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Humanising Critical Care: Role of the Primary Care Physician

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ABSTRACT

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Most of the patients in critical care units suffer prolonged periods of pain and discomfort. The treatment of such patients has become purely mechanical and devoid of any "human touch". The critical care physicians often forget about the patient's anxiety and fears and treat them as just another "case"

A primary care physician with his understanding of the patient and his family is the ideal person in providing the human touch in critical care. He should see that his patients are not subjected to unnecessary suffering and pain. He should serve as an intermediary between the critical care physician and the patient's relatives in addressing their fears and concerns. He should know the limits of care and when to stop aggressive treatment. For achieving all these objectives the primary care physician should have a clear and broad understanding of the principles and practice of critical care.

Keywords: Humanising care, Critical care, Primary care physician, Critical care physician, Narrative competence

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HISTORY

Critical Care evolved in Europe during the polio epidemic in Copenhagen, Denmark in 1952.[1] During this epidemic it was found that the mortality rate of patients affected by respiratory paralysis was considerably reduced by transferring all such patients to a designated specific area in the hospital and by giving manual positive pressure ventilation.

Critical Care in India

During the early seventies the critical care units in India were chiefly designed and equipped to offer intensive care to patients suffering from acute myocardial infarction.

The first coronary care unit in India was started in 1968 at the King Edward VII memorial hospital in Mumbai.[2] Critical Care Medicine in India has presently evolved into a specialty in its own right. As life expectancy increased, the number of patients who needed critical care also increased. Hospitals, especially in the private sector responded to this need by increasing their bed strength in the intensive care units (ICU) and appointing critical care specialists and nurses.

Who really needs Critical Care?

There is no doubt that the critically ill patients are ideally cared for in such a well organized and well equipped units with trained personnel including critical care physicians and nurses. It has been proved beyond doubt that better patient outcome is directly proportional to the presence of trained and dedicated full time critical care physicians in such units.[3]

Selecting the patients who really need critical care is very important, as our resources are very limited. Critical care should be offered to only those patients who have a life threatening medical or surgical problem where organ support systems and monitoring are essential for their survival. However it is often seen that the patients are transferred to a critical care unit just for the convenience of the treating doctors, nurses and the patient's relatives who are under the false impression that ICU care is better than non ICU care in all patients.

Critical Care and the Primary Care Physician

"To cure rarely, relieve sometimes and comfort always" is nowhere more applicable than in a critical care unit. It is often forgotten that the critically ill patient is a human being who is anxious and fearful. He is treated as just another "case" in a critical care unit. His feeble voice is not heard among the beeps and alarms of high tech gadgets. Repeated invasive procedures add to his pain and suffering. He may die a miserable death in a purely mechanised environment, without the loving

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touch of his near and dear ones.

Physicians with narrative competence can play an important role in humanising critical care. Narrative competence is the ability to acknowledge, absorb, interpret and act on the stories and plight of others.[4,5] A primary care physician with his understanding of the patient and his family is the ideal person in providing this human touch in critical care.

When patients under his care are shifted to the ICU and entrusted to the critical care consultant, the primary care physician presumes that his role is over. In fact he should be actively involved in the day-to-day management of his critically ill patient as he only has a better understanding of his patient's problems. He should see that his patients are not subjected to unnecessary suffering and pain. He should be the intermediary between the critical care physician and the patient's relatives in addressing all their concerns. For all this the primary care physician should have a clear and broad understanding of the principles and practice of critical care.

It is often seen that the critical care physician seemingly playing the role of God and subjecting his dying patients to the misery of aggressive management. He considers his patient's death as his failure. He is not ready to accept the inevitable. It is imperative that the physician should know the limits of care – that all his patients cannot be saved – and when to stop aggressive treatment.

END NOTE

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