Review Article

Intersecting vulnerabilities in professionals and patients in intensive care

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Abstract: In the context of healthcare delivery, the vulnerabilities of patients in the intensive care unit (ICU) are intricately linked with those experienced on a daily basis by caregivers in the ICU in a symbiotic relation, whereby patients who are suffering can in turn engender suffering in the caregivers. In the same way, caregivers who are suffering themselves may be a source of suffering for their patients. The vulnerabilities of both patients and caregivers in the ICU are simultaneously constituted through a process that is influenced on the one hand by the healthcare objectives of the ICU, and on the other hand, by the conformity of the patients who are managed in that ICU. The specific challenges of management in high-technology units such as an ICU may have consequences on the practices and work conditions of healthcare professionals. Constructing the patient, collectively redefining the patient's identity, and ascribing the patient to a specific healthcare trajectory enables professionals to circumscribe, contain and fight against the spectrum of extreme vulnerabilities of their patients. Imposing this normative framework is the sole means of guiding these professionals through their daily practices. In spite of this, situations of suffering remain a constitutive feature of the caregiving relation in the ICU.

Keywords: Intensive care unit (ICU); vulnerability; caregivers

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In the context of healthcare delivery, it is difficult to discuss the vulnerability of patients in the intensive care unit (ICU) without mentioning, and putting in parallel, the vulnerabilities experienced on a daily basis by caregivers in the ICU. Indeed, the vulnerabilities of each are intricately linked in a symbiotic relation that could be termed an interactional dialectic. Accordingly, patients who are suffering can in turn engender suffering in the caregivers, in the same way, as caregivers who are suffering themselves may be a source of suffering for their patients. To examine this intrinsic relation to medical and paramedical care is to underline the collectively constructed nature of the suffering of others. The first part of this text will focus on showing how the vulnerabilities of both patients and caregivers in the ICU are simultaneously constituted through a process that is influenced on the one hand by the healthcare objectives of the ICU, and on the other hand, by the conformity of the patients who are managed in that ICU. In the second part of this review, we will underline the specific challenges of management in high-technology units

such as the ICU, and the consequences this may have on the practices and work conditions of healthcare professionals. Lastly, we will discuss the complexity of caregiving relations and the difficulty of adjusting professional practices to the technical and ethical challenges of the ICU environment.

Vulnerabilities: between healthcare trajectories and healthcare goals

In the ICU, as in other hospital wards, the care dispensed by healthcare professionals has one overriding, pre-determined objective, which is a sort of guiding course of action to be followed when faced with a new patient that is admitted for care. However, in the delivery of hospital care, not all units have the same objectives. Typically, three main models of healthcare delivery can be distinguished (1):

(I) The objectives of acute care services are mainly "restoration"; this includes services such as critical care, the ICU and surgical specialties. The goal of care is to help the patient recover their former state of health, or at least, as close to it as possible, by restoring the function of vital organs, or through curative treatment for disease.

(II) In the chronic care model, the goal is maintenance, such as departments of cardiology, respiratory medicine, nephrology etc. The care delivered in these units cannot restore the patient to perfect health, but rather aim to maintain stable the status of a patient already impaired by one or more chronic diseases.

(III) Finally, in the palliative care model, which covers palliative care units and mobile teams, the care is mainly dispensed to people in end-of-life situations, with incurable disease at the terminal phase. The objective is to optimize quality of life for the patient up until their death.

It is important to understand these foundations with their different goals, since it is based on these models that the patient's management is envisaged, through the actions of the professionals that are caring for the patient. In other words, identifying the specific goal of the service informs about the "expected role" of the patient, and consequently, how the patient will integrate a specific trajectory of care. In the ICU, for example, patients are supposed to be on a curative trajectory, and only the professional caregivers can determine the appropriate treatments this entails, how long those treatments must last, and whether they are successful or not. Therefore, viewing disease, its treatment and the vulnerabilities associated with that through the prism of the healthcare trajectory makes it possible to better apprehend these vulnerabilities in the framework of a network of interactions that cannot be dissociated from the "work" necessary to implement the healthcare trajectory. According to Strauss *et al.* (2), "trajectory" is a term coined by the authors to refer not only to the physiological unfolding of a patient's disease, but also to the total organization of work done over that course, plus the impact on those involved with that work and its organization. For different illnesses, the trajectory will involve different medical and nursing actions, different kinds of skills and other resources, a different parcelling out of tasks among the workers (including, perhaps, kin and the patient), and involving quite different relationships—both instrumental and expressive—among the workers.

For the subject at hand here, the idea of a healthcare trajectory helps to envisage the shared vulnerabilities of both patients and caregiving staff around a collective definition of an action and its normative framework; the vulnerabilities will then depend on whether the patient integrates the determined trajectory or not. However, it can be difficult for the patient or the patient's family to accept the trajectory. The different identities defined by the healthcare services serve to segregate: Indeed, patients who are admitted do not have the same rights as healthy individuals, nor do they have the same duties and obligations. If the patient does not integrate or conform to the healthcare trajectory defined by the healthcare professionals, then these latter may find themselves in difficulty, which serves to compound the vulnerabilities for both parties in the caregiving relationship. The patient becomes "non-compliant" or "opposed" to care, and can gain a reputation as "a bad patient", precipitating a deterioration in the carer-patient relationship.

Fighting against death: a high-risk goal?

When the caregiving team imposes a new "identity" on the patient, it can be perceived as a form of violence. Yet this construction of a new identity is essential in order for care to be dispensed, and aims to contain the multiple sources of vulnerability of the patient (physical, physiological, psychological and social). It also serves to protect the caregivers, by preventing the patients from slipping beyond their control, or by avoiding giving the patient the impression that the caregiver does not know what they are doing, or cannot take care of them properly, or as well as

the patient would like. When caregivers find no meaning in caring for their patients, this is an extremely deleterious situation and calls into question their professional and personal identify. As underlined by Paillet with regard to pediatric critical care physicians, it is important for professionals working in medical disciplines with high mortality to ensure they continue to believe in the utility of their work (3). It is estimated that nowadays, two out of three people die in hospital, and more than one in five of these dies in a critical care or ICU (4). The main objective of the ICU is to provide care for patients with multiple organ failure whose vital prognosis is endangered in the very short term. The management of these acute patients requires the mobilisation of a complex array of techniques, devices, and monitoring, all within a very short space of time. Emergency treatment is indeed a prerequisite for the activities of this type of unit, which focuses on the curative and biotechnological paradigm in real-life practice. Indeed, one of the founding principles of the discipline of intensive care, when it first emerged in the 1950s, was to stave off, by all available means, the undue death of a patient (5).

Yet, given the severity of the patient profiles in the ICU, mortality in these units is not merely a marginal phenomenon, but on the contrary, a constant presence; almost regular, one might say. At a national level in France, critical care and ICUs account for a very high rate of death, ranging from 20% to 30%. Accordingly, for almost one in three patients admitted to critical care, the outcome will be death. This frequent relationship with death may cause problems for the professionals working in these units. Indeed, it is a regular and often violent reminder that they have failed in their primary mission, and this permanently calls into question their professional identity. How can we deal with death in an environment that is, by definition, constantly on the alert and incessantly fighting to ward it off (6)? In view of the severity of the medical situations managed in the ICU, end-of-life situations are a major component of their activity, and at a national level in France, critical care and ICUs top the list in terms of number of deaths. Patients die more often in the ICU than in any other type of unit or ward (4,7) and this phenomenon is becoming increasingly accentuated over time, with the advancement of technologies allowing artificial prolongation of life in these patients. Clearly, the relationship to death is completely transformed by the professional and technical-scientific environment; the frontier between life and death is becoming increasingly tenuous and malleable for those managing the patients. As Kentish-Barnes points out (8), death in the ICU is no longer the sign of a natural passing, nor the sign of a sudden rupture with time, but rather, is the result of a medical decision implying discussion, intervention and actions, over a new and defined time schedule, that together constitute a cluster of professional practices. Thus, death is produced in the ICU (9).

Nonetheless, for the professionals involved, the price to pay for this technical (10,11) and scientific rationalisation of the management of death and the deceased (11,12) is the forgetting of the body [or affective mutilation according to Pouchelle *et al.* (6)] and an emphatic denial of the dangerous nature of their work (13). Kentish-Barnes (8) observed that contrary to palliative care (14), critical care does not satisfy the "ideal" of death: death is omnipresent (with mortality rates of 25% in critical care), but does not have a meaning that is understood and shared by all. Death occurs daily, and it does not perturb the work routine, but it can be violent and contributes to the exhaustion of all those involved, both professionals and non-professionals. The individuals who fight to save their patients' lives see death as a failure. Thus, it hides and "goes on" in darkness. Death is a problem for the caregivers, but also for the establishment itself, since this latter can only exist if its members (staff) can justify their role. While their primary function is to save the patient, justifying the production of death is a complex task for healthcare professionals (8).

Indeed, in critical and ICUs, it can be observed that the suffering of the caregiving staff is substantial, and there are a number of telltale signs of this. Professional exhaustion is frequent, with high rates of absenteeism, staff turnover, and burnout. Various studies have reported burnout rates of 46.5% among ICU physicians (15), burn-out syndrome-related symptoms in 33% of critical care nurses (16) and 24–29% of post-traumatic stress disorder, also in critical care nurses (17). Caregiving teams in the ICU also have to face recurrent organisational difficulties, such as the inability to fill vacant positions (18): 36% of French ICUs have at least one vacant medical position, and difficulties recruiting paramedical staff are encountered in numerous medical wards. Paramedical care, primarily carried out by critical care nurses, as well as medical care involves a high emotional burden in the ICU, and is accompanied by a strong perception of pressure in one's work (19). To withstand these pressures, professionals in this discipline activate coping mechanisms and try to keep control of, not to say reduce, the vulnerability inherent to the caregiver-

ICU patient relationship.

Extreme vulnerability and complex relations

A central feature of the caregiver's activity is to maintain a stable and harmonious relation with the ICU patient and his/her entourage, when they are present. In intensive care, the patient is usually artificially kept asleep, or is unconscious and therefore unable to understand or may be comatose. Indeed, even patients who are conscious may be profoundly disoriented, at a loss for their usual landmarks and familiar family environment (6,7). The caregiver-patient relation is therefore rendered complex in the ICU, and paramedical staff in particular can sometimes feel dispossessed of the relational dimension to care. The major risk that this absence incurs is depersonalisation of the patient and of the dying. The frequent use of devices and technical equipment often required for treatment in ICU patients can also encourage the caregivers to distance themselves from the patient. As one 30-year-old nurse stated, "*With all the technology around the patient, and the machines in the room, in the end you can't really see the patient in all that at all. It's like a barrier between him and us.*" By becoming an "object of care", the patient attains an extreme degree of vulnerability. In the case of difficult relationships, where the patient doesn't follow the appropriate "trajectory", either by opposing the care proposed, or by failing to respond correctly to the treatment implemented, then the use of reification (often symbolised by the use of sedation) can be perceived by caregiving staff as a means to make the work easier, including accepting to take a few supplementary risks. Working "on" a patient who is unconscious and inert substantially reduces the level of stress, and makes it possible to focus activities solely on the technology and to be more attentive to each gesture performed. Sedation thus appears as a means for caregivers to protect themselves against the strong emotional burden, and the pain of the conscious relationship with the patient. The way the caregivers manage the distribution of vulnerabilities is therefore a question of arbitration between the search for personification and the search for reification, and both these processes in turn are largely dependent on the types of trajectories imposed on the patients. Accordingly, in the eyes of the caregivers, there are two types of trajectory, which are represented on the one hand by conscious patients, called patients with a relationship, often those who survive; and on the other hand, by unconscious patients, who have become purely "objects to be cared for". Giving the patient too much autonomy could be deleterious for the quality of care, whereas on the contrary, depriving the patient totally of autonomy could lead the caregivers to ignore and eliminate the constituent relational dimension of their professional identity. This dichotomy within the healthcare trajectories of ICU patients (both conscious and unconscious patients) implies that the caregivers must find the delicate balance between putting their own vulnerabilities at stake (both professional and personal), and those of the patient they are caring for.

Conclusions

We have seen how it is clearly necessary not to make a distinction between the vulnerabilities experienced by patients in critical and/or intensive care and those of their caregivers (physicians or nurses). Constructing the patient and collectively redefining—either temporarily or sometimes definitively—the patient's identity, and ascribing him/her to a specific healthcare trajectory enables professionals in these highly technological units to circumscribe, contain and fight against the spectrum of extreme vulnerabilities of their patients. However, imposing this normative framework, difficult as it may be for the patient or his/her entourage to accept and endure, is nonetheless the sole means of guiding these professionals through their daily practices. Yet, despite these collective mechanisms, situations of suffering remain a constitutive feature of the caregiving relation in the ICU. The unique nature of this caregiving relation places professionals in this domain at the fine line between self-preservation, and preservation of others, and requires each party in the relationship to carry out their role so that they can build trajectories of care together.

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Footnote

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