

Review

Bench-to-bedside review: Humanism in pediatric critical care medicine – a leadership challenge

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Abstract

A humanistic approach to leadership is especially important in the case of children in the technology-rich intensive care unit (ICU) environment. Leaders should create a humanistic milieu in which the needs of critically ill children, their families and staff are never overlooked. Humanistic leaders are tactful, accessible, approachable and versatile, and have a sense of humour. Humanness in the ICU environment has many faces and poses a challenge to many in leadership positions. Humanistic leaders treat others as they hope they will become. They are constantly questioning themselves, seeking awareness of themselves and others, but most importantly they are constantly learning and evolving. Ultimately, humanistic leadership creates an ICU culture that supports all, is conducive to enriching lives, and is sensitive to the needs of patients and their families.

Introduction

The practice of critical care medicine involves complex interactions with many individuals (family and health team members) in a sometimes stressful technology-rich environment. It is crucial to maintain good working relationships, particularly when caring for the critically ill child whose clinical condition may change from minute to minute and whose outcome may depend on intimate and continuous collaboration between many disciplines. It is a challenge to provide humanistic leadership and foster morale in this environment. How we treat our colleagues and those entrusted to our care is intricately linked to the morale of the paediatric intensive care unit (PICU) and ultimately to the well being of staff and patients. How do we as leaders foster morale and humanism in the PICU?

The word 'humanism' has a number of meanings. In its broadest sense humanism is 'a system of thought that defines a socio-political doctrine whose bonds exceed those of locally developed cultures, to include all of humanity and all issues common to human beings' [1]. However, humanism also has several meanings, each of which constitutes a

different variety of humanism. Cultural humanism is the rational and empirical tradition that now constitutes a basic part of the Western approach to science, political theory, ethics and law. Modern humanism (ethical humanism) is a naturalistic philosophy that rejects all supernaturalism and relies primarily on reason and science, democracy and human compassion. It has a dual origin, both secular and religious, which constitute its subcategories. Religious (spiritual) and secular humanism both share the same world view and the same basic principles. It is only in the definition of religion and in the practice of philosophy that they disagree [2].

This review attempts to outline the attributes and roles of a humanistic leader in critical care. Although reference is made to the PICU environment, the attributes and roles of humanistic leadership are equally applicable to the adult intensive care unit (ICU).

Fostering humanism by culture

Humanism cannot be legislated but must be instilled in the culture of the PICU. To foster humanism requires us not only to lead by example but also to teach these dimensions to all PICU staff. For physicians it should start early in their medical education. In a thoughtful paper, Branch and colleagues [3] pointed out that professional organizations have repeatedly called for greater emphasis on the humanistic dimensions of medical education [4,5]. However, although it is generally assumed that humanism is learned by medical students and residents through formal teaching and observing faculty physicians as role models, little evidence supports the effectiveness of faculty role modelling as currently practiced.

This is due to the fact that trainees are more likely to learn or be influenced by the hidden or informal curricula. For instance, if the pervasive culture or behaviour does not espouse humanistic care, then students may become cynical and ignore the formal teaching. If the culture of the institution

does not foster humanistic practice, the process of socialization into this culture trumps specific teaching. Branch and colleagues [3] defined humanism in medicine as ‘the physician’s attitudes and actions that demonstrate interest in and respect for the patient and that address the patient’s concerns and values. These generally are related to patients’ psychological, social and spiritual domains.’ However, this seems too restrictive a definition, especially in paediatric critical care medicine, in which the psychological, social and spiritual needs of the patient, as well as those of the extended family and staff, are important. Attending to the needs of patients only while ignoring the needs of families and PICU staff is unlikely to promote a climate of humanism. Such an approach is likely to result in sporadic acts of humanism (good actors for short periods of time) and is doomed to fail. To influence the attitudes and values of others, we must establish a climate of humanism.

Traits of the humanistic leader

Edwards [2] summarized the basic ideas held in common by both religious and secular humanists (Table 1). A humanistic leader must develop a behavioural style that incorporates the basic ideas of Edwards and many of the following attributes [6]:

1. The ability to know when to make changes or recommendations or take action;
2. The ability to make changes or use strategies to obtain desired results with few bruised egos or fractured relationships; superb communication skills and the ability to conduct dialogue are vital;
3. The art of projecting sensitivity, fairness and consistency with all individuals; the ability to project an open, honest sincere and caring attitude;
4. The ability to switch gears, thoughts and processes quickly, while maintaining control of a situation; this allows one to be open without compromising one’s position; and
5. The ability not to take oneself too seriously; it allows one the ability to make mistakes occasionally without losing one’s overall credibility or authority.

These traits will foster a humanistic culture in critical care where several disciplines with differing opinions and agendas may be involved in caring for a critically ill child. For example, in a PICU many disciplines (pulmonology, cardiology, cardiac surgery and critical care) will be involved in making the decision to place a child on extracorporeal life support. When the occasion arises, the critical care leader must demonstrate the traits outlined above. The opinions of all disciplines should be acknowledged; there should be open and honest dialogue; and there should be sensitivity in communicating the plan of action and an agreement to re-evaluate the situation as the clinical course warrants. In addition, acknowledgement of being wrong should be encouraged and applauded rather than viewed as failure and denigrated. Without a humanistic leader who fosters a humanistic culture, the process is likely to be chaotic and lead to bruised egos and dysfunctional working relationships. Development of

Table 1

Basic ideas of humanists

- Explore and challenge all areas of thought
 - Make no claims to possess or have access to transcendent knowledge
 - Reject arbitrary faith, authority, revelation and altered states of consciousness
 - Recognize that intuitive feelings, hunches, flashes of inspiration, and emotion may lead to new ways of looking at the world
 - Regard human values as making sense only in the context of human life
 - Be concerned with meeting human needs and answering human problems
 - Recognize the existence of moral dilemmas
 - Accepts contemporary scientific concepts
 - Accepts today’s enlightened social thought
 - Accepts new technological developments
 - Is a philosophy for those in love with life
-

these attributes requires strong leadership committed to establishing a climate of humanism. Leaders should be coaches and encourage strong collaboration, emphasizing their colleagues’ strengths and enabling colleagues to be the best that they can be. Leaders should be skilled in observation, analysis and working through problems, focusing on a supportive positive atmosphere and exchange of ideas, delegating, and giving and receiving feedback.

An example in our PICU is the approach to the management of postoperative congenital heart disease patients. Although intensivists, cardiologists and cardiac surgeons may have disparate views of management, a humanistic climate with strong leadership has resulted in a collaborative approach. The views of all are heard (free exchange of ideas), key players are asked to write a protocol (delegating) and repeated discussions (giving and receiving feedback) resulted in agreement on the protocol. The opinion of no one individual or group is felt to be more valuable or to trump those of others.

Fostering humanism by example

In all aspects of care an appreciation and attention to cultural, religious and socioeconomic aspects of care is important. For instance, following dietary restrictions, adherence to ritual and religious beliefs such as rejection of blood products in a Jehovah Witness may be more important to the family than the ultimate outcome of the care provided. Recognition of socioeconomic constraints such as the inability to pay for care or to be away from work, and trying to alleviate these hardships are very important aspects of humanistic care.

Humanism in caring for the child

Putting the child first entails a thorough appreciation of their special needs, including their psychological well being.

Putting the child first also means that we must do our best to decrease and allay their fears and anxiety, rather than only treat their symptoms and disease. To a large extent, we are all well trained in recognizing the physiological needs of the critically ill child. It has been a part of our core training, and our special skills and intuition make us unique in this regard. We are also more cognizant in attending to the psychological needs as well as some medical aspects of care such as pain management in children than in the past. Being aware of our shortcomings and striving toward their elimination will, in the long run, increase our ability to provide the best care for children.

In providing care for our patients, we should strive to provide patient-centred medicine. Our patient-centred medicine would be slightly different from that outlined by Laine and Davidoff [7], because in many cases our patients are unable to assimilate the information and participate in meaningful decision making. However, the principle still applies with the parent accepting the decision-making role for the child. Patient-centred care is under siege for a variety of reasons. The tension between the science and the art of medicine and the severe strains related to the rapid changes in medical economics are two major stressors on this relationship [8]. However, despite these obstacles patient-centred medicine continues to evolve in many areas, including medical decision making [9,10]. Although this evolution is also occurring in the PICU, living wills, advance directives and patient preferences are usually not relevant. In the PICU teenagers are encouraged to participate in decision making concerning their care. However, a younger child's care is usually directed by their parents or legal guardian. For instance, parents are involved in decisions to limit or withhold therapy such as cardiopulmonary resuscitation and experimental procedures. Parents' preferences therefore may be the surrogate for the patient's preferences in the PICU. Some have even recommended that patient (parent) preferences become a standard component of the medical record [11]. Changes have also become apparent in medical law, especially as it relates to informed consent and medical education [12]. In addition, patient-based outcomes are often the major outcomes considered in research [13–15]. These trends are important and should be recognized by leaders in paediatric intensive care and incorporated into the daily routines of the PICU.

Caring for children in the PICU also involves responding to the needs of dying patients. It is well recognized that life-sustaining technology has greatly expanded the possibilities of medical intervention at the end of life. However, these technologies may have outpaced development of good judgement concerning their appropriate use [16]. Recognition of this fact led a working group of specialists in critical care, palliative care medical ethics, consumer advocacy and communications to convene a national consensus conference to discuss how best to teach about death and care of the dying in various clinical settings [17].

Although the authors' slant relates more to adults, the principles they espouse are equally relevant to the dying child. The authors emphasized the importance of teaching decision making in the face of uncertainty [18], familiarity with prognostic scoring systems and guidelines for triage in critically ill patients [19–21]. The principles outlined – such as appreciating the patient as a person, communicating effectively and listening to families, being comfortable discussing death with patients and their families, negotiating the overall goals and care, switching from provision of life support and therapy to comfort care, providing excellent palliative care, giving explanations in clear understandable language, and working effectively in collaboration with the multidisciplinary health care team – are also applicable and desirable in the PICU setting [22]. Despite these principles and despite best intentions, the issue of death, especially in the PICU, is difficult to deal with. This is because in many instances (trauma, near drowning and sepsis) the child's death is sudden and unexpected, and so families are unprepared to participate rationally in decision making. In addition, it is more difficult to discuss death in a young child with families than it is to discuss death in an adult, who might have provided a living will or advance directives. Moreover, in many cases death is easier to accept in the adult when the family's perception is that the individual has lived a full life.

Humanism toward families

Humanism also involves paying attention to the needs of the family. Provision of care for the family requires an appreciation of their cultural and religious diversity and life experiences. Families' different fears, hopes, dreams, aspirations and expectations are fuelled by life's experiences. It is important to recognize, more so in paediatrics, that we are treating siblings, parents and, in many cases, an extended network of relatives. Whatever the composition of the family, the humanistic leader recognizes that paternalistic physician–patient/family interactions are outdated and should be replaced by partnership. Patients and parents need to be treated as equal partners as far as possible and be allowed dignity and control to the extent that is practical.

However, participation of parents in deciding what is the best care for their children is complicated. In many circumstances we are unsure regarding which of the many therapeutic options may be the best. Moreover, in an exhaustive review on medical decision making, Schneider [23] reported that the ill (and, I suspect, parents of the ill) were often in a poor position to make good choices; they were frequently exhausted, irritable, shattered, or despondent. Schneider found that physicians, being less emotionally engaged, are able to reason through the uncertainties without the distortions of fear and attachment. Physicians have the benefit of norms based on scholarly literature and refined practice, as well as the relevant experience to assist in decision making. Gawande [24] argues that pushing patients (and in pediatrics, parents) to take responsibility for decisions

if they are disinclined would seem like an equally harsh paternalism in itself. As Schneider [23] stated, 'what patients (parents) want most from doctors isn't autonomy *per se*; it's competence and kindness.' Gawande concurs in stating that, 'as the field grows ever more complex and technological, the real task isn't to banish paternalism; the real task is to preserve kindness.' Quill [25] described the ideal modern patient-physician relationship as a contract under which both parties have unique responsibilities, the relationship is consensual not obligatory, both parties must be willing to negotiate and both parties must benefit. This seems to be the ideal for which we must strive. The physician-patient-family partnership in longitudinal care makes the decision making process between physician, patient and families easier. This is unlikely to be the case in the PICU, where the encounter is usually brief and sudden. However, a prompt, consistent and unambiguous message to families may help in fostering a close working relationship. The humanistic leaders are knowledgeable with the issues outlined and are prepared to step in when conflicts arise.

Humanistic leaders should also be involved in resolving conflicts such as who should be the ultimate arbiter when the parent and the physician disagree. Although we would like rigid protocols to deal with conflicts, this approach seems ill-suited both to a humanistic relationship between doctor and family and to the reality of medical care in the PICU, where many decisions must be made quickly. Under these circumstances the doctor should not make all decisions and neither should the parent. Decisions should be worked out one-on-one as they arise. For optimal care, this would involve to some extent guiding the parent and teaching them in the art of being the parent and child's advocate. For instance, parents should be encouraged to question physicians, insist on explanations, and use persuasion at times when the medical staff insist that a particular treatment may be useless or harmful to their child. Ethicists may find this line of reasoning disturbing and we will continue to struggle with how patients and doctors should make decisions.

Humanism toward staff

The humanistic leader recognizes the need to support staff, including nurses, paramedics, respiratory therapists, laboratory and support staff, and our subspecialty colleagues with compassion and respect at all times. Like us, they work in a stressful and emotionally charged environment where their response to adverse events must be swift and often relies on incomplete data. They are also victims of human frailties, and suffer and agonize when things go poorly. Their emotional highs and lows may mirror their patient's clinical status. These emotional upheavals are superimposed on decisions about their career goals and aspirations as well as the family issues that are part of our daily lives. They should be praised and congratulated when deserved, and they should be respected and their advice freely solicited at times. They should be corrected and criticized when wrong, taught

Table 2

Characteristics of mindful practice

- Active observation of oneself, the patient and the problem
- Peripheral vision
- Pre-attentive processing
- Critical curiosity
- Courage to see the world as it is rather than as one would have it be
- Willingness to examine and set aside categories and prejudices
- Adoption of a beginner's mind
- Humility to tolerate awareness of one's areas of incompetence
- Connection between the knower and the known
- Compassion based on insight
- Presence

ways of doing things better, and encouraged to strive continuously for excellence. They should always be treated with dignity and respect. A humanistic approach relies on timing, tact and finesse in giving advice and criticism. Regardless of the nature of the interaction, the staff should be always supported emotionally.

Provision of support and guidance is easy when a collegial relationship exists in which staff and colleagues are striving to provide superb and compassionate care. This is not always true, and on occasions the belief systems and values of staff are diametrically opposed to the practice of humanism in the ICU. This is likely to result in suboptimal communication, suboptimal care and a disruptive work environment. Part of encouraging humanism in the PICU is not only to provide the appropriate culture and work environment, but also to challenge all staff on a regular basis and to continue to reassess ourselves to determine whether we are contributors to this culture. One way to demand that individuals engage in humanism in the ICU is to encourage reflection and self-awareness. Epstein [26] discussed methods that physicians may use to examine their belief systems and values, and deal with strong feelings, make difficult decisions and resolve interpersonal conflict. Although his report pertains primarily to physicians, the characteristics of mindful practice (Table 2) are pertinent to all involved in critical care medicine. Epstein's dissertation on mindful practice emphasizes that humanistic leaders must have emotional intelligence. This refers to the capacity to recognize our own feelings and those of others, to motivate ourselves, and to manage emotions well in ourselves and in our relationships [27]. If we as leaders in critical care engage in mindful practice, we can then lead others to adopt these principles.

Mindfulness is a discipline and an attitude of mind. The goal of mindfulness is compassionate informed action, to use a

wide array of data, make correct decisions, understand the patient and relieve suffering [26]. These are difficult goals in that barriers to mindfulness, including fatigue, dogmatism and a closed mind to ideas and feelings, are common in medical practice [28,29]. Although an extensive discussion of mindful practice is not possible here, suffice it to say that mindful practice requires mentoring and guidance. It also requires recognition of one's limitations and areas of competence, and is an individual and subjective process. As leaders, we must embody the attributes of mindful practice and identify unique ways to mentor and guide others to strive to achieve the same. Mindful practice should not be in the domain or expectation of physicians only but all staff. Humanistic leaders foster the alignment of the PICU workforce toward the unit's goals of excellence and humanism.

Conclusion

Humanism in the ICU environment has many faces and challenges. Humanistic leaders are those with emotional intelligence who constantly question themselves and seek awareness of themselves and others, but most importantly they must always be genuine, sincere and transparent in dealing with others. They should strive continually to foster a culture of humanness in the ICU and should be constantly encouraging and supervising the personal growth of staff members. Humanistic leadership is part of our responsibility to our patients, their families and our colleagues. This responsibility should spur us on to cultivate a humanistic culture conducive to enriching their lives. Supporting others and treating them as we hope they will become enriches their lives and ultimately enhances our own humanism. If there is a greater reward for leadership efforts, it has eluded me.

Competing interests

The author(s) declare that they have no competing interests.

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