Critical Care Explorations

OPEN

"Get to Know Me" Board

Ognjen Gajic, MD[1]; Ben D. Anderson [2]

Abstract: For best outcomes, clinicians in the ICU need to attend not only to the immediate clinical needs of the critically ill patient, but also to higher human needs including psychologic, social, and spiritual. Understanding your patient as another human being with her or his fears, desires, preferences, and accomplishments is obviously important in order to provide compassionate care and achieve goal concordant outcomes. In an ever-evolving technological ICU environment, this may not be an easy task. All too often, we focus on monitors, devices, electronic records, and ignore the human being. Patients labeled with a disability are particularly vulnerable. Recently, I had the privilege to participate in the care of a Mayo Clinic patient with a history of cerebral palsy. In the midst of a life-threatening emergency, by paying attention to the human touch, the ICU team learned the story of a truly remarkable person. The essay below summarizes the patient's and physician's perspectives.

Key Words: compassion; family; humanization; intensive care; patient

THE PATIENT'S STORY: MY GRATITUDE TO THE TEAM OF HEALTH PROFESSIONALS

Getting Sick

In July 2018, I got really sick and had no idea what was happening, as, despite a history of cerebral palsy, I had been a healthy person all my life. Jokingly, I blamed it on turning 65 years old in June. Soon that became "not funny" because as time went on, I became sicker.

In the hospital, they began to run tests and determined that I had severe inflammation of the colon, ulcerative colitis. We decided the best for me was to have my whole diseased colon removed and that I would have an external pouch from my small intestine. I had my surgery in 4 days

Shock

After a somewhat prolonged recovery due to my poor nutritional status, I was ready to leave my hospital room when my wife and brother-in-law saw me go into what they perceived as a seizure. They immediately ran into the hallway and called the nurse. Within less than 30 seconds, there were 10 people in my room, and in less than a minute, I was taken off to the ICU where a team of medical professionals gathered in my room. The doctor that led the team looked like a choir director as he pointed to his colleagues, and they performed each necessary task.

What a wonderful gift they gave me! I was later told by this head doctor that I had a massive blood clot in my heart/lungs and that I had gone into severe "shock." The blood flow to my brain was compromised causing a seizure. The ICU team pumped a number of medications to improve my heart function and blood pressure (BP), and keep me alive until the medication to break up this blood clot had a chance to work. The doctor told me, "If you had not already been in the hospital and had been instead on that transport van to the nursing facility, you would not be here today." After a rough several hours at the edge of life and death, I started feeling better. I was 3 days in the ICU and then taken to a regular hospital room. The gift that this team of professionals gave me was a gift that everybody would appreciate—they gave me life! I thanked each team member individually as they came into my room. I will always be grateful for the professional care they gave me, and the support they gave my family and friends as they visited. I wanted to share this as I wanted to communicate how life can be taken away in the blink of an eye and that the efforts of these professionals gave life back because they care about their professions and the people they help.

Human Touch

But there was something even more important that I would like to share. The ICU team incorporated a personal patient profile board on the wall; called "Get to know me" (**Fig. 1**) so that the patient's personal likes and activities could be known to the ICU care professionals. They try to bring the human touch to bridge the patient to the medical professionals. It is so good for each patient to know that the care is really "caring." As I am a disability advocate

[1]Department of Internal Medicine, Division of Pulmonary and Critical Care Medicine, Mayo Clinic, Rochester, MN.

[2]Break Through, Inc., Rapid City, SD.

The authors have disclosed that they do not have any potential conflicts of interest.

For information regarding this article, E-mail: gajic.ognjen@mayo.edu

Crit Care Expl 2019; XXX:e0030

DOI: 10.1097/CCE.0000000000000030

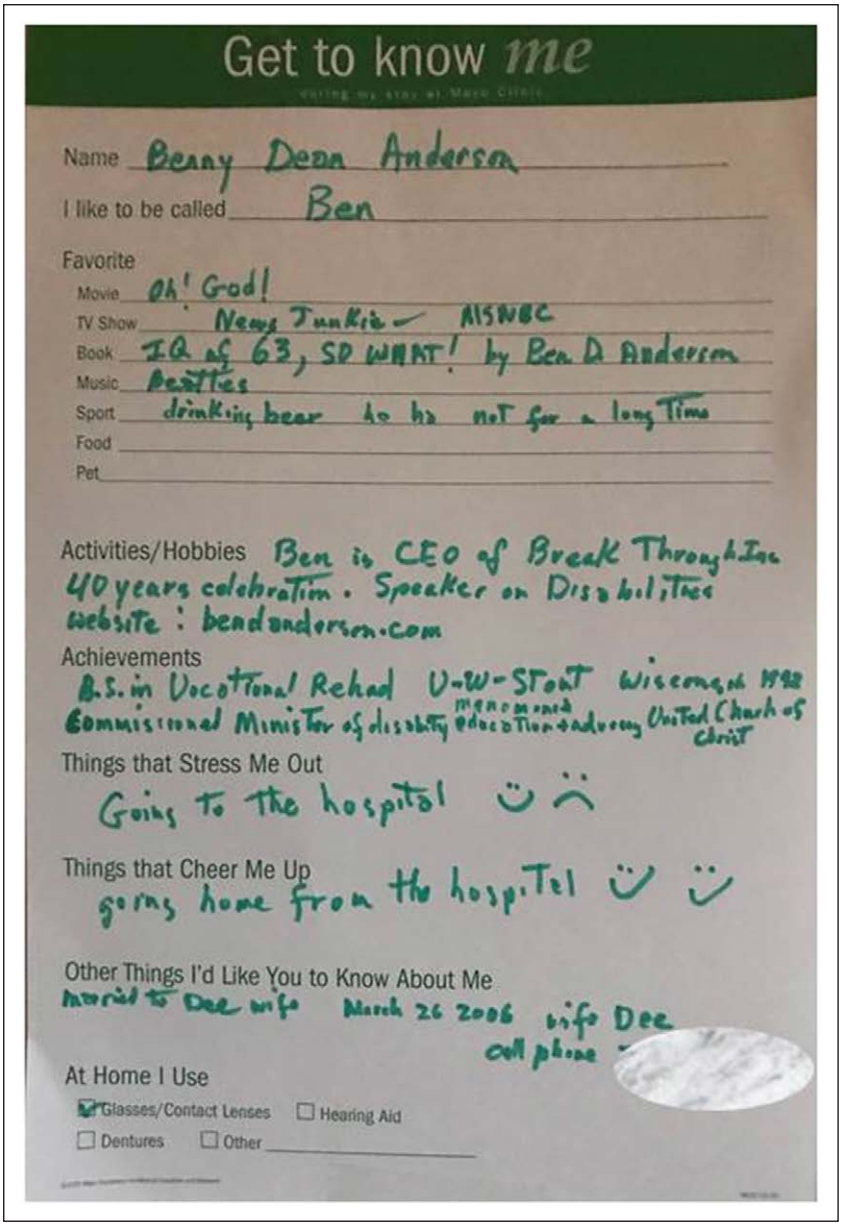

Figure 1. The "Get to know me" board, so that the patient's personal likes and activities can be known to the ICU care professionals.

professional, speaker, and author I gave the head doctor a copy of my book that I wrote about my childhood through college years and marriage—"IQ of 63, So What! Going Beyond Everybody Else's Expectations." After a week or so as I was recovering at home I received the following email from the doctor—

"Dear Ben and Dee,

I have truly enjoyed the inspiring life story that you shared in the book I got as a gift from you. I hope you have recovered completely and I am delighted to have had the privilege to care for you in the ICU. I will cherish the book with your signature ('to my doctor…'). I wish you both all the best."

In conclusion, I want to thank all my doctors and nurses for the superior care they gave me. Thank you to the ICU team for saving my life and for their caring and professionalism. Thank you to all the hospital staff that helped me get better.

THE PHYSICIAN'S STORY: MY GRATITUDE TO THE PATIENT

Code 45

Overhead speaker breaks the silence of an unusually quiet late morning in the ICU. "Code 45" Station XX, Methodist Hospital. I joined the fellow, nurse, pharmacist, and respiratory therapist as we all rushed down to the fifth floor following the signs and being ushered by floor staff toward the room. Hi, we are the code team; I am Dr. XX, the code leader. The bedside nurse anxiously referring: "Patient recovering from colectomy; was preparing to be discharged later today; suddenly become unresponsive with a tonic-clonic seizure of about one minute duration." ICU fellow is loudly scanning Airway, Breathing, Circulation, Disability, Exposure (ABCDEs): Responds to pain only, protects the airway, minimally increased work of breathing, mottled knees, cold hands and feet, faint radial pulse, no rash, no visible bleeding, abdomen soft, nondistended, no gross lateralizing signs. Portable monitor shows sinus tachycardia 140/min, peripheral oxygen saturation (Spo_2) 85% on nasal cannula oxygen, BP 60/30. Technician obtains blood; point of care arterial blood gas cartridge is running the sample. The hand-held ultrasound scans lung fields: No B lines, present lung sliding, no effusions, no fluid in the abdomen, no hydronephrosis, and minimal urine in the urinary bladder. Subxiphoid cardiac view shows hyperdynamic left ventricle, unusually large right ventricle, mildly dilated but collapsible inferior vena cava. "One liter of Ringer Lactate running," the nurse reports. The fellow responds, "OK, hold off after that liter, please give 0.2 mg phenylephrine, 0.5 mg epinephrine, recycle the blood pressure; let's move the patient up to the ICU."

ICU Room

Fifteen minutes later in the ICU: Patient responds to verbal stimuli, BP 85/65 on high dose norepinephrine and vasopressin infusions, arterial line being placed by the respiratory therapist, Spo_2 88% on 100% Fio_2 via high flow nasal cannula, mildly increased work of breathing, mild improvement in capillary refill. Point of care arterial blood gas reveals profound metabolic acidosis, lactate 10.6. Differential diagnosis: sepsis versus massive pulmonary embolism or both. We started IV heparin, broad-spectrum antibiotics, and stress steroids, as patient has a history of chronic steroid use for ulcerous colitis. Repeat ultrasound, grossly enlarged right ventricle, hyperdynamic left ventricle, severe obstructive shock secondary to massive pulmonary embolism becoming more likely. As empiric thrombolytic therapy in a setting of recent surgery is not without risk, we need a confirmation of a clot, CT angiogram. The patient mumbles something I cannot understand, someone in the team mentions that the patient has a history of cerebral palsy. The patient's wife at the

bedside, still in shock with everything says: "he is highly functional; you can understand him talking with little effort."

The Power of the "Get to Know Me" Board

To alleviate my and her anxiety, I bring to the room the "Get to know me" board, a routine I have found extremely useful to connect to the patient and focus away from multiple distractions, interruptions, information overload we are exposed to in the ICU. The wife swiftly fills out the board; I see that he likes to be called "Ben" (Fig. 1). The patient's favorite book caught my attention: "IQ of 63 so what!, by Anderson (1). What a name for the book! I come to the patient; put my hand gently on his shoulder. "Ben, I am your doctor; you are in serious condition, in shock but you are getting slightly better. You are safe here, try to relax. If things get worse we may need to put the breathing tube down your throat but, maybe we can get by without it. The patient mumbles: "thank you, doctor." The heart rate on the monitor decreased from 130 to 120. I say: "I see you wrote a book, quite a title, I would love to read it once." The heart rate went further down. The patient mumbled something I could not quite get. The work of breathing decreased. Spo_2 improved to 95%.

The CT scan confirms a massive pulmonary embolism; the pharmacist is preparing tissue plasminogen inhibitor infusion, surgeons contacted, they approve; the infusion is running. The patient's condition slowly starts improving with lower doses of vasoactive medications. The patient wants me in the room. He tells me he is a disability advocate, he speaks around the country. His wife adds that he was involved with proponents who drafted the famous Americans with Disability Act. The patient tells me he met one of them, the person without upper extremities; they were in the hotel and he watched him swiftly pull a dime from his pocket with his foot to put in the "pay phone" to make a call. Imagining the occasion made my day.

The Aftermath

The next morning the patient calls me again into his room. He has a signed copy of his book for me: "To my doctor" reads on the second page. He is off vasopressors and high flow oxygen and ready to leave the ICU. He said: "I am going to write something about this, too. Doctor, would you be willing to write the foreword?" When I came home, I read the book: "IQ of 63 - So What?" at once. Starting with memories of a loving grandparent who believed that there are no limits his disabled grandson cannot reach. I learned of the tremendous obstacles a disabled child growing up in the sixties would go through but also of fantastic friends, family, and staff. What was amazing, always positive thinking, and never giving up. Despite an incorrect testing and a label of low IQ preventing him from getting advanced learning in the high school, Ben never gave up. He persisted and persisted. The pursuit of the college degree and the effort involved was truly inspirational. Then a successful marriage, and a life lived to the fullest passionately pursuing advocacy for integrating disabled community in the society for everyone's benefit.

A few weeks later, I got the e-mail from the patient with the draft version of his account of the life-threatening hospitalization. We agreed that I add my side of the story to it. We both hope it resonates with patients and clinicians alike. I remain fascinated with the positive effect the simple "Get to know me" board had on both this patient and the clinicians taking care of him. The "Get to know me" board has been first used by palliative care practitioners at Massachusetts General Hospital "to bring the patient from anonymity" (2). Soon it spread to other U.S. academic hospitals (3). Mayo ICU nurses first introduced in one of our surgical ICUs. Later it spread and it is now routinely used in most of our ICU patients. The families gather around a blank poster asking them: What is Dad's favorite movie? Favorite food? What is he is proudest of? The whole process forges recollections on their family member's life and loves, and prepares them for the tough question "What would Dad have wanted if he was able to talk with us now?" The photos that accumulate on them can be quite entertaining for the staff. It has been observed that families often take the poster with them … never leave it behind … no matter how good or tragic the ICU course (Taylor Thompson, personal communication, 2018).

Humanizing ICU through using a simple "Get to know me" board is not only something we ought to do to help our patients in the time of need. It may also help prevent ever-increasing burnout among ICU staff continuously exposed to the severe illness and death, high workload, and alienating technology.

ACKNOWLEDGMENTS

We would like to thank Dr. Taylor B. Thompson, Massachusetts General Hospital; Dr. Brian Pickering and Dr. Alex Niven, Mayo Clinic for thoughtful review and helpful comments on the article.

REFERENCES

1. Anderson BD: IQ of 63 - So What! Going Beyond Everybody Else's Expectations. Rapid City, SD, Break Through, 2007
2. Billings JA, Keeley A, Bauman J, et al; Massachusetts General Hospital Palliative Care Nurse Champions: Merging cultures: Palliative care specialists in the medical intensive care unit. *Crit Care Med* 2006; 34:S388–S393
3. Blair KTA, Eccleston SD, Binder HM, et al: Improving the patient experience by implementing an ICU diary for those at risk of post-intensive care syndrome. *J Patient Exp* 2017; 4:4–9