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### Editorial

## The courageous practitioner during end-of-life care: Harnessing creativity in everyday acts



There is no doubt that critical care is a complex and demanding clinical area where nurses work alongside patients and families who are exposed to the prospect of death and dying.<sup>1</sup> Within this complex milieu, nurses manage challenging end-of-life situations on a daily basis<sup>2</sup> and are therefore well placed to make a significant difference to the care of patients who will not survive their critical illness.

The last decade has seen a substantial increase of international research in the area of end-of-life care in critical care settings. Previous studies published in *Australian Critical Care* provide us with understanding of the experiences of intensive care nurses when providing care to the patient at the end-of-life,<sup>3,4</sup> as well as the concomitant barriers and challenges of this work.<sup>5</sup> In addition, nurses have described their perceptions of the privilege and honour when engaging in this area,<sup>6,7</sup> and there is increasing evidence of specific practices nurses offer that provide meaningful care to patients at the end-of-life and their families.<sup>8,9</sup> We are not referring here to standard practices such as how to ensure comfort and withdraw treatment at the end-of-life. By 'meaningful', we are referring to specific acts of care that speak to what is important to that patient and family, whether it be a last visit home or a taste of the patient's favourite ice cream. Understanding how such practices can be integrated into personalised care planning is not always easy, especially in the challenging and uncertain world of practice. In such critical times, meeting individualised needs of the patient and family, of what the patient and family want at the end-of-life, must be balanced against potential consequences. For this, nurses require courage to engage in creativity in practice.

Courage is a word often used in popular conversation, but what is courage? The word 'courage' is derived from the Latin word 'cor', the same root as for the word heart. It is therefore unsurprising that intentionality, personal fear, noble acts, and personal risk are key components used when describing courage.<sup>10</sup> Courage has been variously described in the literature as an ontological concept (way of being in the world), a moral virtue, and an ethical act.<sup>11</sup> Whilst these areas are well understood, what courage looks like in end-of-life care nursing practice where creativity and opportunity is often required has not been explored.

Spence and Smythe<sup>12</sup> describe courage as a creative capacity when change is made somewhere in a place between chance and security to advance the quality of care, in other words, considered risk taking is undertaken. Courageous nurses take opportunity to challenge decision-makers to change and develop practice and call into question the actions of authorities.<sup>13</sup> In this way, resisting the pressure to 'do as always' and bring in imaginative creativity to

prioritise individual patient needs demonstrates a strong commitment to nursing values and positive (patient and family) outcomes.<sup>14</sup>

Thus, thinking about courageous and creative practices in end-of-life care, what are some examples of this? What are the opportunistic end-of-life practices that result from nurses assessing patient risk alongside assessing the personalised needs of the patients and family members? There is little literature in this area to inform thinking, although there are probably many examples of acts of courage in practice that are never written about. A mixed-methods study by Cook et al.<sup>15</sup> gives some insights into this area. The study explored effects of the '3 wishes' project on dying in a single intensive care unit (ICU). The project identified three wishes, generated by the patient, family members, or clinicians, to honour each dying patient. The wishes were implemented before or after death. Participants in the study included 40 decedents, at least one family member per patient, and three clinicians per patient. A total of 159 wishes were implemented and classified into five categories: humanising the environment, tributes, family reconnections, observances, and 'paying it forward'.<sup>15</sup>

Some of the wishes from the work of Cook et al.<sup>15</sup> that we would recognise as frequent practices at the end-of-life include use of personal mementos in the patient's room; watching the patient's favourite television programmes, and listening to his/her favourite music. However, others are less reported, requiring greater creativity and courage to challenge usual norms and push at the boundaries of end-of-life care. Such wishes in the study by Cook et al.<sup>15</sup> included recreating date night in the ICU or renewal of wedding vows at the bedside; organising a sing-along with friends and holding a tea party at the patient's bedside; encouraging visitation by a beloved pet; and allowing the mother to lie in bed with her son as he dies.<sup>15</sup> A review 'of memory making for patients at the end-of-life in the ICU by Riegel et al.<sup>8</sup> provides further overview of other end-of-life activities including use of word cloud images to foster remembrance and sharing of patient life stories and use of an electrocardiogram as a memento. However, as Riegel et al. acknowledge, whilst these practices are valued by family members, they have not received large-scale evaluation and therefore warrant further exploration.<sup>8</sup> Until that time, we must rely on dissemination of case exemplars and findings of descriptive, exploratory, and observational studies to contribute to the development of this area of practice.

How can we develop these skills in our own practice and amongst our teams? In a recent study on compassionate leadership in end-of-life care, the theme of challenging existing practices provides insight

for this area of practice development.<sup>16</sup> Hewison et al.<sup>16</sup> assert that being challenged with appropriate support can improve practice as creativity is stimulated enabling unique and meaningful solutions for practice.

Having courage to be creative at the end-of-life challenges others to be courageous rather than adopting risk-averse approaches that can constrain quality of care. Considered risk taking requires courage to know when to, and when not to, navigate end-of-life expectations in the context of that particular patient situation. Courage also includes knowing how to address, or work with, resistance within clinical teams and provide collegial support when others are facing end-of-life challenges.

Courageous creative practices are of value in humanising the patient at the end-of-life and to draw closure for the family as they transition to a future without their family member. Critical care nurses are encouraged to think creatively to develop significant experiences for the patient and their family, such as a visit to the garden, and to have the courage to act to fulfil these meaningful moments at the end-of-life.

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