How to humanise the COVID-19 intensive care units

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The COVID-19 is altering the way patients and families endure illness and death. To mitigate the spread of the virus, patient isolation and visitor restrictions in hospitals have been implemented at a scale never seen before. This means that once hospitalised, patients are isolated from their families until discharge. There remains a sort of undefined mental space of wondering if this is a temporary separation or a step towards final departure.[1 2] At the same time, outside the hospitals, there are the relatives of patients waiting anxiously for updates. In some cases, because of the exposure to patients, they are quarantined and may live with the feelings of guilt and anxiety of having unwittingly contributed to the spread of the illness.

This traumatic separation could make both patients and relatives vulnerable to different degrees of stress disorders as well as depression and anxiety.[3] Because these symptoms will likely continue even after the pandemic has subsided, virtual and/or on-site psychological support should be proposed promptly to patients and their families during the hospitalisation and after discharge from the hospital.[3]

Social isolation during the COVID-19 outbreak also means that patients often die without family and significant others by their side. The patient' relatives, in turn, are forced to relinquish two important moments of human remembrance, to accompany the dying in their final moments and to bury them according to individual funeral rituals.[4] The coronavirus pandemic has revealed how unprepared we are, as a culture, as individuals and as healthcare workforce, to face suffering and death on such a large scale. In Western culture, suffering and death are rarely discussed and are often considered a taboo. However, in the last few months, since the pandemic exploded, they are consuming us and invading the mass media.

What to do? How to act?

In this hectic period of emergency care and human needs, the stretched and often overburdened healthcare workforce is called to respond to the COVID-19 outbreak both clinically and humanely.[5 6] That means not only providing patients with excellent medical care through the appropriate treatment and supportive measures but also taking care of their emotional well-being continuing to promote and ensure the humanisation of the intensive care unit (ICU).[7]

Doctors and nurses cannot go into a patient's room unless strictly necessary and only if they wear masks and are completely covered with protective equipment. Although that places severe limitations on human interaction, different strategies can be adopted to provide emotional and psychological support for patients, families and staff, while keeping everyone as safe as possible.[8 9]

Simple acts of physical contact, like holding hands, a touch or a gentle massage, can make the patients feel connected to their loved ones. Moreover, if infrastructure and model of care permits, non-pharmacological interventions, like progressive muscle relaxation, guided imagery, music therapy and meditation, could be proposed to both patients and families for alleviating pain, discomfort and anxiety.[10–12] Furthermore, where appropriate, the use of personal tablets and mobiles could represent a valid strategy to allow patients to maintain contact their relatives. Where available, the introduction of TV, laptop or radio could also help patients to mitigate their sense of isolation. These acts of care should meet the individualised needs of the patient and family.[8] Equally important for the humanisation of the COVID-19 ICUs is the communication between the healthcare professionals, patients and their relatives. Good communication is more than just the simple exchange of information, representing an important tool to build trust and respect, and facilitate joint decision-making. At its best, communication encompasses emotional understanding and responsibility and, especially in the case of the worst prognosis, can help the process of mourning. That is, when done well, it offers reciprocal benefits: patients would be less anxious, and their families could have more time to accept the clinical condition of the loved ones.

Humanising ICUs also means paying attention to the mental and physical health of healthcare professionals who are forcing to work strenuous hours to fill staffing gaps, and are dealing with the shortages of personal protective equipment. While all are dedicating attention and efforts to the care of patients, the healthcare workers are putting themselves at risk of infection. To cite a case, at the time of writing this paper, at least 261 Italian healthcare workers have died after contracting COVID-19, as reported by the Italian National Federation of Orders of Surgeons and Dentists (FNOMCeO) (https://portale.fnomceo.it—data accessed 16 December 2020). That is, the emotional workload and stress of healthcare workers are stretching their resilience to the utmost.

Specific measures have been adopted for helping the ICU teams to process and grieve the loss of patients and colleagues, to alleviate stress and to prevent the burn-out syndrome. These include cognitive behavioural therapies, establishment of support groups and stress reduction trainings. Not least, the creativity of healthcare

professionals to humanise the ICUs could be itself helpful with their work strain and satisfaction in care delivery.

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References

1 **Guan W-jie**, Ni Z-yi, Hu Y, *et al*. Clinical characteristics of coronavirus disease 2019 in China. *N Engl J Med Overseas Ed* 2020;**382**:1708–20.
2 **Giuliani E**, Melegari G, Carrieri F, *et al*. Overview of the main challenges in shared decision making in a multicultural and diverse society in the intensive and critical care setting. *J Eval Clin Pract* 2020;**26**:520–3.
3 **Duan L**, Zhu G. Psychological interventions for people affected by the COVID-19 epidemic. *Lancet Psychiatry* 2020;**7**:300–2.
4 **Taiana C**. Mourning the dead, mourning the disappeared: the enigma of the absent-presence. *Int J Psychoanal* 2014;**95**:1087–107.
5 **Bogle AM**, Go S, Bad B. Breaking bad (news) death-telling in the emergency department. *Mo Med* 2015;**112**:12–16.
6 **Bloomer MJ**, Bouchoucha S. Editorial: COVID-19 and what it means for end-of-life care in ICU: balancing the priorities. *Collegian* 2020;**27**:248–9.
7 **Ranse K**, Coombs M. The courageous practitioner during end-of-life care: harnessing creativity in everyday acts. *Aust Crit Care* 2019;**32**:449–50.
8 **Galvin IM**, Leitch J, Gill R, *et al*. Humanization of critical care-psychological effects on healthcare professionals and relatives: a systematic review. *Can J Anaesth* 2018;**65**:1348–71.
9 **Parmet WE**, Sinha MS. Covid-19 — the law and limits of quarantine. *New England Journal of Medicine* 2020;**382**:e28.
10 **Liu K**, Chen Y, Wu D, *et al*. Effects of progressive muscle relaxation on anxiety and sleep quality in patients with COVID-19. *Complement Ther Clin Pract* 2020;**39**:101132.
11 **Giordano F**, Scarlata E, Baroni M, *et al*. Receptive music therapy to reduce stress and improve wellbeing in Italian clinical staff involved in COVID-19 pandemic: a preliminary study. *Arts Psychother* 2020;**70**:101688.
12 **Behan C**. The benefits of meditation and mindfulness practices during times of crisis such as COVID-19. *Ir J Psychol Med* 2020;**37**:1–3.