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Person-centered care during organ procurement surgery: Is it still important?

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Abstract
Person-centered care places the individual's human dignity, respect, and needs at the core of its focus, and its applicability has been demonstrated within multiple environments. The perioperative environment, nevertheless, frequently invokes positivist discourses that move away its focus from such approach, materializing in the operating theatre a space sterile from subjectivities. Furthermore, the conjugation of death as a professional failure, the debates concerning the end of life and the loss of the personhood after death, separates the person-centered care from the perioperative care of dead people, such as during the organ procurement surgery. Despite this dichotomy, person-centered care channels Perioperative Nursing towards an integrative care, for which it could be reframed as human-centered care and perpetuate dignity beyond death.
Key words: Perioperative Nursing. Perioperative Care. Patient-Centered Care.

Introduction

Person-centered care can be understood as the delivery of care in which individuals' subjectivities are placed in first place, averting the paternalistic, prescriptive vision of biomedical care by placing emphasis in a holistic care that allows empowerment, autonomy, dignity and respect.[1, 2] In the person-centered care, they are understood throughout their own narrative, circumstances and biography that have built the socio-historical and cultural process in which they have broken through.[2] The approach is not only a specific form of care delivery or health system organization, it comprises an active research field to the benefit of collectivities from a biopsychosocial focus leaded by people.[3-8]

If the ultimate value of person-centered approach lies in, precisely, the appreciations they have regarding healthcare, it is convenient to analyze what individuals expect during an intervention guided by such approach within the vast diversity that Nursing specialties encompass, such as in perioperative care. In regards to this topic, person-centered care has been described using a variety of terms that speak from a humanized point of view: "being recognized as a unique entity", "being considered important", "being touched by the perioperative nurse", and the latter being present during surgery.[9]

Consequently, in the perioperative environment, the person is positively nourished by the physical and emotional closeness and the respect to them as values of the ultimate importance in the care delivered. This is essentially important inside a highly technological, clinical, protocolized environment surrounded by potential critically ill people, which leads to specifical dilemmas regarding autonomy or respect along the person-centered approach.

If the discussion is placed in the frame of a specific procedure, the latter gains special relevance. As trauma and stroke victims exponentially grow year after year, multiple brain-dead people arrive to nursing care,[10] especially when they are potential candidates for organ procurement surgery in an increasingly high technical and technology-involved process.[11] Therefore, the aim of this paper is to reflect on the person-centered care within the organ procurement surgery.

Delineating person-centered care in surgery

Antagonizing widely reproduced reductionist epistemological discourses, the concept of person-centered care problematizes since its own declaration core philosophical values in health sciences. Even the most basic discussions such as the meaning of "person" in opposition to more popular terms as "patient", often considered vane, lie at the center of the aforementioned approach, which not only involves clinical practice but research, education, and policy making.[12]

In addition to the social implications introduced above, the approach traces social, political and economical complex roots since its origin that nourishes its development and implementation. For instance, in the specific context of Latin America, it holds also some social, political, and economic special de-

terminants, since it arises in opposition to not only an hegemonical biomedical paradigm that places special value upon illness and technology as core elements, but also the neoliberal economical model that underpins it, who sees health as a consumption good and not as a basic human right.[13]

Historically the paradigm is born in the sine of Psychology and begins to extrapolate throughout all health sciences. Despite it doesn't emerge directly from Nursing science, it is undoubling the close epistemological relationship between them both. The essence itself of the discipline, human caring, has been argued as inextricable from the centrality of the person in the nurse-client relationship. In other words, it is not possible for the caring to take place if the person is not in the center of the care.[14]

This crucial allegation is not strange in the nursing perspective, since the assumptions of the person-centered care have been tackled to a greater or lesser extent by classic nursing theorists, such as Nightingale or Peplau,[12] those being some of the most fundamental principles in their thought and that are reproduced in the calling to personalize nursing care.[13]

Nevertheless, to pay attention to the personal narrative and the possibility to personalize nursing care are typically seen as easier to perform within those contexts dealing with people considered "stable": it is not a surprise that person-centered paradigm have had a further theoretical and practical development in the sine of chronic care, such as dementia or mental health issues.[16-18] If that logic is to be followed, therefore in critical, urgent or high acuity clinical situations the application of the person-centered model remains doubtful.

This perception of barriers is nourished by multiple factors that go beyond the apparent urgency that a life threat supposes. Aspects as power, that produces a vertical relationship between health professionals, intertwines with the biomedical knowledge (which undoubtedly arises as the only valid knowledge and generates a skeptical attitude towards the mentioned approach), technology, and communication barriers to end up being equally (or more) important when it comes to limitations to person-centered care. This dialectics configurates for certain healthcare areas to be perceived as less "friendly" to materialize this model in front of others, such as emergency departments, intensive care units or operating theatres.[19, 20]

On the contrary, despite the perception of a lack of relevance of this model in the perioperative practice, the Association of periOperative Registered Nurses (AORN) has instructed research and practice by placing person-centered care at the very medullar place in perioperative nursing, positioning it at the same level of importance as interdisciplinary work, evidence-based practice or patient safety.[21]

In fact, the AORN have developed a theoretical model specifically for perioperative nursing that contemplates four domains: safety, physiological responses, behavioral responses, and health system. Multiple nursing theorists underpin such model and the main propositions of person-centered care are deliberately included, ensuring that the focal point of perioperative nursing care, regardless of place or complexity level, must be the person.[22] Although it still remains research to do in order to support (or refute) the model, it provides nurses with theoretical tools to center their care on individuals regardless of the phase of perioperative period.[23]

Person, death, and surgery: frontiers in person-centered care

Death is not strange to the perioperative environment, as well as it isn't to the majority of health sciences' practice. However, the surgical environment holds some special characteristics that causes a difference in the way healthcare providers react towards death, which constitutes new barriers to person-centered approach.

The stereotype of surgical practice involves a generally masculine team (in the most hegemonic version of what it means to be "masculine"), who focuses on "doing" and "fixing", in a highly competitive environment, with elevated self-confidence and lacking of emotions and empathy.[24]These characteristics interact negatively when put into contrast with person-centered care, where elements as active listening, communication and empathy are crucial to delivery of care.[25]

Indeed, this negative perspective of surgical staff is perceived by people, which in fact turns out to be one of the biggest determinants of satisfaction within these units: it is recognized a low satisfaction of care received by surgeons, additionally, recognizing that Nursing professionals frequently are so merged in administrative duties that are not able to provide care.[26]

Likewise, the surgical staff archetype as a not emotional being conditions for the person to be seen as work, and the resolution (or not) of their problem as a personal success or failure. Thus, the job of the surgical staff of "doing and fixing" naturally has the extreme antithesis: death. Decease is, then, seen as the biggest failure in surgical practice.[27]

The last assertion is crucial since it tears the naturality of death, denying it as one more step of the life cycle and subordinating it as a health problem, susceptible to be treated and fixed by the savior vision of medical science. From this perspective, death as a failure, as the cease of efforts of medical science to restore health, it seems to be incompatible with person-centered care. Certainly, who is to be cared for, if there is no more person?

In this manner, discussion must move towards the most essential elements of human nature: the notions of death, life, and personhood. Death in the context of Western society, which reproduces the constant interaction between the neoliberal economical system and the dominant biomedical paradigm, is no longer seen only as a failure but the product, the dead, as a waste. The duality life-death (success-failure) severs vulnerability, human experience and, ultimately, the possibility of appropriate human caring.[28] Therefore, the manufactured dichotomy life-death turns out to not be very useful in order to contextualize human caring.

At the same time, the notion of personhood, of being a person, poses other questions: although the condition of being a person has been "expanded" in states of ceased cortical function, some may argue that in the moment neurological death is declared, personhood is lost.[29, 30] This notion, in fact, has been widely used in legal effects and has a huge repercussion in health sciences.

Despite not being considered a "person", when neurological death is declared then ¿the body?, might undergo the organ procurement procedure and becomes a potential organ donor. Consequently, in the current crisis for the lacking of organs, health system sight falls upon this bodies in order to potentiate

transplant and life support is maintained as long as necessary.[31]

Hence, the arguments drafted at the beginning of this section return: surgery deals with "doing" (resecting) and "fixing" (transplanting), in an inert body that can no longer be saved. Furthermore, reproducing one more time the political and economical neoliberal model, the once "disposable body" that no longer produces economically speaking, one more time becomes appealing to the eyes of the system since it becomes an exploitable source of resources: organs. In the light of these arguments, person-centered care doesn't seem to have a place in the context of neurological death since, again, there is no longer a person.

Resecting organs from a body: Dignity beyond life

While it has been frequently argued the determination of death as the attribute of being a "person", this does not mean that the corpse loses its dignity. The Kantian notion, applied to this context, indicates dignity and respect are maintained beyond death.[32] The concept of person doesn't allude to a "what" but to a "who", and even though death is by definition a biological change, it has cultural and social implications that contribute to reinforce this permanence of dignity of who was a person beyond its decease.[32]

On the other hand, the vision of human body as physical representation of the being, that transcends the mechanistic vision of the body as a machine, argues before the eyes of who takes care of it once life has extinguished, that dignity remains intact and as such deserves respect.[32] Especially for Nursing, the concept of "person" is strongly imbued by decision-making processes, autonomy, and the ability to act by its own will.[33] According to the fundamentals of person-centered care, such as dignity, respect, autonomy, and decision-making, these prevail once life no longer exists due to one simple reason: there had been a person, at some point in the past, therefore, the approach is applicable beyond death.

It is no aim of this paper to refute the vision that personhood extinguishes beyond death. This, in addition to pose a significant legal conflict, may be detrimental for the families, who need clear words that express the irreversibility of the situation and facilitate grief.[34, 35] Nonetheless, it would be convenient to explore and re-think the statement "person-centered care" towards a "human-centered care": in that way, critiques and discussions regarding the beginning and end of life and the impact this has over the concept of personhood could be eluded, allowing nurses to keep focusing their care in the human being they interact with.

Despite the high philosophical contradiction it may represent to attribute the ethical characteristics of "person" to someone after a brain death, the reality is that such vision allows nursing professionals to maintain the perspective of person-centered care, especially in the organ procurement surgery.[36] This is especially noticeable during the preoperative period, when Nursing has the opportunity to intervene with the family, and the postoperative period, when post-mortem care is often delivered invoking the aforementioned criteria of dignity and respect, as core values of person-centered care.[35]

Inside the operating theatre, nurses have the ability to contemplate the person from a holistic perspective, respecting their autonomy and their integrality, offering psychosocial support through empathy, and allowing participation in decision-making processes, even when such decisions were those expressed by the person during their life or those which the family is sure they would have wanted.[36, 37]

Additionally, during intraoperative period it can be contributed to minimize the vision of "doing and fixing", or cutting and resecting organs, transforming in that way the vision towards the donor person that lies on the operating table and ensuring they receive the same care as if they were alive.[37]

Conclusions

Person-centered care offers nurses the possibility to care accordingly to their own philosophical underpinnings and respecting dignity regardless the context. Despite this, surgery is an especially reluctant space to the implementing of this models, perhaps due to the stereotypes that surrounds it and that snatches the possibility to think itself as an empathic space.

In a similar way, it is necessary to shift the vision of organ procurement surgery from a task-oriented perspective, focused on the "doing and fixing", towards a person-centered one. The procedure, although it has to be done extremely fast, should not restrict the right of the human being that lies on the operating table to be respected, nor their family's to transit their death in an appropriate fashion.

Furthermore, even though the term has been coined through years as "person-centered care", perhaps to the analytical and practical extent it could be useful to understand this concept as "human-centered care", for the sake of not dealing with bioethical struggles regarding the beginning and end of life and allowing nurses to focus their care on that being before them and demands at all times dignity, attention and respect; not because what they now are (a cadaver), but because of what they once were (a person).

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