Figure 1. Dehumanization and Humanization of Intensive Care Unit Patients

DEHUMANIZATION of ICU patients

MEDICAL TEAM BEHAVIORS

- Talking "over" the patient and not "to" the patient (often when the patient was assumed to be unaware)
- Not introducing themselves or explaining what they are doing or why
- Not learning about the patient as person outside of the hospital
- Not allowing family presence
- Ignoring or minimizing suffering
- Saying distressing, dismissive, or offensive remarks (often when the patient was assumed to be unaware)
- Blaming, mocking, or getting angry (e.g. for soiling themselves)
- Touching roughly or without explanation (e.g. during bathing or repositioning)
- Neglecting hygiene or usual appearance (e.g. oral care, hair, dentures, eye glasses, etc.)
- Disregarding privacy and modesty
- Interrupting sleep (or other patient centered activity)
- Preventing the patient from exercising any control or participation
- Not preparing the patient for ICU or post-ICU events

CONSEQUENCES

Patient/family

- Felt devalued by (or a bother to) the medical team ("just a body in a bed")
- Loss of trust in the medical team
- Loss of motivation to participate in recovery plan
- Disorientation (misinterpreted reality)
- Distress (fear, panic, anxiety)
- Loss of encouragement and support
- Loss of patient advocacy
- Suboptimal medical treatment (neglect)
- Family guilt, depression, anxiety

CAUSES

Patient/family

- Medicalized and ill appearance
- Impaired cognition (sedated or not interactive)
- Language barrier (does not speak English)
- Perceived to be difficult or have exceptional needs
- Perceived to be the cause of their own illness
- Absence of family advocate at bedside

Medical Team

- Coping mechanism for the medical team's own distress
- Focus on task completion
- Lack of situational awareness (of the patient's suffering or situation)
- Time constraints
- No training in or modelling of humanized care
- No personal experiences of being an ICU patient or family

Medical System

- Computers, medical records, prioritization on documentation
- Dehumanized culture (aspects of dehumanized care are normalized)
- Fragmented care (e.g. shift changes) leads to less engagement
- Protocols do not allow for humanizing behaviors (e.g. CPR protocol)
- Hospital schedules do not fit individual patient needs

HUMANIZATION of ICU patients

MEDICAL TEAM BEHAVIORS

- Talking "to" the patient and not "over" the patient (even when the patient was assumed to be unaware)
- Introducing themselves and explaining what they are doing and why
- Learning about the patient as a person outside of the hospital
- Allowing family presence
- Compassionately addressing suffering
- Providing a personalized environment (e.g. favorite music or items from home)
- Using empathic and encouraging language
- Using appropriate physical touch (e.g. holding a hand) and notifying/explaining to the patient before other physical touch (e.g. repositioning)
- Attending to hygiene and usual appearance (e.g. oral care, hair, dentures, eye glasses, etc.)
- Respecting privacy and modesty
- Respecting sleep (or other patient centered activity)
- Finding ways to allow the patient to exercise control and participation
- Preparing the patient for ICU or post-ICU events

CONSEQUENCES

Patient/family

- Improved physical recovery
- Improved emotional and mental well-being
- Better comprehension of reality and less delirium
- Felt valued ("treated me like I was family")
- Increased trust in the medical team
- Improved physician/family relationship
- Increased sense of involvement and purpose

Medical Team

- Increased empathy for the patient
- Increased motivation to help the patient
- Spent more time with the patient
- Valued the patient as a person
- Developed a personalized care plan
- Better understood goals of care
- Found joy and felt "humanized" themselves (shared humanization)