Man's Inhumanity to Man

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Address given at Rhodesia Nurses' Congress, Salisbury, May, 1978.

OPSOMMING

Die onderwerp van die referaat is dat so baie van wat in die naam van intensiewe sorg gedoen word, dikwels — onnodig en onnadenkend — 'n waardevolle menslike pasiënt in iets minder as mensliks verander. En, hoe kort die metamorfose ook mag wees, glo die skrywer dat die letsel onuitwisbaar is. Dat ons moet sorg, ly geen twyfel nie. Maar word die klem t.o.v. die hele begrip van intensiewe sorg nie miskien verkeerd geplaas nie? Behoort ons nie intensief te *versorg* nie en behoort ons nie daarna te streef om uiters versigtig te wees om die essensiële menslikheid van die vir wie ons sorg, te beweer nie?

Die intensiewe sorgsaal moet nie net as 'n tydelike plek beskou word waar die verlangde toestande van fisiologiese, chemiese en anatomiese balans herstel of bewerkstellig sal word nie — dit moet eweneens die eerste fase van sielkundige herstel wees. En deurentyd moet die klem op vriendelikheid en die behoud van die individualiteit en menslikheid van die pasiënt val.

All aspects of intensive care — intensive coronary care, intensive post-operative care, post-traumatic intensive care, and so on — are justified on the assumption that human life is valuable and that this value cannot be measured in terms, for example, of cost. Similar exertions are not expended on what might be called subhuman species unless a particular value has been placed on them — usually a monetary value when dealing, say, with a racehorse with stud potential, or a trained dolphin with entertainment potential, and sometimes a scientific value, when a laboratory animal's continued survival is thought to justify extraordinary measures.

My theme is that so much of what is practised in the name of intensive care serves, often needlessly and thoughtlessly, to transform this valuable human patient into something sub-human. And for however short a period of time this transformation may be, I believe the scar to be indelible. Moreover, the very fact of intensive care may threaten needlessly the human life we are striving to preserve — there is now ample evidence that myocardial infarction is best treated at home, if home circumstances permit, and that the pay-off from intensive therapy in cardiogenic shock is painfully, and very expensively, small. That we must care is indubitable. But is not the emphasis in the entire concept of intensive care perhaps misplaced? Should we not be **caring** intensively, and should we not be striving to be intensely careful in preserving the very humanness of those for whom we are caring?

Here are some examples of what I mean by implying that the paraphernalia for supporting human life may defeat its end. I intend to use, as my model of intensive care, post-operative care after cardiac surgery, most of which is elective. Much of what I have to say is applicable to other aspects of intensive care.

An intensive care ward for patients who have undergone a cardiac operation will usually have in it six or seven beds. Unless one is lucky enough to work in an intelligently designed new hospital, the intensive care ward will usually be a modification of a previous building, rectangular in shape. The beds will be in a row, separated by some seven or eight feet. To facilitate access to patients, the beds will nowhere be

in contact with a wall, and further to facilitate access to the patient's head, this is often nearer the centre of the room, so that the patient stares at a wall — often the wall on which the monitors are mounted. The ward will usually be clean and empty first thing on a Monday morning. The first operations are usually the shorter, more calculable ones — ductus division, closed mitral valvolotomy, closure of atrial septal defect.

The first two or three patients are in the intensive care ward by 9 or 9.30 a.m. The first of the valve replacements begins to be trundled in at 11 or 12. By five or six in the evening the ward is full of males and females, young and not quite so young, and the activity, noise, light intensity and so on must, to the uninitiated, be akin to bedlam. Of the seven patients, 3, 4, or 5 will be on ventilators and most will be conscious, some having been more or less wakeful since mid-morning.

The conscious patient is thus confronted by a strange land of confusing sights and sounds. He is attended by strangers, often gowned and masked, whose attention seems to be perpetually directed towards intricate machinery, tubes and bottles, charts and records. His state of alertness is obtunded by anaesthesia, the operation and post-operative sedation, so that he will certainly misinterpret and distort what is happening around him. Should he demonstrate his anxiety by restlessness and agitation, further sedation is given — the staff, preoccupied with his physiological and chemical needs, have not the time to consider his emotional needs, and long periods may elapse during which nothing is said to the patient beyond perfunctory words of reassurance or, more usually, caution.

The environment is surely not dissimilar from that used for brainwashing, and the more sophisticated forms of torture. Often there are no windows. There is no distinction between night and day. There is a high intensity of artificial lighting. Already demoralised and muddled by sedation, the timelessness of intensive care wards serves further to disturb the patient. Then there is the noise — the chug and hiss of ventilators (not one, but often four or five, all chugging and hissing at different rates); pulse rate meters (six or seven, pinging at different rates and with different noise intensities); and alarms, happily started in error far more often than to draw attention to genuine emergency. Alarms to draw attention to apnoea, to ventilator failure, to extremes of blood pressure — but none to draw attention to the patient's own alarm at all that is happening around him. And should he open his eyes, there in front of him is the monitor screen, often with a digital display — meaningless figures constantly changing; bizarre wave forms. The scurry and bustle of attendants and their chatter — abrasive at the best of times, but in these circumstances mind-bending. You will have heard the music of *My Fair Lady* and will recall Professor Higgins pronouncing on the folly of letting a woman in your life, at the end of which lament he turns his various recording apparatus to both loud and fast. To the patient, that must be what intensive care wards sound like. Prolonged, loud discussions at the head of the bed — out of sight, disembodied voices — are they talking about him? (usually not); why are they laughing? (probably at the Monday morning joke brought in by the consultant surgeon who goes racing on a Saturday). It is commonplace to find 8 nursing sisters, 3-5 doctors, one or two radiographers and a brace of physiotherapists, and 2 or 3 technicians monitoring blood gases and checking monitors, all together in an intensive care ward housing 7 patients — 20 additional bodies, and all talking at the same time.

Not only is the patient beset by noise and blinding light — he is also uncomfortable. Even if free from the ventilator there will be a cannula in a radial artery, a CVP cannula in his neck — a particularly uncomfortable addition to intensive care — and at least one other drip; a urinary catheter and a rectal telethermometer probe; ECG electrodes and 2 or even 3 intercostal drainage tubes. Little wonder patients complain of feeling chained to the bed. If being ventilated, the patient is further restricted by the endotracheal tube and possibly by the use of a muscle relaxant. There can be few more terrifying experiences than being partially conscious, pharmacologically rendered apnoeic, unable to speak, and having absolutely no insight into what it is all about.

Misfortune overtakes one of the patients and skilled resuscitative measures are undertaken. To the uninitiated these measures can only be interpreted as criminal assault and, if unsuccessful, literally a beating to death. Put yourself in the place of an imaginative youngster, alert enough 6-8 hours after ductus division to take some interest in his surroundings, witnessing the re-opening of a thoracotomy for cardiac tamponade in the next bed. And at the other end of the scale, imagine the embarrassment of a nubile young female, both of whose hands are restricted by drips, for whom all movement is painful, and whose inelegant reversed nightgown slips from her shoulders to reveal her bust. In appropriate circumstances and at proper times, baring one's bust may well be a very proper social gambit, but as long as the practice of nursing together men and women in intensive care wards prevails, it remains reasonable to make a few concessions to modesty. One's dignity is very precious. A sense of modesty is not altogether out of place.

I think it is also important to remember that many patients have access to quasi-medical information. Most people read magazines and many watch television. Quite a lot of medical terminology is, therefore, imperfectly understood. The patient able to hear bits and pieces of discussion between doctors and nurses at the bedside is quite likely to arrive at incorrect conclusions based on the words that he has misunderstood. Already fearful of unexplained events, these ill-heard partial conversations are easily interpreted in morbid terms. It is of particular importance for nurses and doctors not to forget that lack of patient response does not mean lack of perceptual ability. The tendency to discuss the patient in his hearing as an inanimate object is prevalent. So is the tendency to become so preoccupied with the equipment that nursing staff appear to be more interested in the monitor than in the patient to whom it is attached. And, in emergency, those intent on saving a life may well lose sight of the impact of their words or actions on neighbouring patients.

Literature abounds with information regarding the psychological stresses of patients and nurses in intensive care wards, but **patients' families have been given scant attention.** The paucity of literature on families of patients who are in an intensive care ward may reflect an actual lack of staff involvement with families. Very few intensive care areas offer facilities in which relatives may sit, have a cup of tea, and even spend a night. Those caring for the patient tend to forget relatives' anguish — this aspect of intensive care is forcefully brought to our notice by Joyce Travelbee — of seeing loved ones in pain and being unable to help; of waiting many hours between the five-minute periods one is occasionally given to visit a loved one in an intensive care ward; of

listening to the sounds of ventilators and watching the spikes of the monitor attached to one's son, or daughter or mother; of leaving the hospital because one is told that there is nothing one can do and dreading the phone call that says there is not much time to get back; of listening to a doctor when he explains that, if one's relative lives, he will probably be a "vegetable"; and occasionally perhaps of being placed in the position of having to decide whether or not extraordinary measures being used to keep one's relative alive should be continued or to agree to a recommendation that they be discontinued, knowing that whatever the decision may be, one must live with the effects of this decision for the rest of one's life.

You may think that I have parodied the situation, but, while admitting to caricaturing a little, this is what I see every day in my working life. Ten or twelve open cardiac operations and as many closed cardiac operations each week, undertaken by skilled and devoted surgeons, cared for by skilled and devoted anaesthetists and nurses, with incredibly good results. In our hands the operation of, for example, mitral valve replacement carries a mortality of less than 1%. In 200 consecutive replacements one patient has died. Patient care — intra-operative and post-operative — can only be of the highest standard. But need it take the impersonal form it presently does? Can it not be humanised without jeopardising the presently superb clinical results?

The alleviation of distress is the stated goal of physicians and nurses. If distress comes from, for example, an inflamed appendix, we treat it appropriately and without hesitation — why is it that distress arising from fear, anxiety and confusion is so often seen as a nuisance and ignored whereas it will very often respond to intelligent management?

Anxiety can be greatly relieved if the patient can understand better what is happening to him; if he can fit this alien environment into some sort of framework. He needs constant reassurance, not by an attitude of "we know best, you are alright," but by simple explanation, especially of the purpose of the various machines, observations and procedures, and these explanations will need constant repetition.

Meaningful sensory stimuli, especially talking, must be provided. Such stimuli are especially important for patients who are unable to respond for whatever reason including unconsciousness. Nurses must learn to carry on one-sided conversations and commentaries. A patient's mental activity must be mobilised as soon as his physical condition allows and wherever possible prolonged periods of stupor from narcosis must be avoided. Nurses play a vital role in helping patients regain and maintain orientation in time and place. Speak to the patient by name. Tell him the time of day and the day of the week, frequently and repeatedly, and if possible see that there is a clock and a calendar to reinforce this information.

All procedures, nursing and other, should be modified to allow the maximum number of undisturbed sleep periods. Establish from the start a sequence, even if only fragmentary, in which patients can recognise the passage of time, the passage of day into night. If the lights cannot be turned off, at least dim them in relation to a patient who need not be observed in full artificial light. When feeding begins, attempt to identify a familiar sequence of breakfast, lunch and dinner, irrespective of the meal's contents.

If we are to look after patients in a humane way, architects and administrators must collaborate and spend money. Patients should be nursed in individual compartments. They should never be disturbed by activity occurring around other patients or kept awake by the need to maintain a lighted room in order to observe others. They must not be made more anxious by emergency procedures performed on others or by deaths in close relation to them. Monitoring equipment should not be visible or audible to the patient. The monotony of any constant rhythmic signalling sound or light and the anxiety which is inevitably produces, must be removed. Those patients who are aware of the significance of these signalling devices and the danger implicit in any change in their pattern, must not be exposed to this additional stimulus. Patients must be allowed increased mobility by removing as many tubes and wires from their extremities as soon as it is safe so to do. When a rectal telethermometer is no longer being used it must be removed — not found two days after the operation, completely forgotten, when for some other reason the bedclothes are turned back. Intercostal tubes must be removed when they cease to serve a purpose in the individual patient — not the next morning because it is more convenient so to do. To keep a ten year-old whose ductus has been divided in an intensive care ward until the next morning because it is convenient so to do as there are insufficient nurses elsewhere to look after him, is unfair on the child. Adequate numbers of nurses must be found. Stay in the intensive care ward must be tailored to individual needs and not the convenience of staff. In appropriate circumstances, in order to provide a greater variety of meaningful stimuli, where possible each patient should be provided with a patient-controlled radio, and possibly a television set. Centrally controlled ones serve only to increase patients' sense of helplessness.

The intensive care nurse should visit patients for elective surgery pre-operatively, just as should the theatre sisters, since a relationship established before an operation is more effectively used post-operatively. In the same way surgeons and anaesthetists should not be strangers to their patients. It is important to give the patient a feeling that he has some control over what is being done to him by explanation and enlisting his co-operation. Technical discussions on treatment programmes or patient progress in the patient's presence should be avoided. If such are unavoidable, always try to carry the patient with you and in no circumstances dehumanise him by ignoring his sensitivities.

The intensive care ward must not only be regarded as a temporary place where a desired state of physiological, chemical and anatomical balance may be restored or established; it must equally function as the initial phase of psychological recovery. And throughout this, emphasis must be on kindness and the maintenance of the individuality and humanness of the patient.

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