EDITORIAL

Building communities of respect in the intensive care unit

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“R-E-S-P-E-C-T”, calls out Aretha Franklin in her legendary 1967 soul anthem, you “don’t know what it means to me”. As we have spent several years considering the question of respect as it applies in the intensive care unit (ICU), we’ve come to appreciate both the power of Franklin’s song and the conundrum posed by the reality that we don’t know as much about respect as we think.

Many groups have been whittling away at that ignorance. We and collaborators have proposed a conceptual framework and research program [1, 2] and reported the results of a modified Delphi consensus process to provide guidance to health systems attempting to improve the practice of respect in healthcare [3]. Some investigators have implemented systems for monitoring and responding to disrespect events [4]. Others have documented the ubiquity of disrespectful ICU cultures across the world [5, 6]. We have also explored unintended consequences and tragic trade-offs in respect [7]. To facilitate discussion, we have adopted a practical definition (admitting considerable complexity in the philosophical debates underlying questions about human dignity [8]) for the key terms, respect and dignity: “dignity represents the inherent worth of all human beings, and respect represents the actions that appropriately honor and acknowledge such dignity” [2].

The importance of respect for all participants in the ICU is clear [2, 4, 7, 9]. In this commentary, we focus on the interdependence of respect among participants in the healthcare system, sketching out the ecosystems—a biological metaphor which draws attention to the many individuals, systems, infrastructures, constituencies, and

hierarchies within which medical care occurs—within which respect unfolds. It is important to see respect and dignity as more than a patient advocacy question, however important such advocacy is. In a word, this is not a story about improving experience scores or achieving “customer satisfaction”. Instead, it is the old, admittedly nebulous question of what it means to be human, how we might improve contemporary and future healthcare systems, and how all of this applies to the ICU.

The ecosystem of respect is profoundly vulnerable to the function of healthcare’s systems of care. Poorly functioning systems can create tragedy for patients and clinicians alike. We note with sadness for all involved the recent case of a pediatrics trainee (Dr. Hadiza Bawa-Garba) in the UK who was convicted of gross negligence manslaughter after missing progressive (ultimately fatal) sepsis and failing to prevent the mother administering an outpatient anti-hypertensive medication to a 6-year-old boy [10, 11]. The errors occurred in a systemically terrible situation—with information technology failures, lack of supervision, and a crushing census. Essentially all physician observers have responded in horror at the failure of systemic accountability in this case. For many European clinicians, the Bawa-Garba case is emblematic of grave, systemic disrespect for clinicians within increasingly dysfunctional institutions. Respect for all participants within healthcare systems, including clinicians, helps create both a humane working environment and the best possible care for patients.

We emphasize two orienting points. First, respect (from Latin meaning to look again) and dignity (from Latin indicating worth or merit) call us to recognize that the people we encounter are worth seeing [7]. Second, respect is closely tied to humanization—the belief that the other person has a perspective on the world that matters [12].

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Respect is about how human beings interact with each other. It's fundamentally a story about the integrity of a healthy community. That healthy community stands at the basis of respect. We draw attention to the members of the community within the ICU, with an eye toward helping to understand how they may show respect to each other. We also acknowledge that the family and friends of clinicians have a role to play in this broader community.

One of the difficult aspects about modern intensive care is the sense of depersonalization, alienation, and separation from prior points of community support. This is true for patients and families, for whom the ability to work may be permanently interrupted by critical illness and its aftermath. But it is also true for clinicians. Today, work has become central to personal identity. Clinicians often derive their identity from professional status and the workplace environment. A key change—still in evolution—is that physicians have historically been at the pinnacle of the medical hierarchy, but today physicians increasingly feel displaced from that position by administrators, executives, and regulators. This displacement of physicians creates new risks for disrespect. As non-clinicians concentrate more power in themselves, it will be incumbent upon them to practice respect for clinicians and others. The call to respect remains important for physicians in their interactions with other staff, patients, and families, even as they may feel embattled in the new system.

Systems of mutual respect will require teamwork and an ongoing commitment to the collaboration necessary to support that teamwork. The design of work teams and contexts will have an outsized influence on the practice of respect in the ICU, and these designs will need to support clinicians, patients, and families as well. We cannot build functional teams if key team members are physically restricted on a routine basis from the bedside in the ICU [13, 14]. Teams built on mutual respect are necessary and should encompass managers, clinicians, patients, and families.

We should distinguish between being respected and having one's own way. All participants will have to make compromises to make systems work. Not all of us will be perfectly content with every choice that is made. That give and take is central to community. But the point is that there must be a give and take that reasonably acknowledges the personhood of all participants. We also will need to be cautious about the risks of unintended consequences with any specific approaches we take to improving the practice of respect [15–19].

We know that when physicians treat nurses poorly, everyone is worse off, and vice versa. We know that when clinicians treat patients or families poorly, everyone is worse off, and vice versa. Rudeness and dehumanization

are contagious, self-propagating beasts [20–25]. Here we draw attention to the role of managers and regulators too, who must also heed the call to respect or risk negatively affecting patient safety and quality in spite of the best intentions. Even when we disagree, we can do so respectfully. We must not wait for others to practice respect before we do so ourselves.

We are, as the old saying goes, all in this together. It's time for us to acknowledge that fact of interdependence, across the spectrum of society and healthcare systems. Therein lies the path to mutual respect.

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