

HUMANIZING END-OF-LIFE EXPERIENCES IN HEALTH CARE

Part 2 of 2

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A PERIODICAL FOR CONTINUUM OF CARE

PART 2

Reclaiming the Roots of Caring through Emotional Intelligence

In 2014, the New Mexico Nurse published an article on the role of caring among nurses, authored by Camille Adair, RN and Amy McConnell Franklin, PhD. Caring comes from a human, relational capacity, which is lacking in nursing and medical education and health care practice. A growing number of health care professionals seek ways to revive caring through relationships with self and others. The following are excerpts from the New Mexico Nurse Article, with a message that applies not only to nursing, but also to anyone in the caring professions. The ability to care is greatest professional asset in serving people at the end-of-life.

The roots of nursing are grounded in caring relationships. Nurse theorist, Jean Watson defined human caring as “the moral ideal of nursing in which the relationship between the whole self of the nurse and the whole self of the patient/client protects the vulnerability and preserves the humanity and dignity of the patient/client.”(1) “Increasing the wholeness of a system is about establishing a pattern of relationships among its elements that is more and more coherent.”(2) In a recent lecture in Albuquerque, Jean Watson also proclaimed, “our job, as nurses, is to serve humanity” and “to be relational is to be ethical.”

Emotional Intelligence, Neuroscience and the Roots of Nursing

Emotional intelligence is also sometimes abbreviated as EQ, a reference to emotional quotient, a measurement of emotional intelligence. EQ is the term most familiar in education in northern NM as a result of more than a decade of training and development of emotional intelligence concepts and skills in school communities. It is also the term used in the trademark EQ/Health, a component of the FairCare model. For simplicity, the authors are choosing to use the abbreviation 'EI' when referring to emotional intelligence in this article.

Historically nursing and healing took place within the context of relationships. Patients were known by the caregiver and vice versa, or there was typically the time to create a patient – caregiver relationship. Most care was provided by and received from someone known over time and in a human context.

This is no longer the case. Many people lack the trust and bonding within health care that develops when relationships are formed. An increasing number of health care professionals are treating patients whom they hardly know or are meeting them for the first time. Might this lack of relationship be part of what ails health care? Might better relationship skills be part of the solution? Might practice in increased self-awareness, more compassionate communication skills, and greater clarity of intention, help care

providers create the trusting relationships that have so often been at the roots of caring and healing?

Emotional intelligence (EI) is the ability to effectively blend thoughts and feelings in order to create and sustain more mutually respectful relationships and make optimal decisions. EI skills are teachable, learnable and become more permanent with practice. EI training develops the skills of self-awareness, clarity of intention and an increased sense of choice in thoughts, feelings and actions, contributing to better communication skills, decision making and resilience.

The amygdala, a bundle of nerves nestled deep in the brain acts as a reaction center, useful in helping us stay alive in the face of danger and threat. It can also, however, be the cause of overreaction and behaviors that do not help with problem solving. The emotional brain, including the amygdala, needs practice in working effectively with the cognitive centers of the brain. Research posits that simply naming feelings calms the amygdala reducing emotional reactivity. (6)

The skills of emotional intelligence also include emotional literacy, empathy and perspective taking. These skills need to be nurtured and practiced regularly so that emotional information can be integrated with incoming cognitive information. The result is improved decision making that is both empathetic and accountable, in order that relationships address the needs of self and others and are contextually appropriate.

Health care is ready for a shift. Integrating the concepts and skills of emotional intelligence into nursing and medical education and practice may help tip the balance and create the needed paradigm shift.

The following questions have become resources for the emerging practice of emotional intelligence in health care: Is it possible to care for self, developing a practice of self-care in the absence of self-awareness? Is a steadfast commitment to a calling possible without the silence and opportunities to befriend an inner voice? Is it possible to provide genuinely empathic service without the skills to pause, listen and thus gain a broader perspective?

Emotional Intelligence as an Emerging Practice in Health Care

As a field, EI is increasingly recognized as a meaningful component in understanding human behavior in individuals as well as in organizations. The Yale Center for Emotional Intelligence, a multi-disciplinary research center at the intersection of the Departments of Psychology, Education and Public Health is at the forefront of those studying the impact of EI training in education and health care.

While EI is a relatively new scientific concept (1990) (7) it can be considered old wine in a new bottle - many philosophies of life and spiritual traditions advocate greater self-awareness and increased alignment of daily actions with higher self and intentions.

Human beings and organizations are complex and multi-faceted. While “best practices” are too frequently an illusion, “good practices” and “emerging practices” might more accurately describe efforts to provide humane, empathic, honest, sustainable care. Developing expert nurses into confident mentors for the next generation of nurses is essential. The development of EI in preparing nurses for the task of mentoring the next generation is relevant and potentially critical to the future of nursing.

Individuals and organizations that recognize that relationships matter and establish practices that intentionally and systematically strengthen relationships through training and coaching, nurture a climate and culture that is better able to serve self as well as patients and staff. These practices foster empathic and sustainable care, strengthen nurse leadership and cultivate inter-professional collaboration.

How to Develop Self-Awareness & Emotional Literacy As the Foundation For Emotional Intelligence

An increasing number of health care professionals and personal caregivers experience burnout, making self-awareness and self-care essential priorities. In order to know how to provide ourselves with appropriate self-care, we need self-awareness. If we don't know who we are, how can we know what we need?

How do we know ourselves? Exploring this question can be distorted by our title, image and catering to others expectations, rather than developing a deeper knowing of what makes us tick. Self-awareness is the foundation of emotional intelligence. Emotional intelligence is a set of learnable and teachable skills that enable us to integrate thoughts and feelings for optimal decision-making. The first step in developing self-awareness is to build emotional literacy, which is the ability to identify our feelings without judgment. Our feelings come from emotions, which provide important information for self-awareness.

EMOTIONAL LITERACY PRACTICE

When we are able to identify how we feel by accurately naming our feelings, the amygdala in the brain is deactivated, taking us from a state of fight or flight, to feeling a greater sense of calm.

The following is a list of feeling words. You may add to this list as you become aware of more feelings. It is suggested that you carry a printed version of a feelings list. Throughout the day, take a few moments to identify how you are feeling. Over time, we become more skilled at experiencing our emotions as information and our feelings and important messages about who we are. It is important that we remember there are no good or bad emotions. All feelings are valid. Over time, we learn to become smart with our feelings, which leads to the ability to respond before we react.

Angry

Confused

Hopeful

Capable

Fearful

Grateful

Safe

Ashamed

Lonely

Generous

Relaxed

Relieved

Distracted

Anxious

Eager

Jealous

Embarrassed

Trapped

Uneasy

Vulnerable

Confident

Sorry

Content

Reassured

Overwhelmed

Joyful

Challenged

Ambivalent

Rejected

Curious

Because professional health care training views that death as failure, the first and most important steps to humanizing end-of-life care is for health care professionals to look inward at their own thoughts and feelings related to death and dying. The second and natural humanizing next step is to cultivate a deeper understanding that death is not a medical failure, but an opportunity for closure, meaning making and reconciliation and is as much a natural part of the human story as birth.

Our own relationship to death and dying is what informs therapeutic proficiency and capacity for effective end-of-life care, in how we relate to families, other caregivers and colleagues. Our skills and awareness, or lack thereof, can either support or harm the process and experience.

The following excerpts from the Solace Teachings documentaries provide examples of health care professionals who demonstrate emotional intelligence in their caring practices.

I have learned that there isn't one particular way and that there is, I think, great wisdom to be had. People need a lot of support, and that's why we need the team, not just the patient but the family, because they get sick, too. It's really important to take care of everyone, including the healthcare providers. I'm always taken aback in some ways, in a good way, at the amount of care that I see that's provided by people who are truly loving each other and being selfless, whether that's from the caregiver to the person who's ill, or vice-versa, really, because I think people don't realize how powerful they can be, even when they're sick, what an impact, what a legacy, how much they really do matter.
Holly Yang, MD

Hospice, even more so than many other disciplines, has tried to approach from this place of saying we see the patient in the context of their family, but I think hospice can take that even further. It says not only do we see the patient in the context of their family but we see the patient in the context of their whole community, and also their internal emotional place, and their psychosocial spiritual place, and really try and address or being open to address all of those places in a way that I think many family doctors probably wish to do but are constrained. Hospice really allows for that. Karin Thron, MD

When you're trying to figure out what's next in a difficult situation, they're heart-to-heart conversations, and you can't have a heart-to-heart conversation with a person standing over you, looking as if he'd like to be gone. Now I often feel like I'd like to be gone but putting myself in a chair keeps me from being one of those, what patients call a doorknob doctor, the doctor with his hand on the doorknob ready to leave. Patients can really sense when you're afraid. And, when a doctor says to you, "We have nothing more

to offer; there's nothing more we can do for you," the doctor's almost always wrong, because there's always more you can do for a person who's suffering.

Patrick Clary, MD

There's this assumption that people come to the emergency department wanting everything imaginable done because everyone wants to live as long as they possibly can. Well, if you don't ask people, then you don't realize – and I do ask people – a lot of times they just come because they don't know what to do. They want their symptoms managed. They want to know that they're not going to die in severe pain or with untreated symptoms, but they don't necessarily want you to stick them in an ICU on a breathing machine and with all sorts of drips and spend their last days in that fashion versus spending their last days in a place they're far more comfortable.

We were talking about how people teach Do Not Resuscitate and how the residents sometimes will go in and say, "So if anything happens, do you want me to do everything?" and that is a real problem. "So do you want us to do everything?" and he said, "Well, yeah." So the 'do you want us to do everything' is just a ridiculous question to ask patients, because the opposite of that they assume is you'll do nothing. You mean I'm just going to die? There's nothing going to happen here?

First, you need to talk with the patient, and you need to gain some trust. Then the emergency department is actually a place where you gain trust fairly quickly because people are in crisis. I would say, "I know we haven't had a long time to establish trust here, so I hope you feel comfortable trusting me," and most people would say, "Oh, yes, Doctor, I trust you." I would say, "Well, good because I think we need to have a somewhat difficult discussion. The first thing I want you to know is I'm hoping everything's going to go great here. I'm going to do everything that I can to get you healthy again. I need to ask you if, despite our very best efforts to get you healthy, we walk in the room and you are not breathing and your heart is not beating. You're going to look very peaceful to us. Should we let you go naturally, or should we do everything we can to try and bring you back? Let me talk with you a little bit about what I think coming back might look like for you given," whatever their particulars were.

If they had three, or four, or five co-morbid conditions, the likelihood of them surviving with intact functionality would be very low. I can't tell you how many people over the age of 80 have said, "Honey, if I'm dead, you just let me go." So I think there's this perception when you say, "Do you want us to do everything," people aren't afraid to be dead, but they're afraid to die because they haven't done it before. It seems like it would be scary, and it seems like maybe it's painful. When you describe them as dead and say, "Now what do you want us to do," an awful lot of people say, "Let me go. Don't try and bring me back." A lot of them have quite a sense of humor about it, like, "Honey, if I'm dead, you just let me go. Don't you dare touch me."

Basically, statistically speaking, we know that the more elderly you are, the less likely it is that you will be able to tolerate a code. One of the things that I sometimes like to explain

to people is that CPR was developed by the military, and it was developed to assist people that had traumatic injury. Those were otherwise very healthy people. Everything was healthy; their kidneys were healthy; their heart was healthy; their lungs were healthy, but they had a trauma that caused them to go down. In those circumstances, the likelihood of getting the patient back is excellent and is definitely worth doing.

What has happened in our country is we have generalized that to anyone and everyone that dies, regardless of their age, regardless of their co-morbidities. If the reason you arrested is because your heart is already weak and then we're only going to be able to provide a small amount of assistance in that regard, your heart is not going to be stronger. I think a lot of times, pointing out to people, "I know you came here to be cured, but the likelihood of returning you to where you were two years ago is impossible. Each time you come to the hospital, the likelihood slips further and further away when you come in with the same shortness of breath that you've now been here for five times."

Unfortunately, I actually have experience with people with congestive heart failure and with COPD coming into my emergency department and saying, "Doctor, could you please refer me to a good doctor for my CHF or my COPD?" and I would say, "Well, who've you seen and how many doctors have you seen?" Many times, they'd seen several very good doctors, but their perception was that CHF or COPD is like the flu or like a cold and if you find the right doctor, they'll cure you and make you well again.

Denise Waugh, MD

I think it comes back down to this really human experience, and that's the piece I would call out in everybody, because even those physicians who are in the emergency room or in the intensive care unit and who are doing everything they know how to do, they're doing it from their best possible place, and fundamentally from some human place. If we can get back down to the human piece of it, they've had relatives that have died. They've seen the good parts of it and the bad parts. They've seen good deaths in the emergency room and bad deaths there; and by good death or bad death, it's really about how the people – how the individual feels in that process and how the people around them feel in that process, whether they did every possible thing that medicine has to offer and somebody passed away anyway and how they felt about that.

The interesting thing really is to bring those pieces out, I think, because we don't talk about those in medicine. How does it feel to have done everything and lost somebody? How did it feel for the people who made the decision not to do everything and passed with their family around them? There isn't anybody who, I think when it comes right down to it, wouldn't prefer, at the very end, to have it be calm, and quiet, and peaceful with the people around them that they love in as much as it's possible.

I think we humans, we have this conflict in ourselves about wanting to do everything to stay alive and then also knowing somewhere, given the opportunity to know, that

ultimately, we're all going to die, and we would want it to be in a certain way, that we really don't want to die with chaos all around us, with tubes in every orifice, with noise, and all the kinds of drama that we can create so well in medicine. So I think really appealing to people on that level and then asking them to find it in themselves to know what it is that makes sense for them. Then we extrapolate from there and we say, "Well, how would we get there? How do we come to those conclusions, even in a hospital setting, even in an emergency setting? Where are the appropriate lines? When do we have the conversations, and how do we personally feel about it? How do we learn from our experiences in that process?"

Medicine isn't great about that, not in the sense of learning from our own emotional experiences, and then addressing those, and adapting them, and really bringing those experiences to our patients and their families as a way to speak about things differently and maybe think about things differently in terms of doing, and doing, and doing versus being there and being present with them. Karin Thron, MD

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