programme allows clinicians some protected time to undertake and develop their research skills alongside their clinical practice to apply for higher studies.

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