EMERGENCY MEDICINE: DO SOCIETAL PRESSURE, STRESS AND TECHNICALITY LEAVE ANY PLACE FOR HUMANE TREATMENT AND COMPASSIONATE APPROACH CARE?

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ABSTRACT

Introduction: To look after a person in an emergency situation leaves little time for philosophical reflections. A life must be saved. The sensitivity of care receivers and their relatives is however at its highest when faced with the caregiver's humane negligence, which they perceive as abusive.

Materials and methods: Creating a working group of the different professional caregivers and of care-receivers. Writing down a list of shared values of care, and of what is considered to be unacceptable behavior. Definition of care, both that which is respectful of the individual person and that which is not, and what to do in the case of excesses of abusive situations. Conclusions of the French Ministerial Group "Humane treatment in health care institutions (2010-2011)".

Results: The ordinary, involuntary non-respectful care treatment (the "bad care") is found in all our activities, mostly through the trivialization of the human being and the caregivers' indifference, preoccupied more with urgency, action, the medico-economic and administrative contingencies, and technicality. Awareness must be increased, which will allow the questioning of all those who take part in the care chain. Discussions should be led with a selection of caregivers, which would allow them to express their human values and their feelings about the quality of their work environment. A virtuous circle unites humane treatment of care receivers with that of caregivers.

Discussion: All caregivers' efforts must tend to an improvement in quality of life of care receivers, to a care system which respects the human being. Nevertheless, recent concepts which tend to make the patient a "health system user", if not a "client", carry within them the seeds of a consumerist tendency which, far from building a joint relationship of trust, where one requires the other, impose its views while asking the other to assume all the responsibilities. And, unlike the past paternalistic approach in medicine, it is not the caregiver that put themselves in such position. Good care can only come from shared trust and respect.

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INTRODUCTION

In our sometimes schizophrenic societies, reign many ambiguities. The citizen, the healthy taxpayer, thinking himself shielded from the vicissitudes of the life, requires from the health system timely efficiency, standardization and rationalization; while the sick person hopes for time, attention, listening, personalized and attentive care. The one recommends a right for the prioritization of the care in the cases which he considers important (sometimes wondering why to look in the situations which seem lost beforehand or in slight chance of success, if he does not question the care to the people without welfare), while the other one, the ill people is ready for anything to be looked after, at all costs, whatever is its age, its health or its financial situation.

A faintness reign, which can result in situations of ill-treatment, for lack of a debate on what the society expects from the caregiving persons and on the ways which it attributes them to act. And that it is true in economically advanced countries **(Figure 1)** or in economically depressed regions **(Figure 2)**; certainly in establishments welcoming elderly, sick handicapped persons, people at the end of their life; but also in the units treating people affected by acute pathologies, in emergency structures whether projected on a disaster field, in pre-hospital or hospital phase, or more and more often in research situation, very time time-consuming, of an "after-care" structure.

INSTITUTIONAL DE-HUMANIZED TREATMENT PREVAILS: CARE IS MORE THAN JUST TECHNIQUES OR STATISTICS

The people, caregiver or care receiver, suffer at the hospital. The health system designed to help, to relieve, is at the origin of a new suffering, in particular in the societies considered the most evolved, while they are sometimes (often?) the most dehumanized, not hesitating to put aside the unproductive and the elderly. This suffering is a curious and destabilizing mixture made by incomprehension, by absence of listening, of respect or valuation of other one. The individual is likened to the mass, his humanity ignored by the tyranny of the obvious evidence based medicine which denies the particular for the benefit of the collective and statistical reasoning; or of the respect for the "precautionary principle" which removes all sense of responsibility from the professionals.

It would be an error to think that only the units of long stay live this fault favored by the wear-out which generates the indifference. Acute care or technical services, emergency structures present the same abnormalities. Certainly the causes are then sometimes different, bound to the increasing technicization, to the computerization, to the lack of time, to the stress or to the limitation of the ways but often, let us recognize it, to the small number of caregivers, whether in their white coats or performing administrative or logistical functions. The urgency, the blood, the lives which we have between hands do not excuse everything, do not allow everything. The blind implementation of protocols, procedures and other laws which want to guide our occupations do not either.

It is a very strange world, where some get lost to writing and to legislating while the others are lacking everything. It is high

Figure 1: A mobile intensive care unit of Fire Brigade of Paris transporting a patient with acute stroke from home to a neurovascular unit. BSPP\LefortH©

Figure 2: French Army in French Guyana Forest combating illegal gold mining. Medical care provided to a Brazilian clandestine worker close to the frontier. SSA\LefortH©

time to boost the reflection and to define the "good humane care" and the "ill-treatment", to think about the quality and safety of this care expected by the one and provided by the other, before benefiting from it one day in return… because the good care, the "bientraitance", does not amount in techniques and in figures. "Have we chosen a caregiver profession only for the management, statistics and other analysis of activity? Most probably not. The measures of efficiency are necessary today, but the study of the medical activity does not have to result in the only economic performance. The qualitative analysis, with the relationship with the patient in the front row, the respect and the humanity, has to remain our priority. To be able to be "humane", nursing people must feel valued, respected and protected. Their actions have to be rich in meaning and values" [1].

TRIVIALIZED MISTREATMENT

Obviously, nobody considers themselves responsible for ill treatment: it can only be "the act of the other", if it is not the object of a negationist approach which does not honor our ethical values. In many ways, medicine is dehumanized because of the everyday acceptance by the one or of the indifference from the other one, doubtless often related to tiredness, stress or burn

out of the caregivers, in perpetual search of the productivity. Also, related to the caregiver running away, trying to protect themselves from the suffering by withdrawing from human relations with the patient, then often reduced to a number when not a disease, an organ or a subject of publication. The days of life earned are no longer survival moments carrier of projects, but rather figures that feed statistics. Who cares really, humanely, about the quality of life, about the feelings of the people receiving care? Who organizes the communication and the information due to the patient? Who weaves a human relationship with the family and the close ones?

And nevertheless, can we imagine a medical organization without thinking of the sufferings endured by the patients who see their life tipping over, without attention on the dramas lived by families and close friends, who see a dear being disappearing or suffering, feeling useless in this struggle for existence, because not associated and not informed? Is it the medical approach we want? Is this the way we would like to be treated? Do we wish to promote an only technical activity or a human, and so truly medical approach, of the person who entrusts in us?

The ill-treatment exists in all our establishments **(Insert 1)**. And, maybe, even more in societies considering most evolved, where the person often dilutes in the technique, where the humanity of other one can be less recognized, less respected. This ill-treatment, this "mistreatment" which does not confront in the size of an hematoma or a wound (it would be too simple!) is closely correlated in the asymmetry of the relation between the caregiver (often in standing position) and the care receiver (often sitting or lying).

In all our civilizations, the patient considers themselves inferior to the caregiver. He depends on the other one, just when care should allow a well-balanced relation, otherwise an action where the caregiver would put himself actually in the service of the suffering person **(Figure 3)**. Didn't Levinas say : "The hospital is a place of humanity because the person lying forces the person standing? The patient is the heart of our action?" [2].

It is about an ordinary ill-treatment [3], daily, commonplace and trivialized, about an ill-treatment of the details [4] which makes its nest of the little gifts of the life **(Insert 2)**. Latent, consubstantial of the care, it proceeds most of the time of the misunderstanding, the indifference otherwise of the routine; of the withdrawal, sometimes, of a caregiver, who does not find any more in him the energy to deal with the suffering person. It often escapes the consciousness of the one in charge, or the team which surrounds him, quite worried by everyday life, the urgency, the everyday acceptance of these victims whom we forget. This ill-treatment raises the whole question of harm, in its daily commonness. It may be defined – in the welcoming, support and the institutional treatment of the person – as: "every act, voluntary or non-voluntary, attitude, comment, and omission, any action or lack of one, affecting the dignity, authority, physical, psychological or moral integrity of the treated person or their relatives."

Figure 3: Nurse form Fire Brigade of Paris providing pre-hospital medicalization to an elderly woman during her transportation to the hospital. BSPP\LefortH©

Insert 1: Few daily situations. Who among us, whether in emergency situation or in scheduled care, was not:

- Detained by these stretchers, these chairs cluttering the hallways of our facility or our care centers. Do we still realize that these are not furniture lying there but people waiting? People like the caregivers, who have their stories, expectations, experiences, beliefs. People, who watch, observe, analyze and sometimes judge. People who, in addition to physical pain, suffer from not being acknowledged nor heard. People who have nothing to do with concerns of caregivers, our race in the hallways. People who hope, simply to exist and be recognized for who they are: human being, citizens rich in their rights, like all others, even though weakened and vulnerable. People who expect to be respected.

- Feeling uncomfortable at the welcoming of someone from different ethnic, cultural, philosophic origin than ours. Did we first make the effort to make inquiries, to understand the other, to try to know their lifestyle, their beliefs? Did we take the time to listen to them? how many missions in foreign countries did fail, or at least faced great difficulties, from the mere fact of this ignorance?

- Bothered by the conditions of announcement of a coming death/end of life, of the involvement of a prognosis, of a disability, an emergency amputation for example. Announcement made sometimes in a rush, by a caregiver feeling uncomfortable, looking to escape this situation that destabilizes him.

- Disturbed by a look, those empty, distraught, shallow, hopeless looks. Those looks that can no longer see. Those suffering looks, of abandonment, awaiting the end.

- Stunned by a silent tear, of a person sinking into incomprehension. Whether that person is the care receiver or caregiver…

Mistreatment can, in the welcome, the support and the institutional treatment of a person, be defined as: "any act, voluntary or not, attitude, word, carelessness, omission, any action or absence of action striking a blow at the dignity, at the autonomy, the physical, psychological integrity or the morality of the patient or their relatives".

HUMANE TREATMENT: WHAT ARE WE TALKING ABOUT?

Aim at "Bientraitance", at humane care, a whim of "Care Bears"? An often heard argument. But it is nor an obsolete thing for right-thinking people even for professionals who would be bored; nor a strategy of suitability, a latest fad, a behavior of circumstance, a policy of opportunity or propriety; nor an approach of good consciousness; much less an attempt of manipulation of caregivers, distraught by the social evolutions and the medico-economic constraints, that we would want to incite to work, nevertheless, by playing on the sensitive rope of ethics and humanism.

We can define the French word "bientraitance", humane treatment to move closer to the English concept of *care* [5;6] as "a dynamic, individual and collective professional posture of care, that reflects the commitment of the professional and the whole medical team. A single person can do nothing "to adapt the evolutions of the society thanks to monitoring and constant vigilance". The expectation of the society is indeed evolutionary. The expectation of a group is not that of another one. An Afghan chief once told us: "Why to come to give us lessons, you who, in west, lock your elderly into homes, to leave them to die, while we honor them…!"? Any speech must be adapted to the situation, to the time, to the considered society. It remains up to the community, in the frame of well understood "world globalization", to define what is collectively unacceptable.

"The *good care* requires a long-lasting confidence between the stakeholders and therefore the contradiction, the listening of the words and the silences, then the permanent, ethical and technical questioning, of all the actors of the medical community whose actions and the commitments it centers on the well-kept person and their close ones. It declines the various aspects of the respect for the human dignity, for the otherness, for the interiority of the people in care and their families. It requires the control of the professional best practice (thanks to initiatives of initial and continuous training), the coverage of the fundamental needs of the patient and his family [7], the care of the pain and the suffering, for both the care receiver as well as the caregivers team, the active prevention of mistreatment."

Active approach, the "humane care" is the respect, the humanism [8] put into action. Never acquired, it associates "knowledge", "know-how", "social skills", "good manners" and decency.

Even if both notions are partially correlated, the "bientraitance", the "good and humane care" is not the simple opposite of the ill-treatment. Doing no harm does not mean doing good. Just as not doing good does not mean doing harm. Not mistreating does not mean treating humanely. But, of course, no action to tend to humane treatment is possible if the ill-treatment is not prevented by a reflection of the professional, the team and the institution, by a shared definition of the ill-treatment and "good and humane treatment", by an elaboration of the course to follow if facts of ill-treatment were discovered or suspected.

Insert 2: The risk of non-respectful care treatment towards victims and members of the caregivers' team is important during emergency care. Contrary to what happens in a conventional hospital setting, the relationship between caregiver and care receiver comes in a very short time herein, during which many things are exchanged. In particular, the following problems are raised:

- The quality of the relationship to be established, which conditions the confidence between caregiver and care receiver sometimes equally stressed, during this short period where the future of the victim lies. There is a great risk to see the caregiver confined to technical procedures, including the acts of resuscitation, without any consideration to humanity, decency, moral suffering of the victim («one among others ...») and the family.

- The direct confrontation, visual of caregiver to the pathology, wounds, blood, and prognosis, to mud and dirt, to odors, to the context of field and its difficulties including the security of caregivers and care receivers.

- The difficulty of providing care, on the technical as much as the psychological level, to aggressive, offensive, refractory, intoxicated victims.

- Announcing to the victim the first conclusions and difficulties to answer questions… which emergency caregiver, during a public road accident, a disaster or a mission projected on a foreign territory has never been questioned by a victim of other involved wounded victims, that we sometimes know are dead? Were we always up to the standards? Were we able to anticipate our answers by adequate training? Did we take the time to debrief to reconsider these situations? Did we know how to criticize ourselves?

And this is without speaking of our lived failure experiences, in front of this person that we cannot wake up, this impossible intubation, these veins that do not fit , this poly-traumatized on the edge of a highway that we cannot immobilize , these children in the Sahel that we want to feed but they are starving to death, all the same, because their parents, meaning well, gave them double dose of hyper protein product distributed them without explanation, without ensuring compliance with adequate hydration etc.

CONCLUSION

Like everything that touches the human being, the emergency medicine is only meant for particular situations. It is practiced in a difficult professional and economic context, in France as elsewhere. The involved people are in precarious, physical, moral and psychological situation. They expect from the professional more than a technical quality treatment: attention, listening, humanity. In brief, humane care.

Easier to write than to apply on the ground, but caregivers must accept to challenge themselves to answer what the other expect from them to be able to understand and support them. This work can only be done by the whole team, in particular through the definition of common shared values. Some subjects can serve to introduce a reflection : the expectations of the victims (prior to providing care, before the transfer); the difficulty of announcements to the victims and to their close friends ; the words to be used to speak about pain (are we always conscious that a stressed brain does not understand the negation : for example the "I am not going to hurt you" of the compassionate caregiver is only heard as "I will hurt you") ; the good information; violence against women; organ donations by people in a brain-death state; the "sorting" in disasters and the prioritization of the care delived; the vigilance and the attention to the collaborators.

This work cannot be carried out without a joint reflection on the quality of life at work of the professionals: how could a care giving person, not valued, nor recognized in its commitment durably invest in a humane action towards others? **(Insert 3)**

Let us not doubt: a virtuous circle unites the "good care" of the care receiving person to the quality of life at work of the care giving person. Emergency professionals, if they are relatively protected by their frequent youth, their motivation, their implication, the good stress that they live on a daily basis, the teamwork, are exposed to the risks of over-investment, to difficult real-life experiences, to doubts in front of failures, immediately perceptible herein.

A reflection to tighten and to promote the "humane good care" takes then all its meaning, allowing the nursing people to refocus on their values, and restores sense to their commitment.

Insert 3: Stephanie's testimony, a 42 years old nurse on international mission. "After 20 years of investment, my professional assessment is globally negative… No recognition despite many personal and family sacrifices, a desire to do well. I am a pawn that we move from one mission to another regardless of my expectations and without valuing my work. I crumble under multiple administrative burdens, protocols that I do not always understand and that seem useless! We lack time to care for the patient, to learn. Material is counted. Conflicts between professionals are becoming more numerous. I feel a real suffering at work. I used to believe in it, but now I say: what is the point of all this…"

"If there is no shame in deceiving oneself, there would be shame in not wanting to change"

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