A CASE OF A LIFE SUDDENLY LOST

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Introduction

For many persons, dealing with the ordeal and imminent admission to an intensive care unit (ICU) and palliative care environment is outside the bounds of their everyday life experience. Nevertheless, it presents a crisis, mainly when the probable consequence of the admission is the death of a person. Therefore, social work intervention aims at helping the family adjust to the traumatic event by providing short-term, intense support, with both a practical and therapeutic focus that is holistic and client-responsive (McCormick, 2011).

As a medical and psychiatric social worker, the researcher shares the family's journey to help them make sense of the loud, frantic, and intricate setting confronting them as they encounter ICU and palliative care. The researcher tries to bring peace to the pandemonium, be supple and inspired, and the researcher often undertakes an array of responsibilities. Families of patients in ICU often experience fear, anger, helplessness, shame and are often astounded by anguish. The cognitive reactions observed by staff caring for patients and their families include confusion, disorientation, and search for meaning (Briere & Scott, 2006). Families are at more risk of multifaceted troubled responses when death follows a traumatic event, particularly involving a loved one who was also a productive member of the family.

Background

Raj (an implicit name used for the patient to shield the family's privacy) was a 60-year-old married man who came to Chennai from another district in Tamil Nadu. The client was self-employed in the real estate business, developed the habit of drinking alcohol daily, up to 180 ml of hard liquor per day, and used some other psychoactive substance and daily drinking. One day, he reportedly fell unconscious at his workplace, and when his family members reached there, he was unresponsive.

Raj's admission to ICU in a private hospital in Chennai for resuscitation care was routine medically but presented complex social and cultural issues. He was diagnosed with a stroke with intra ventricular bleeding. Three nerves were damaged; consequently, he lost his ability to move his right arm and leg and had difficulty breathing, put on ventilator support. The family shifted him to RMD pain and palliative care clinic on the physician's advice who treated him there. Knowing the patient's trauma and unconsciousness, the family's first questions to the medical team were, "*Why is our loved one unconscious*?" and "*Will he be OK*?" The family understandably appeared to be in an acutely traumatized state. They appeared sleep deprived, confused, and exhausted, but their pressing need was for information about their father's condition and was hopeful to see him normal again.

The client required long term palliative treatment, had undergone tracheostomy and was taken care of by RMD Complete Care – (Karunasagar, Maduravoyal). The client was undergoing physiotherapy daily, even though he was bedridden the entire 24 hours. He moved only his left arm and left leg. His left hand was tied to the bed, as he tended to pull away from the feeding tube fixed for giving him liquid nutrition. The medical care team checked his vitals regularly and frequently and obtained a specialist opinion. A nebulizer arranged on view with saturation levels and chest congestion. The accumulation of excess phlegm is periodically removed from his lungs using suction. The patient was on symptomatic care. He had a caretaker assigned to him who fed him regularly and cleaned him up.

Psychosocial and Spiritual aspects

The client was physically inactive, and his facial expression revealed that he was depressed. However, while interacting, his widened eyes revealed that he was very anxious and had slight restless movements of his left hand. In response to questions asked about his stay in the palliative centre, the patient could nod his head and wave his left hand.

The client's wife and daughter regularly visited him twice a week and spent much time with him. The family believed that due to the palliative treatment given by the doctors, he was progressively recovering from disease, and they initially also hoped that he would return home typically as he was before.

The client's belief system, spiritual orientation, and well-being were unexplored as he could not speak. However, the patient's family believed in God and hoped to come back normal after the palliative treatment.

Crisis Intervention

In a crisis, families need honest and accurate information, given in a timely manner at a level of their understanding, and most importantly, they want reassurance. This aspect is always challenging for staff; however, bad news conveyed with genuineness, empathy, and compassion can reassure a family that their loved one has not suffered and that the medical team is doing everything to give him the best chance of survival.

In the intensive care context, families need time to process the devastating news that the intensivists often convey. They need to ask the same questions over and over. They always hope that someone will tell them the information they want to hear. The social worker's role was to gently reinforce what the doctor had explained to them to help them make sense of the news and events. Raj's parents needed time to process that their loved one's death was inevitable. The researcher engaged the social work role to support and promote adaptive behaviours to validate and normalize feelings of intense raw grief. Raj's wife displayed feelings of intense loss, shock, guilt, disbelief, and grief. The palliative social worker had to spend the time in such a situation by just being with the affected family, sharing their silence, and listening to their life story. It was a time of profound sorrow, where there were shattered hopes and dreams.

Being with the family provided an opportunity for them to share something important, or they might take something that gives insight or give meaning to their tragedy. Through the conversations, the researcher built a picture of the family's strengths and vulnerabilities and their support networks. Such discussions brought the complexity and diversity of people's unique life experiences and the vast differences in beliefs. In the RMD pain and palliative care centre, the health care staff are available 24 hours a day to provide emergency medical services for patients and their families at a minimal cost to the family.

Families often view the withdrawal of care as abandonment. However, there is no withdrawal of medical care in hospitals in India, as families feel enormous stress and guilt with end-of-life decision-making. The daughter and his spouse particularly needed time, space, and privacy at the end of the life of their loved one. In addition, they need to feel a rapport and connection with the medical team and share in the decision-making process. As a medical and psychiatric social worker, the researcher was able to play a vital role here to coordinate care and communication. Throughout their day with the medical care team, Raj's relatives witnessed the care given to their loved one. The team was responsive to their needs by providing opportunities for them to say farewell to Raj by giving them privacy and space, allowing the spouse to wash him after his death and at all times showing reverence for their deceased family member. Compassion and care were part of the treatment, giving the relatives clear messages that Raj's trauma was not survivable and sharing the end-of-life decision-making process as Raj ultimately became brain dead.

Bereavement Care

Following a person’s demise in the Intensive Care Unit, the social work role involves providing practical and bereavement support, including explaining procedures and assistance with funeral arrangements to advocate culturally appropriate experiences. For example, after negotiation, the funeral director allowed the relatives to observe the actual cremation process to ensure it was their loved one whose ashes they collected, as this was the custom in India. The palliative care efforts give the relatives a sense of control; by validating their experience, the family reassured that their loved one's life was worthwhile and was valued. An important aspect of grief counselling is validating the family's need for rituals to preserve a connection to their dead family member. Raj's family returned home repeatedly, acknowledging and appreciating the efforts of the whole palliative care team. A medical colleague often says, "If

we cannot make someone better, then we must give the best possible end-of-life care", and as a palliative team for this family, this outcome was accomplished.

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