

Reflecting on healthcare and self-care in the Intensive Care Unit: our story

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ABSTRACT

Health care professionals working in Intensive Care Units (ICUs) are exposed to high levels of stress-provoking stimuli. Some may unconsciously employ negative coping skills which may contribute to burnout and negatively affect patient care. We chose to explore ways of facilitating and encouraging self-reflective practice in an effort to increase empathic traits and enhance communication. A narrative medicine series, which included six sessions that were focused on different narrative approaches, was organized for staff of an academic teaching hospital. Totally, 132 interdisciplinary ICU staff attended the sessions. They were generally open to exploring the selected approaches and discussing their reflections within the interdisciplinary environment. The narrative medicine series provided tools for health care professionals to enhance self-reflective skills utilizing a team-based learning approach. The anticipated outcomes were improved self-care, increased empathy and communication skills, enhanced team functioning, which all contribute to better patient care at the bedside.

Keywords: Intensive Care - Narrative Medicine - Interdisciplinary Learning – Empathy - Self-Care

Riflettere sulla cura degli altri e la cura di sé nell'unità di terapia intensiva: la nostra storia

I professionisti che lavorano nelle terapie intensive (TI) sono esposti a sollecitazioni che provocano elevati livelli di stress. Alcuni possono sviluppare inconsapevolmente capacità negative di coping, che contribuiscono al burnout e influenzano negativamente la cura del paziente. Abbiamo pertanto scelto di esplorare percorsi che facilitassero una pratica autoriflessiva, finalizzati a implementare gli atteggiamenti empatici degli operatori e la comunicazione. È stato organizzato, per lo staff di un ospedale universitario, un ciclo d'incontri di medicina narrativa di sei sessioni, basate su differenti approcci. Hanno aderito al percorso in totale 132 operatori delle TI, che si sono generalmente rivelati aperti rispetto gli approcci proposti e nella discussione delle loro riflessioni, in un contesto multidisciplinare. Gli incontri di medicina narrativa hanno fornito agli operatori strumenti per sviluppare l'autoriflessione, a partire da un apprendimento basato sul gruppo. I risultati attesi erano accresciuta cura di sé, empatia, capacità comunicative e miglioramento del funzionamento del team, tutti aspetti che contribuiscono al miglioramento delle cure.

Parole chiave: Terapia Intensiva - Medicina Narrativa - Apprendimento Multiprofessionale - Empatia - Cura di Sé

As Chief of a critical care department (AB) in a busy urban academic health science center, I am aware of the wide range of factors that affect the wellbeing of our team members. It has led me on a quest to provide opportunities that introduce or develop skills that enhance their ability to thrive professionally and personally in this high stress environment. Specifically, improving communication, observation and reflection may lead to a more effective therapeutic milieu, fewer maladaptive responses and higher degrees of professional satisfaction and engagement. I imagined that a curated Narrative Medicine series with a focus on these skills might result in the nurturing of these traits.

Healthcare professionals' interpersonal functionality and personal wellness are important foundations in the provision of high quality healthcare. Intensive Care Units (ICUs) typically present unique challenges to the growth and maintenance of this wellbeing due to the inherent complex nature of care in these environments. In the ICU, higher levels of team communication and trust may augment the quality of practice to allow for an enriched degree of personal satisfaction and even allow for the experience of joy in caring. Importantly, patient outcomes such as family satisfaction and reduced conflict between clients and caregivers are also the products of more highly skilled and experienced clinician communicators and teams. These outcomes are in sharp contrast to the well-documented rates of unhealthy responses to a high stress environment in critical care health care workers. (Dewa et al., 2014; Shehabi et al., 2008; Shehabi et al., 1996).

There are many factors which could challenge the effectiveness of a narrative approach, ironically highlighting both the need for, and potential value of storytelling in the ICU. Healthcare workers from all disciplines may self-select into this specialty as a result of naturally occurring traits such as increased (or decreased) levels of empathy, specific communication and conflict styles and tolerance of stress. In addition, ICU clinicians must display a high attention to physiologic numeric details, the ability to perform tasks requiring manual dexterity in life-threatening situations, the ability to rapidly assess, deal with and, notably, have the ability to move on to the next life-threatening situation without hesitation. Professionals working in ICUs likely have differing combinations of positive and maladaptive traits that allow them to tolerate the uniqueness of the environment itself. They are frequently exposed to sudden and premature fatalities or accidental illnesses, intense noise stimulation (background and alarms), as well as other disruptions.

The critical care environment also presents many interpersonal challenges for the healthcare worker. Being able to "move on" to the next demanding challenge can result in a self-selection of team members who may not invest in either reflection or "superfluous communication". In large ICU facilities, multiple teams, shifts and student turnover can result in a relative unfamiliarity with colleagues, yet high degrees of cooperation are still required.

Finally, relationships with families and patients are unique, because the onset of the therapeutic relationship is rapid and intense. The patients themselves are often unable to communicate because of intubation or impaired levels of consciousness. The concepts of patient-centered care and helping families understand suffering can be lost. For staff, this can contribute to moral distress, compassion fatigue, a gradual loss of empathy and burnout.

The ways that narrative medicine may contribute to the positive outcome of some of these challenges in critical care has not yet been well described in the literature. Many ICU staff may seek resilience in ways other than reflection. Furthermore, while a narrative session can be introduced, the

sharp difference in the pace, structure and content of the seminar may be perceived negatively. Some staff may be uncomfortable discussing personal stories in front of colleagues, as it is not culturally “normal” to reveal feelings of uncertainty, “weakness”, or doubt regarding the value of certain therapeutic interventions. Finally, those who might benefit the most may choose not to attend or participate optimally.

Despite these apparent obstacles, we (132 interdisciplinary ICU staff) embarked on a Narrative Medicine series because we believed that our team was likely to be receptive and that it would be possible to “up-regulate” certain traits that result in enhanced empathy, communication and reduced stress and burnout levels.

On curating narrative reflection and wellness sessions for clinical learners across disciplines

As a psychiatrist and Head of our Medical School’s health humanities program (AP), my assumption was that ICU narratives would be different from others I’d worked with and that staff would carry many dramatic stories that they had not fully explored or metabolized.

Dr. Baker contacted me in summer of 2013 about setting up some *Narrative Medicine Rounds* for his staff in the ICU. His concerns about the pace and lack of time for reflection in his busy unit at first seemed at odds with the goals and techniques of narrative-based medicine. Yet, we both believed that reflective capacity is one of the cornerstones of *all* quality patient-centered care.

Reflection has been defined as “a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to a new understanding and appreciation” (Boud et al., 1985, p.3). The reflective practitioner, then, is one who uses reflection as a tool for revisiting experience both to learn from it and for the framing of murky, complex problems of professional practice. Reflective practitioners take better care of their patients but they also take better care of themselves, because they develop mindfulness and awareness of their own thoughts, feelings, bodily sensations, stressors and vulnerabilities. One of the most promising, well-studied methods to assist in this process is the use of reflective writing and close reading of literary texts in the teaching curriculum (Charon, 2006).

Reflective writing undertaken by medical and nursing students helps them to use a language-based narrative to represent their experiences in the study and practice of caring for patients. The meaningful interactions with patients, colleagues and society at large can often be best described in emotional and personal terms, as they are unable to be captured through comparatively dry scientific reporting. Such reflection includes consideration of the larger context, the meaning, and the implications of an experience or action, allowing the student or practitioner to integrate or re-work concepts, skills and values into their cognitive framework or understanding. Learning is a cycle of action and reflection; to encourage the development of reflective skills in practitioners, then, will allow them greater insight into the self and their own learning needs. Practitioners who have developed their reflective abilities through writing and reading can identify and interpret their own emotional responses to patients, identifying and acting upon hidden attitudes or feelings that may hinder communication so as to care for their patients with engaged concern, rather than detachment. As one’s professional identity is developed, there are aspects of learning that require understanding of one’s personal beliefs, attitudes, assumptions and values, in the context of those of the professional culture; reflection offers an explicit approach to their integration. Developing a penchant for reflective writing

and close reading of literary texts may help to sustain a health practitioner's sense of personal identity, to reinforce their professionalism and to provide a means to reflect upon the significance and consequences of their interactions with others (Peterkin & Roberts, 2012).

In curating narrative sessions, my goal was to provide written literary texts that dealt with challenging situations pertinent to ICU care, like the delivering of bad news, team conflict or clinical error. Problem-solving around a short story or poem would model a non-threatening form of collective conflict resolution around relevant real-life workplace dilemmas without “naming names or pointing fingers”.

Reflective writing exercises were designed to be brief and done “on the spot” (without pre-assigned homework), either individually or collectively (“team writing”).

In assembling the members of Team Narrative to deliver the six ICU Narrative Rounds, I placed an emphasis on having educators from numerous clinical disciplines to capture the inter-professionalism inherent to the unit itself. Sessions were designed to be one and a half hours so as to allow a brief presentation, narrative-based exercises and to leave ample time for discussion and collective meaning-making. The seminar topics were as follows:

- I first *introduced the field of narrative medicine* through the close reading of a poem about delivering bad news to a family and a writing exercise related to that poem and theme.
- A social worker suggested practical yet meaningful ways of building *moments of mindfulness* into a highly stimulating environment.
- A nurse from another ICU unit *shared intense narratives* from her own published memoir for discussion.
- A nurse ethicist explored *issues of moral distress* and *ethical ambiguity* in the ICU setting by distributing case summaries and inviting both discussion and written responses.
- Another psychiatrist and PhD candidate in English literature explored the significance of and need for *emotionally processing highly traumatic visual content inherent to the ICU* (as related for example, to disfigurement, limb loss and complex wounds and burns).
- Finally, the Poet-In-Residence from Mount Sinai Hospital conducted an *exercise in collective poem-writing* by bringing a “Poetry Crash Cart”.

That last session is described in detail below as a personal narrative, so as to flesh out the actual process and technique of using narrative exercises to foster team creativity and collaboration.

One day in may: reflections on the poetry crash cart at St. Michael's hospital

I am the Poet in Residence at Toronto's Mount Sinai Hospital (RB). When I am invited to give a talk or workshop, I am asked, like any presenter, to send 3-5 “learning outcomes”. And I do. I say things like “poetry offers a place for people to develop their reflective capacity”. I say, “Participants will learn the five rules of writing”. I say “You will develop a tool that can be used for self-care and to reflect on your work with your patients, colleagues, yourselves”.

All true. But when I was asked to provide learning outcomes for an event I'd be bringing to the ICU at St. Michael's Hospital, I said: “I want to give you something”.

I'd been thinking about those who work in hospitals, in critical care, or anywhere else as a health-care provider. Feeling the heft of the words, "provide" and "care" and "critical", I told those assembled around the seminar table – students in scrubs, doctors, nurses, other team members – I said: "You are giving all the time. This is your job. I want to give you a place to rest and receive".

Then I read a poem. It's difficult here to capture the feeling of a poem being read aloud, but my experience is that it allows a listener to slow down, to drop into their bodies, and feel themselves as "porous". The poem enters the system in a different way than ordinary speech.

"Tell all the truth, but tell it slant," says Emily Dickinson.

I started the talk with the poem *At Least* by Raymond Carver (1998) In the poem, Carver begins (p. 81):

I want to get up early one more morning
before sunrise. Before the birds, even.
I want to throw cold water on my face
and be at my work table
when the sky lightens and smoke
begins to rise from the chimneys...

He goes on to list the things he'd like to see as he drinks his coffee: the ships in the harbor, the activity on board. And he ends:

I want to spend the day watching this happen
and reach my own conclusions.
I hate to seem greedy – I have so much
to be thankful for already.
But I want to get up early one more morning, at least.
And go to my place with some coffee and wait.
Just wait, to see what's going to happen.

It's a bit of shock to move from the intensity of hospital life to the space that a poem makes. I said, "What I'd like to offer is an opportunity for what Carver described. The opposite of what you normally do in your day, under stress and always in motion. To have a chance here with a few poems, not to rush, but to wait... to see what's going to happen".

What happens generally is that the poem meets each person in a unique kind of alchemy. Whatever he or she is bringing – the patient they just left, their home life, the pressing in of the hospital institution – all "fizz" with the chemistry of the poem.

I call the event I offered at St. Michael's ICU "The Poetry Crash Cart". It's quick. There's less writing than most workshops. I simply want to give them a "hit" of poetry that reaches in and meets

whatever they are carrying. I read poems about grief, love, tending to others, tiredness. And at the end, there is a chance to express what has resonated.

To prepare for the writing, I described something I do at Mount Sinai called “The Spontaneous Poetry Booth” (SPB), where I sit at a table and write people poems for a dollar. In the SPB, I ask the person in front of me “What do you need a poem about?” Then I write it for them.

At St. Michael’s Hospital I said, “Now, after 30 minutes of hearing poems read out loud, what does each of you need a poem about?”

I asked them each to write it down in one line on a piece of paper. The rules for writing onsite are “Don’t think, just write,” and “you don’t have to share”. A few people did read that day, but most didn’t. But something happened in the room. I collected all of the anonymous one-liners, shuffled them and handed them back out. We went around the room with each person reading in sequence the line they had just received. What emerged was a collaborative poem expressing something of the lives of real people working in critical care on a particular spring day.

Here’s the poem (used with permission).

I Need a Poem

I need a poem about surviving.
I need a poem about the scientific rationale behind this.
I need a poem to alleviate my suffering and bring calm to the chaos.
I need a poem to come fully alive, to help me sleep at night, for getting through the winter.
I need a poem about psychic energy, joy, and family.
I need a poem about overcoming my struggles.
I need a poem about life and death.

Staff observations about the narrative rounds

As a Nurse Practitioner in our ICU (NM), my colleagues and I bear witness to the gruesome, untidy business of the sick and injured human body. We sit with our patient’s families and reveal the extent of illness or injury, while trying to keep hope alive. We have been taught to carefully control our external expressions, but what about our internal responses? There is little discourse at the bedside or in regular educational offerings that permit clinicians reflect upon the life-changing and life-ending events that we witness every day. This systematic repression of our internal and external reactions may have negative impacts on our relationships with patients, co-workers and family, and negatively affect our own mental health. We cannot care for patients without recognizing our shared humanity, but by doing so, we risk facing our own vulnerability.

The Narrative Medicine sessions we’re discussing were advertised and all of the nursing and allied health staff were encouraged to attend. The series was intriguing, yet the concepts seemed familiar. In nursing, there is much discourse about the embodiment of caring in our work. To “care” for one’s patients requires reflective practice; being aware of what you bring to each interaction and understanding that the patient creates their own meaning of the illness/ health experience. So, I attended the rounds with a sense of curiosity, but assumed that I might already understand the topic.

The truth was, this was unlike any discussion I have participated in before. The difference was that the sessions encompassed perspectives from across the interdisciplinary team. There were facilitators from outside our Unit to guide the discussion and exercises, so we were able to consider our experience from a slightly different perspective. It felt great to discuss these same issues with my interdisciplinary colleagues. After all, these are not nursing issues or medical issues: they stem from the complexities related to caring for fellow humans with compelling stories and experiences.

Even so, the seminars felt a bit unnatural at first. We listened to the presenters and then were asked to remember very personal and sometimes difficult moments in our own lives. I realize now that although the concept of reflective practice is embedded in nursing practice, the truth is that I have never encountered opportunities to do so safely and efficiently within the clinical environment. Even the one and a half hour duration of the seminars seemed uncomfortably long. But as the sessions unfolded, I found myself immersed in the process that was being demonstrated, and each time relaxed a little more. About 30 of us from across disciplines attended each of the 6 monthly sessions.

In one exercise, we were invited to recall an early memory and describe the scene in as much detail as we could. Each of us in the room had many stories about why we had been drawn to healthcare as a profession in the first place.

The act of listening and reflecting on poetry was novel and refreshing, and so out of context at work, that it seemed like a “mini-holiday”. The collective poetry writing activity described by Ronna reinforced my realization that although each of us is separate, we are actually a collective, strands of a net that catches and supports our patients through their critical illness. We co-create the patient’s story with them and learn more about them as people. How they respond to their illness and the treatments we provide. We can also co-create and deepen a rich narrative of collaboration using the techniques we learned in the seminars.

In the session where we shared our interpretations of several paintings, I was struck with how perceptive people were. Was it my imagination, or were we all slightly alarmist, seeing danger and injury in the images where others might not? I thus had a sense of shared perspective with the people in the room. The exercises in exploring the narrative within visual art reminded me about how context-specific the interpretation of visual information can be!

I also had a renewed sense of community with my colleagues during the mindfulness meditation session. I had had some experience with meditation, but often found it difficult and time-consuming. The instructor reassured us that meditation is difficult, but also rewarding. We were reminded to be kind to ourselves. Not to judge ourselves harshly for not being able to clear our minds, and to allow the process to be what it was in that moment. I suspected that most of us were not always kind to ourselves.

I thought about how rushed we all usually are. I remembered my grandmother who was an avid practitioner of meditation. She was a navy nurse during World War II. I thought about how she must have seen some terribly disturbing things and was reminded about the importance of taking time for myself, making space for stillness and reflection.

Despite the unconventional content and process for the Narrative Rounds, the verbal feedback from staff was positive. Individuals expressed gratitude and appreciation for the bold approach to

opening a new discussion. Others mentioned that although they would not have asked for this type of session, they felt relieved with the opportunity for open discussion among their peers that otherwise would feel impossible. There were benefits to the individual, but also, importantly, a renewed sense of the collective emerged as we began to know more about ourselves and others and our shared work.

The Narrative Medicine sessions gave us tools to address many of the problems that we face as ICU clinicians. We must cope with the disturbing and be attentive to our responses, while working in a complex environment. Narrative medicine practices open the space for us to pause and reflect. We hypothesize that reflective practices such as those described in our narrative sessions may be key in helping professionals to be more caring while concomitantly giving them protective strategies to help prevent burnout and its complications (Reiss, 2010).

We were delighted with our introduction to the process of Narrative Medicine. We are now committed to advancing our skills in this discipline because we believe that this will make us better and healthier clinicians and team members. We believe that this approach will also be helpful in other ICU settings and are in the process of capturing and analyzing written feedback about the sessions in order to summarize best practices.

Finally, all of us involved in the writing of this chapter – an MD-intensivist, a psychiatrist, a poet and a nurse-practitioner – were able to celebrate the fact that our narrative work was able to continue after the sessions themselves ended. With each of our different lenses, we were able to collectively tell the story of a highly successful collaboration.

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