Communication

Professionalism

Update October 2010

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LEARNING OBJECTIVES
After studying this module on Communication, you should be able to:
1. Identify and utilise effective communication skills appropriately
2. Recognise the communication needs of, and barriers to, communication with ICU patients
3. Communicate effectively with relatives to facilitate their involvement in care and decision-making
4. Ensure effective communication with ICU team members and other clinical teams in order to promote a collaborative approach to patient care.

FACULTY DISCLOSURES
The authors of this module have not reported any disclosures.

DURATION
7 hours

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**INTRODUCTION**

*‘What we’ve got here is... failure to communicate ...’*


The goal of communication is to convey information. Everyone communicates, but not everyone communicates successfully.

There are many reasons for conveying information. Among them: to add to knowledge of a subject; to motivate someone to act; to exchange ideas; to express emotions. All these come into play in an intensive care unit. The ultimate goal of communication in the ICU is to improve patient outcome and quality of care.

Most people think of communication only in terms of delivering a message, but communication is bidirectional: it requires not only that a message be sent, but also that a message be received. What’s more, effective communication requires that the sender’s message is understood as it was intended to be understood.

Many factors influence comprehension of a message. Your tone of voice, word choice and volume affect interpretation of a verbal message. There is a world of difference between telling a co-worker: ‘I’m a little concerned about the fact that you didn’t give Mrs Baker her medication this morning’ and ‘What do you mean you forgot Baker’s meds!?!’ Likewise, an informed consent form that asks whether a patient ‘agrees to undergo hemipelvectomy for extended neoplastic intervention’ won’t be very effective if the patient 1/ doesn’t have a medical background, 2/ only speaks Spanish or 3/ can’t read.

Your message must be adapted to the situation. Communicating your message effectively requires that you:

- Know what you want to say
- Are aware of the characteristics of your audience
- Choose the most appropriate format for communication
- Deliver a clear message
- Verify that your message has been understood

Your goal as an ICU professional is to use your communication skills to enhance the care of your patients. The more aware you are of the factors that influence communication, the greater your chance of communicating effectively. In the following pages we will clarify some of the factors that are important for successful communication in the ICU.
1/ COMMUNICATING WITH PATIENTS

The physician–patient relationship

Early physicians had only limited therapies and treatments at their disposal. With so few options for physiologically treating patients, there was much more emphasis on the physician–patient relationship. Over the course of the 20th century, however, the availability of everything from antibiotics and immunisations to mechanical ventilation and computed tomography changed the face of medicine. Unfortunately, modern medicine sometimes falls into the trap of emphasising technology at the expense of good interpersonal relationships.

This is especially true in the intensive care unit. Frequently, disease, medications and interventions leave patients with only a limited capacity to interact with their physicians and nurses – if they are able to interact at all. This does not mean that ICU professionals should be satisfied with a lack of interaction. Outside the ICU, competent communication between doctors and patients has been shown to enhance patient satisfaction, compliance, and functional status. There is a significant association between patient health outcomes and how physicians communicate.

Since 2001, national healthcare policy in the United Kingdom has increasingly focused on ‘patient empowerment’. However, according to an article in the nursing literature, nurses’ desire to protect patients from harm and worry can create a parent-child relationship, and ‘nurses may be no more likely than medical staff to empower patients. They may simply disempower them in a different way.’


A Toronto study found that placing photographs of patients and their families at the patient’s bedside increased the caregivers’ empathy for the patient and helped make the highly technical environment more personal.

Acknowledging conscious and unconscious patients

As a first step in building a professional–patient relationship, you can start by acknowledging all your patients – regardless of their capacity to respond. This relays the message that you see each of them as a person, not a body in a bed.

If you are the physician treating the patient, introduce yourself to the patient and family, explain your role, answer questions, find out how much your patient knows and understands about his/her condition. As the leader of bedside rounds, always greet the patient before beginning a discussion about him.

Q. What might you say to your sepsis patient, Mrs Roth, at the start of rounds?

A. ‘Good morning, Mrs Roth, I’m Dr xxxx. I’m in charge of your care today. The team and I are going to go over how you’ve been doing since yesterday, and then we’ll be happy to answer your questions.’

And later: ‘Mrs Roth, can you tell me what you know about your illness?’

Often, patients are more aware of what is being said around them than healthcare staff realise. Some patients have reported awareness of healthcare workers’ attempts to communicate with them while they were unconscious, and others have reported frustration and alienation over lack of such communication. In addition, patients may be upset by staff discussions of the patient’s condition or care or by other inappropriate conversation. As the patient’s nurse, you should give information and explanations even to patients who are unresponsive.


Several decades ago it was found that increased verbal communication with unconscious patients leads to a proportional reduction in the incidence of ICU syndrome, an organic brain syndrome manifested by psychological reactions such as fear, anxiety, depression, hallucinations, and delirium. Yet on average, nurses spend only 5% of their time communicating verbally with unconscious patients, and presumably doctors spend even less.

The majority of comatose patients have normal brainstem auditory evoked responses and may be able to hear. Sensory stimulation programmes have been used to increase arousal and awareness in comatose patients and have not been shown to be detrimental in any way.
Encourage family members of unconscious or non-alert patients to announce their presence and say hello to the patient when they begin a visit. Suggest that they describe the ICU for the patient, relate what is going on in the world, or read greeting cards that the patient has received.

Overcoming communication barriers

Although barriers to communication are common in unconscious patients, it may also be difficult for conscious ICU patients to communicate with healthcare staff. The barriers may include intubation, hearing difficulties, lack of a common language and illiteracy.

Intubation

For most patients, being intubated (orotracheal tube or tracheostomy) is an unfamiliar and frightening condition. Being unable to talk can lead to feelings of panic and insecurity, sleep disturbances and stress. Patients should be reassured that their inability to speak is temporary and that they will be able to communicate again verbally once the tube has been removed.

A patient who had been intubated in the ICU remarked later: ‘No one had told me that I was unable to speak. Should I really have understood that myself?’

Nurses have reported that ‘the less communicative their patients were, the less communicative they were in return.’ Most interactions between nurses and intubated patients last less than 30 seconds, and consist of instructions, explanations, information related to physical care, yes/no questions, and commands.

Failure to communicate, and frustration over not being able to understand the patient, cause stress in caregivers as well. Stress leads to a reluctance to persevere and results in caregivers minimising or avoiding interaction with intubated or tracheostomised patients. Critical care nurses identified the following factors as limiting communication with intubated patients: heavy workload, patient’s severity of illness, difficulty in lip reading, patient’s inability to write, preoccupation with physical or technical aspects of care, personality of the patient, and lack of appropriate communication skills training.

Although for most people speech is the preferred method of communication, there are other ways to communicate. Non-vocal communication can include such behaviours as gesturing, nodding, mouthing words, blinking, lip reading, and touch. Alternative communication methods include pencil and paper, magic slates, felt-tip markers and dry erase boards, picture boards, language cards, one-way speaking valves, computer keyboards and electronic voice output.
communication aids (VOCAs). A Passy–Muir Valve™ may enable patients with a tracheostomy to communicate vocally at a very early stage.


**Hearing difficulties**

Speech is not the only sense that may be affected in the ICU. A significant number of critically ill patients – even those younger than 40 – fail auditory testing at thresholds in the normal conversational sound level range.

Numerous factors can cause acute hearing difficulty in ICU patients. These can range from cerumen impaction and middle ear fluid changes to trauma and electrolyte abnormalities. Often, these will be reversible. The toxic effect of drugs such as aminoglycosides and frusemide (furosemide) may not be reversible.

Not being able to hear properly may increase a patient’s confusion and disorientation or lead to unnecessary fear. It may be a significant factor in patient agitation or delirium. Since assessment of mental status requires an intact auditory processing system, ICU professionals should verify that a patient can hear before coming to a definitive conclusion about his/her mental state.


**Foreign languages**

Many hospitals serve foreign patients who may have little or no ability to speak and understand the local language. Language barriers are a challenge for ICU professionals.

While translators may be useful, it may difficult to accurately translate the complaints of patients or the information coming from medical/nursing staff – particularly if the translator does not have specific training in this field. Multilingual family members or hospital staff have the advantage of being continuously involved in the situation. They can help with communication on a day-to-day basis. There is, however, also evidence that family members may interpret or modify the information rather than merely translate. Another option is to provide illustrated cards that translate commonly used ICU phrases into other languages.
Charades and Pictionary™ are popular games that require a player to communicate a concept to teammates without speaking. Charades uses pantomime and Pictionary™ uses drawing. Create a set of cards that list ICU devices, concepts, and procedures. Then test the cards by playing charades or Pictionary™ with your co-workers. The next time you encounter a patient with limited language abilities, apply what you learned.

**Illiteracy**

Poor reading skills are associated with poor health, and are especially prevalent in the elderly, the poor, members of minority groups and immigrants. However, because many people who cannot read are very adept at hiding their inability, healthcare providers need to be aware that every day they are likely to encounter patients and family members with limited literacy skills.

Unfortunately consent forms, questionnaires and surveys, brochures and handouts, and instructions for medications and self-care are often written in language that patients and their families cannot fully understand. This should be avoided wherever possible. Materials such as audio- and videotapes, slides, models and picture books can be used to provide healthcare information with no or minimal reliance on text.

Above all, healthcare professionals should not assume that patients or their surrogates understand information, just because they receive it. It is your job to check their understanding. The communication skills in the final Task can help.


**Q. How might illiterate patients or relatives respond when confronted with materials they are unable to read?**

**A.** They may

- Claim they have forgotten their glasses
- Glance at the papers and then ask for more time to read them at home
- If accompanied by a spouse or adult child, hand the materials to the other person without looking at them
- Ask where to sign a document without reading it at all.

**Considering the patient’s perspective**

One way that you can improve the care of your patients is to look at the ICU from their perspective. Physicians who spend most of their time talking but not listening, miss important opportunities to allow patients to communicate their values and
goals. Clinicians should view the goals of treatment from the patient’s perspective, and cannot assume that they understand their patients’ priorities.

Patients have a basic need to express themselves. Being allowed to communicate may even be therapeutic. When possible ask your patients what is important to them, and how you can improve their ICU experience. Patients in focus groups ‘invariably provide suggestions different from those that group after group of clinicians and administrators characteristically pursue.’

Misak CJ. The critical care experience: A patient’s view. Am J Respir Crit Care Med 2004; 170: 357-359. PMID 15105165

**Meeting the patient’s needs**

Once a patient’s needs for survival and safety are met, his/her psychological needs become most important. Among these are the need for the presence of other people, information, honesty, compassion and hope. In order to meet these needs, you must communicate – or make it possible for others to communicate.

**Presence**

Positive reinforcement and encouragement from family and friends can strongly influence the patient’s recovery. ICU patients who have companionship from loved ones suffer fewer hallucinations, and flexible visiting hours allows family members to provide emotional support. Although some nurses believe that visitors are physiologically stressful for patients, there is no scientific basis for restricting visitors to the ICU. Allowing patients to influence the timing and number of visitors may have advantages for the patient in comparison with visits controlled by staff.

**Information**

Informed patients tolerate pain more easily, recover from surgery more quickly and cooperate better with therapy. A patient’s failure to ask for information does not necessarily mean that they do not want it. Many patients never ask their physicians for prognostic information, yet most want to know their prognosis. However, it is a good idea to ask a patient first: ‘How much do you want to know?’ Children should receive age-appropriate explanations of their illness, treatment options, and – if they are terminally ill – the concept of death.
Patients generally do not understand percentages or numerical data, and often they are not as interested in statistics as they are in knowing the impact their disease will have on their lives. See the following references and the PACT module on Clinical outcome.


**Hurwitz CA, Duncan J, Wolfe J.** Caring for the child with cancer at the close of life: “There are people who make it, and I’m hoping I’m one of them”. JAMA 2004; 292: 2141-2149. PMID 15523075

**Hope and honesty**

For physicians treating critically ill patients, it can be difficult to find the right balance between being honest and offering hope. Most people do not want to be deceived; they want ‘accurate information pertaining to their condition shared with them candidly.’

Some ways to provide hope when communicating prognosis include:

- Stress that numbers apply to groups rather than individuals.
- When appropriate focus on outliers, and on positive and achievable goals.
- Speak in terms of reaching goals or landmarks or overcoming hurdles.
- Focus on the things that are controllable.
- Highlight the aspects of the patient’s situation that might improve their chances.
- Emphasise quality of life rather than life expectancy.

**Butow PN, Dowsett S, Hagerty R, Tattersall MHN.** Communicating prognosis to patients with metastatic disease: what do they really want to know? Support Care Cancer 2002; 10: 161-168. PMID 11862506

**Q. Without using percentages, how would you communicate a hopeful prognosis to a patient with a 75% chance of surviving to ICU discharge and a 45% chance of completely regaining physical function at the end of one year?**

**A.** ‘Mrs Johansson, I think there’s a very good chance you’ll be able to move back to the general ward if you continue to improve as you have up until now. For every four patients in your situation, three become well enough to leave the ICU, and you’ve shown a great deal of improvement. First we need to get you breathing on your own, though. That’s our goal over the next few days, and we need your help to reach it. There is a fair chance that in a year from now you may even be back to living a normal life. Nearly half the patients in your situation have completely recovered by then.’
Dealing with ‘difficult’ patients

Every healthcare professional encounters ‘difficult’ patients. These are not necessarily patients with complex medical problems but rather patients who may be demanding, aggressive, dirty, rude, or violent. In 1978 Groves defined four types of difficult patients: ‘dependent clingers’, ‘entitled demanders’, ‘manipulative help-rejecters’ and ‘self-destructive deniers’. These patients may evoke negative feelings in ICU staff ranging from depression to anger to guilt.

Try not to feel personally attacked by reactions of anger and disbelief


Sometimes there may be conflicts in the ICU over whether to provide non-beneficial treatments demanded by the patient. Other conflicts may arise from cultural gaps between the physician and the patient.

Regular communication can improve understanding, emphasise the limitations of medical science, and diffuse anger and aggression. Negotiating with, and educating, the patient can reduce conflicts. The frequency and consequences of violent and abusive behaviour can be reduced through staff awareness, recognition of the verbal and non-verbal signs of aggression, and training in communication skills.

Some means of coping with difficult patients include:
- Empathy
- Non-judgmental listening
- Patience and tolerance
- Directness (‘I know you’re angry at us for not being able to cure your cancer...’)
- Setting clear limits for an encounter (‘Over the next 15 minutes we will...’)
- Referral to consultants for mental health services
- Humour (cautiously)
- Deferring to patient requests for treatments which are unhelpful or irrelevant
- Involving the patient’s family
- Relaxation
- Relating personal experiences

Obtaining informed consent

Informed consent, whether for treatment or for enrolment in a clinical trial, involves five principles: disclosure of information, competency, understanding, voluntariness, and decision-making. The specifics of obtaining consent differ for adults and for children, as well as by nation/jurisdiction.
A French study found that only 25.8% of patients were capable of making decisions in the first 24 hours after their admission to the ICU. Trauma, disease, sleep deprivation, various treatments, and stress may all be factors. If the patient is not competent, someone else (a physician, a legal representative or, in some jurisdictions, a relative) must make decisions on their behalf.


Luce JM. Is the concept of informed consent applicable to clinical research involving critically ill patients? Crit Care Med 2003; 31 (Suppl): S153-S160. Review. PMID 12626961


**Anecdote** A four-year-old girl was asked to donate bone marrow to save the life of her baby sister. Encouraged by her parents, she agreed. After the harvesting procedure, she asked the doctor when she was going to die. It was only then that the doctor realised that the little girl had assumed she would have to die in order to save her sister’s life.

**THINK:** How might obtaining consent differ for a competent adult and a 10-month-old child?

For a detailed discussion of the issues surrounding consent see the PACT module on Ethics.

**Consent forms**

Unfortunately, most consent forms are written significantly above the reading level of the average reader. To simplify your text you can do the following:

- Use short, simple words and sentences
- Limit the amount of technical jargon
- Use parallel sentence structure
- Present one idea per paragraph
- Consider a question-and-answer format.

Easy-to-read forms are associated with higher patient satisfaction and less consent anxiety. If well written this will not offend well-educated participants.

Discussing end-of-life care

For some of your patients, continuing aggressive treatment will be futile. It will then be up to you to prepare the patient and/or family for the new focus on palliative care, and in many cases for the withdrawal of life support.

It is essential that you make clear to your patient and/or the patient’s family that although you may have decided to withhold or withdraw a particular treatment, you are still committed to providing care. The withdrawal of life support may evoke great anxiety in both patients and family members – particularly if the patient is aware. You should provide clear and explicit explanations of what will happen. End-of-life care can cause considerable conflict among families, patients and caregivers, and addressing it requires the utmost of care.

Helping the patient cope with the ICU experience

Many patients experience pain and anxiety during their ICU stay. Since the 1980s, the practice of maintaining a personal diary for the patient during his/her ICU stay has been adopted in numerous European countries, among them Sweden, Norway, Denmark, and the United Kingdom. The purpose of the diary, which is maintained by staff, relatives, or friends, is to provide ‘a framework to reconstruct a life disrupted by illness and fragmented by loss of memory.’ Diaries can help ICU survivors make sense of their experience and can help families of deceased patients cope with their loss.

The transition to the limited care in the regular wards can also be stressful. Some patients may be afraid that something will happen to them if they are not under constant surveillance. Others develop long-term psychological problems such as post-traumatic stress disorder in reaction to the ICU experience. As part of the discharge process, the critical care team should attempt to answer patients’ questions, provide reassurance and solicit input on aspects of care that can be improved.

Communicating effectively

Many potential reasons for failure to communicate effectively with critically ill patients have been proposed, some with more supporting evidence than others. Among them are:

- Communication with ventilated patients is technically difficult
- Patients are not viewed as individuals due to their medical conditions and invasive treatments
- Staff have little time due to a heavy workload
- Caregivers are hesitant to become attached to patients who may die
- Busy critical care clinicians are unable or unwilling to wait for patients who are slow in generating messages

For more information about nurse–patient communication in the ICU see the following reference.


Aspects of quality communication with ICU patients include:

- Attentiveness
- Congruence (‘a harmony between the verbal and non-verbal aspects of communication’)
- Empathy
- Facial expression (pleasant or smiling)
- Humour when appropriate
- Reassurance
- Reliability and credibility
- Respect for the patient’s privacy and confidentiality
- Simple and non-technical language
- Soothing vocal tones
- Timing
- Touch

2/ COMMUNICATING WITH FAMILIES

Usually your ICU patients will be visited by relatives and perhaps close friends. Interacting with families is an integral part of caring for a critically ill patient. Although there is a temptation to feel that spending time with families takes you away from your 'real' job – patient care – you should remember that families are important to patients; increasing your support of the family may indirectly improve your patient’s response to treatment and thus his/her chances of leaving the ICU alive.

Providing information

Intense feelings such as despair, fear, worry, anger, and exhaustion are common among the families of patients being treated in the ICU. Families of critically ill patients have many needs which continue or even intensify when the patient remains in the ICU for a long time. Above all, relatives and close friends need information about the patient and what is happening to him. The information should be clear, accurate, honest, timely, and in language they can understand.


Who should meet the information needs of families?

It is up to the ICU team to provide the family with information. As soon as possible after admission there should be an initial meeting to explain the patient’s situation and answer the family’s questions. This meeting will usually last a minimum of ten minutes and should preferably be attended by the physician in charge. Family members want more frequent contact with physicians (they often state that they have too little access to physicians; they never say that they have too much). They prefer to receive all information in person from the same physician each time. The problem of conflicting information from more than one source should be recognised and addressed.

Anecdote A few hours after Mr S was admitted to the ICU the surgeon spoke with his wife: ‘Hello Mrs S, it’s nice to meet you. I wanted to let you know that the operation was quite difficult but we were finally able to stop the bleeding and we’re confident that your husband will recover soon.’ Less than an hour earlier, the physician in charge of the ICU had told Mrs S that despite a successful surgical intervention there was a very high risk that her husband would develop multiple organ dysfunction syndrome in the next few days and die. Mrs S didn’t know who to believe, and had doubts about the competency of the team.
What do families want and need to know?

The family is primarily interested in information about the patient’s status. What is wrong with my mother? How is she doing? Are you going to stick tubes and needles into my husband? When will he come home? Information helps families form reasonable expectations and cope with their distress.

You should:

- Explain the primary diagnosis, and which organs are involved in the disease process.
- Give a balanced but cautious estimate of the patient’s chances of survival (prognosis).
- In simple terms, describe the treatments that you will use (‘We’re going to hook him up to a machine that will help him breathe’).
- Provide printed materials or links to online information about the procedures and equipment in the ICU.
- Briefly explain the roles of the members of the ICU and hospital teams.

**CAUTION:** Half the families of ICU patients don’t understand the patient’s diagnosis, prognosis, or treatment.


Lee Char SJ, Evans LR, Malvar GL, White DB. A randomized trial of two methods to disclose prognosis to surrogate decision makers in ICUs. Am J Respir Crit Care Med 2010; (epub ahead of print). PMID 20538959

The Society of Critical Care Medicine provides information for patients and families on its website [click MyICUcare]:
http://www.sccm.org

It also sponsors a website specifically for families which contains information about common diseases and about technologies available in the ICU:
http://www.icu-usa.com/

Q. How would you translate the following statement into terms a lay person can understand?

‘Your husband’s CT scan shows the clinical signs of a pulmonary embolism, including obstructive shock because of acute severe right ventricular failure. We’re going to intubate him, treat the shock with fluids and inotropes or vasopressors if needed, and see whether his vital signs improve over the next 24 hours.’
A. ‘We’ve now looked at the pictures of your husband’s lungs. It seems that a clot of blood has travelled to the lungs and blocked an artery there. This makes it much harder for the heart to pump blood to the rest of the body. Overall this results in a life-threatening situation for your husband. We’re going to put a tube down his throat to make sure he gets enough oxygen and try to help the heart pump by giving him fluids and special drugs. Then we’ll see whether he improves over the next 24 hours.’

**How can you improve family comprehension?**

Often information is communicated but not understood. Some factors that can influence comprehension include:

- Amount of time devoted to communication (the more the better)
- Emotional state
- Language (vocabulary, foreign vs native language)
- Conflicting messages

People who are stressed and upset may have trouble concentrating and may hear but not retain your message. Non-native speakers in particular have difficulty comprehending information. Not only is it harder for them to understand your words, but they may also have different values, expectations regarding healthcare, and rules of etiquette.

**What you can do**

- Communicate with the family as often as possible.
- Coordinate with your team so that all members are giving the same message, or designate one person to communicate with the family.
- Choose one family member to be responsible for disseminating information about the patient to the rest of the family.
- Make sure your body language reflects the message you give verbally.
- Provide translators and translated materials for speakers of foreign languages.
- Ask the listener to restate your message in his/her own words (see ‘Checking understanding’ in Task 4).
- Give information in an organised and logical sequence, using signposting and summarising (see Task 4).
- Reinforce your message by using various communication methods.

**Q.** You tell your patient’s husband: ‘We are planning to wean your wife from the respirator today.’ He answers: ‘Yes’. What do you say to make sure that he has understood?

A. ‘I just want to make sure you understand what’s involved in weaning your wife from the respirator. Can you describe what you think will happen? If you’re not sure, I can explain it in more detail.’

**Using printed materials to aid comprehension**

Often – especially at admission – families of ICU patients receive an overwhelming amount of information at a time when they are emotionally unable to comprehend it. One option for helping families process and retain information is to provide a family information brochure that can be referred to repeatedly.
A brochure might contain the following:

- The name of the physician in charge of the patient.
- Titles and primary duties of the various ICU personnel.
- Telephone number of an ICU team member who can provide daily updates.
- Contact information for the hospital’s clergy/pastoral team and social workers.
- A glossary of major equipment and procedures, described in simple terms.
- Visiting hours.
- A floor plan for the unit, including labelled restrooms and waiting rooms.

The brochure may also address patients’ and families’ information needs when the patient is transferred out of the ICU.

You might also suggest that the family member use a small notebook in which additional information can be recorded, including:

- Telephone numbers of family and friends who need to be updated.
- The patient’s diagnosis.
- Information about treatment plans and goals.
- Questions to ask the medical and nursing staff.
- Answers to questions previously asked.

In a study of the impact of a family information leaflet, Azoulay et al. found that the brochure reduced the proportion of family members with poor comprehension from 40.9% to 11.5%.

In another study, relatives of patients who were dying in the ICU were randomised either to receive a brochure on bereavement and be exposed to a proactive communication strategy (longer conferences and more time for family members) or to receive the usual treatment only. Three months later the psychosocial distress in the relatives in the intervention group was significantly lower than in the control group.


Develop a simple brochure for relatives that provides basic information about your ICU. Then survey family members to determine their reactions to the brochure.

Hinsdale Hospital (Hinsdale, Illinois, USA) developed a structured communication programme for families of ICU patients, consisting of a discussion with a nurse, an information pamphlet and a daily telephone call. The intervention led to a significant reduction in the number of incoming calls from family members, an increase in family satisfaction with care and the perception among family members that their information needs were better met.

Medland JJ, Ferrans CE. Effectiveness of a structured communication program for family members of patients in an ICU. Am J Crit Care 1998; 7:24-29. PMID 9429680

**Providing support for the ICU family meeting**

Family meetings often fail to occur on a timely and regular basis in many ICUs. Gay et al. suggested the following strategies to help ensure that family meetings take place: identifying convenient blocks of time for the meeting, using print materials, including the family meeting on checklists or daily goals sheets, including nurses, supporting communication skills training, and relaxing restrictions on family presence in the ICU.

In addition, a toolkit designed to make family meetings simpler proposes using a family meeting planner, a meeting guide for families, and a family meeting documentation template.


**Involving the family in patient care**

Family members of critically ill patients have a strong need for proximity to the patient. This need to be with or near the patient is most intense in the initial
stages of the critical illness and lasts until the patient shows signs of stabilisation, improvement or recovery.

Allowing families to be present while you care for the patient or to help care for the patient themselves is one way to meet their need for proximity. Being present during rounds at the bedside allows them to contribute information about the patient and to observe the complexity of care. This may, however, require modification of the language used on the ward round to avoid misunderstandings or causing offence. Encouraging relatives to keep a daily diary of events can also be of great value later, contributing to an understanding of the stresses of being the patient and being the relative.


**Family presence during resuscitation**

The first time you meet your patients they may be in need of resuscitation. Traditionally, family members have been excluded from resuscitation based on the belief that seeing aggressive, invasive procedures would distress them and that their presence would compromise the performance of the clinical staff. Although several studies have shown that allowing family members to witness resuscitations in emergency rooms or before hospital admission is not detrimental to them, a study by Fernandez published in 2009 indicates that the presence of a family witness impacts physician performance during simulated medical resuscitations. The time to delivery of the first defibrillation shock was longer, and fewer total shocks were delivered, for the groups with witnesses than for the groups without.


Leske JS, Brasel K. Effects of family-witnessed resuscitation after trauma prior to hospitalization. J Trauma Nurs 2010; 17(1):11-18. PMID 20234233


**Pain assessment**

Patient comfort is one of the major concerns of family members. Compromised mental status, mechanical ventilation and language barriers can inhibit communication with patients, thus hampering health professionals’ ability to identify and treat pain. ICU nurses are trained to assess patients for signs of pain, including restlessness, hypertension and tachycardia. Family members, who know the patient well and are often motivated to foster improvements in
care, can provide an alternate source of pain assessment. By helping to communicate the patient’s needs they can be an asset to the healthcare team.

Devlin J. Pain assessment in the seriously ill patient: can family members play a role? Crit Care Med 2000; 28: 1660-1661. PMID 10834736

**Daily care**

Participation in daily care may give families a feeling of usefulness, thereby contributing to the alleviation of negative feelings such as guilt. Some examples of options for family involvement in patient care include feeding and bathing the patient, swabbing the patient’s mouth, and possibly performing tracheal suctioning.

Although there is little reported evidence that participation benefits families, Azoulay et al. noted that ‘performing some of the acts usually left to professionals may lead to an awareness of the caring nature of interventions used in ICUs, which may otherwise seem frighteningly aggressive.’ By involving families in daily care, healthcare professionals communicate that family members are not outsiders but welcome members of the ICU team.


**Q. Your 83-year-old patient Mrs Henry, who is semi-conscious after being struck by a car five days earlier, moans frequently. Mrs Henry’s daughter spends a great deal of time at the bedside, and has complained to another patient’s wife that the nurses are ignoring her mother’s pain. The nurses are frustrated. How might you take advantage of the daughter’s ongoing presence at the bedside to improve the situation?**

A. Ask Mrs Henry’s daughter if she would be willing to help the nurses keep track of her mother’s pain and response to pain medications. Suggest that the daughter use a notebook to record instances when she thinks her mother is in pain, how long the pain lasts and whether the pain seems to go away soon after medications are given. Ask the nurses to look at the daughter’s record after a period of 24 hours to see if their evaluation of Mrs Henry’s pain corresponds with the daughter’s, and to consider whether pain medication should be increased.

**Involving the family in decision-making**

More than 90% of ICU patients are too ill or too sedated to be aware of what is happening with regard to their care. Thus surrogates are often involved in the process of decision-making regarding ICU treatment. Although it is the physician who is ultimately responsible for determining care plans, he/she may wish to obtain input from family members before making decisions that may
have great significance for the lives of many. Clinical practice guidelines for supporting the family have been published by the American College of Critical Care Medicine, and are based on empirical research.


**Differences between countries**

Whether physicians consult patients or families regarding treatment preferences can vary greatly depending on whether the ICU has a culture that places primary emphasis on the ethical principle of beneficence or of autonomy. This may reflect the medical system of the country or local custom and practice.

**Beneficence**

The principle of beneficence assumes that physicians know/discover what is best for a patient and will make decisions in the patient’s best interest. It is often linked with the concept of paternalism, in which decision-making is the responsibility of the person with the most knowledge i.e. the doctor rather than the person(s) affected by the decisions – the patient and family.

A study in France found that 60% of families were informed that discussions over whether to withhold or withdraw life-sustaining therapy were being held, but only 17% participated in the decision-making process themselves.


**Autonomy**

The principle of autonomy assumes that individuals have the right to make decisions about treatments that affect them, or to appoint someone familiar with their values and wishes to make those decisions. Physicians are viewed more as partners in the decision-making process.

In 1990 the US Congress passed the Patient Self-Determination Act, which allows people to specify their treatment preferences and designate a proxy decision-maker at any time before they lose decision-making capability (and in fact, even before they become sick).

**Seeking input from families**

Healthcare professionals may feel that families are unable to comprehend the many issues that affect medical decisions and thus should not be allowed to make those decisions. Rather than excluding families from decision-making, healthcare providers can and should educate patients and families on the risks and benefits of proposed therapies so that there can be informed discussion of the best approach to the patient’s medical care. This requires an emphasis on communication between clinicians and families.

**Note** In the USA, families participate in 70-80% of medical decisions about their critically ill relatives. In Northern Europe, families are significantly more closely involved in end-of-life decision-making (88%) than they are in Southern Europe (48%)


Hardart GE, Truog RD. Attitudes and preferences of intensivists regarding the role of family interests in medical decision making for incompetent patients. Crit Care Med 2003; 31: 1895-1900. PMID 12847380

**Determining the patient’s preferences**

The increasing emphasis on patient autonomy means that many families may expect you to consider the patient’s wishes in planning your approach to care. If you did not have a chance to talk with your patient before treating him or her, you can ask the family for information (‘Can you tell me about your husband? What does he value most about his life? How do you think he would feel about being hospitalised for a long time?’). The key question is not what the relatives wish for but rather ‘What would the patient say if he/she was able to talk to us?’

**Factors influencing relatives’ perspectives**

Fewer than 2% of relatives reported that prognostic information provided by the medical staff had the greatest influence on their beliefs about the patient’s prognosis. Other factors cited by family members include the patient’s character, illness history, and physical appearance; the relatives’ presence at the bedside; belief in God; and the relatives’ own optimism, intuition and faith.
Although many surrogate decision-makers are doubtful of the accuracy of physicians’ prognoses, they highly value discussions about prognosis and use the information for multiple purposes. Acknowledging that many factors play a role in patient and surrogate assessments may help clinicians identify and overcome disagreements about prognosis.


**Educating the family and encouraging discussion**

Families must have a reasonable level of comprehension of the patient’s problem if they are to participate in decisions about care.

According to the Society of Critical Care Medicine, a skilled physician will ensure that family members have been informed but have not been overwhelmed by issues they don’t understand. Written information may improve families’ decision-making capacities.

In addition to scheduling regular meetings between family and staff members, you should encourage family members to discuss issues among themselves. Since many families make cooperative decisions, consider including extended family in major discussions with staff.

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One third of family members of intensive care unit patients have post-traumatic stress symptoms three months after the stay of their loved ones. Higher rates have been found for family members whose relative died after end-of-life decisions (60%) and who shared in end-of-life decisions (81.8%). This may indicate a risk of creating a feeling of guilt among relatives who share the burden of decision-making. The physician should avoid asking the family for a decision but rather seek consensus with a plan of action originating from the clinical staff (see figure below).

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Davidson JE. Do cultural differences in communication and visiting result in decreased family desire to participate in decision making? Crit Care Med 2004; 32(9) 1964-1966. PMID 15343030

Illustration: Example of an end-of-life decision-making process

Adapted from a figure provided by Professor Jean-Claude Chevrolet, Geneva, Switzerland

Decisions Near the End of Life, a multidisciplinary quality improvement programme conducted in the USA from 1987 to 1994, found that ‘involving surgical residents in case-based discussions of end-of-life decision-making led to greater communication between residents and attending intensivists and to greater discussion about goals of care among residents, attending physicians, and families.’

The next time a decision must be made about whether to withdraw life support from one of your patients, document the decision-making process. Who is involved? How many individuals and categories of caregivers? Are the family consulted or informed? How long does it take until a decision is made? Has consensus been reached? Do you see aspects of the process in which communication could have been improved? If you have suggestions for improving the process, share them with your team.

Q. You think it is time to recommend palliative care for a 27-year-old cystic fibrosis patient. With whom do you communicate, and how do you proceed?

A. Once it is clear from the consensus of clinician decision-makers in this patient’s case that continuing life-sustaining therapy is futile, you should talk with the patient himself (in the rare instance in which he will be alert enough at this stage of his ICU course), and with close family members, to find out whether they are ready to make the transition. Explain that you and the clinicians attending the patient do not think the patient will benefit from further invasive treatment. Once the patient and family agree that it is time for palliative care, ask for their input into the process. Then schedule a meeting of all ICU team members e.g. physicians, nurses, physical therapists, clergy,
social workers and any other personnel (such as hospice representatives) who will be involved. After the staff meeting, inform the patient and family of the plan, answer their questions, and acknowledge their point of view. Note: depending on differences in ethical guidelines and medicolegal or general conditions, the procedure may be different at your institution.

**Handling differences of opinion**

Sometimes you will not see eye-to-eye with the family on the issue of how to proceed with care. Perhaps you will disagree over the goals of treatment, whether to proceed with ‘futile’ interventions, or who has the right to decide. There may also be differences of opinion between members of the clinical team. These need to be handled sensitively, with respect for others, and may require a detailed explanation to the family about the nature of probability and clinical uncertainty. Handling differences of opinion requires an open mind and superior communication skills.


**‘Difficult’ relatives**

 Relatives are perceived as ‘difficult’ when they create more work for the ICU team members e.g. by telephoning frequently, when they are unable to comprehend medical information, when they are aggressive, accusatory or threatening, and when they are persistent in their demands for ‘futile’ treatment(s).

Many of these problems can be addressed with an emphasis on communication. As seen earlier in this section, regular updates from the staff and the use of written information and other aides can improve both the satisfaction and comprehension of relatives. Aggressive family members should be treated with compassion; they may simply be reacting to their feelings of helplessness, and should be reassured that you are doing everything in your power to provide optimal care. Often relatives who demand futile treatments either do not have sufficient awareness of the extent or severity of the patient's illness or they have been given an inaccurate picture of the patient's chances of recovery.

**Reaching consensus**

Disagreements often occur when individuals or groups have different points of view. Often these points of view are based on different belief systems, and neither system can be described as ‘right’ or ‘wrong’. Reaching consensus requires that all parties make an effort to see the problem from the other person’s point of view. For steps in conflict resolution, see the figure, above.
What you can do

- Calm yourself.
- Listen attentively so as to better understand the other point of view.
- Know the laws and professional guidelines in your country regarding who has the right to make decisions.
- Involve people from outside your department (clergy, ethicists, specialists, friends of the family) in the negotiations to reduce the emphasis on ‘us’ vs ‘them’.
- Allow the family time to consider your point of view and to discuss your recommendations among themselves.
- Avoid proceeding with a controversial treatment until both staff and family agree that your approach is the best one.
- Be open-minded – it may be your opinion that needs to change!

See the following references and the PACT module on Ethics

Luce JM, Alpers A. End-of-life care: what do the American courts say? Care Med 2001; 29 (Suppl.): N40-N45. PMID 11228572


A study from Brigham and Women’s Hospital and Harvard Medical School in 2000 looked at using an intensive communication intervention to help patients, families and the critical care team evaluate the use of advanced supportive technology. Regular discussion of goals and care plans and greater interaction between caregivers, patients, and families permitted an earlier transition to ICU-based palliative care when technology was found to be ineffective. The intervention resulted in a significant reduction of the median length of ICU stay from four days to three days.


Q. A 58-year-old man with acute myeloid leukaemia is admitted to your ICU with acute severe respiratory distress caused by pneumonia. He is intubated and mechanically ventilated. You discuss treatment options with the patient’s girlfriend, and she firmly underscores that everything possible should be done to save her friend’s life. An hour later another woman arrives and says she
is the patient’s wife. She states that her husband told her in the past that he should never be admitted to an ICU and that he does not want to be kept alive with circulatory or respiratory support. What do you do?

A. First, attempt to communicate with the patient himself, to find out his preferences for treatment and whether he would prefer that his girlfriend or his wife make decisions about his care. If he is not competent, try to determine how close each of the women is to the patient, and whether discussions of preferences for medical care were held with the patient recently.

Note: Remember that many countries have a legal hierarchy setting out which family members have most influence in discussions about treatment and may have provisions that specify for example that the senior doctor in charge of the patient’s care decides the approach that is in the patient’s best interest.

If the women know each other (and are on civil terms), you can invite both to a team meeting to discuss the best approach to the patient’s care. If there is no consensus, you should do what is necessary to keep the patient alive if such course is medically reasonable, at least until he is competent to communicate his preferences or clarity on his preferences otherwise emerges.

This procedure may be different at your institution.

Breaking bad news

Breaking bad news is one of the most difficult tasks you will face as a physician, but it is a necessity in the practice of critical care medicine. Doctors and nurses may be afraid to add to relatives’ distress, or to express their own emotions, or they may be uncertain about whether they are capable of dealing with unexpected reactions from relatives. They may experience feelings of inadequacy due to lack of training, knowledge and the necessary communication skills.

Preparing families for the possibility of a bad outcome

It is surprisingly common for a family to have no idea that the situation is serious until the doctor proposes moving from active treatment to palliative care. If you don’t tell the family about the seriousness of the situation until death is imminent, it may be difficult for them to ‘catch up’. From the beginning of the patient’s ICU stay, you should be cautious in making any promises about the patient’s recovery. Present a balanced picture, highlighting the possibility of both positive and negative results. One way of achieving this is by explaining the possible clinical pathways the patient’s course might follow – death in ICU, death in hospital, death within a certain period after discharge home, or long-term survival – and the emotional and physical burdens attached to these outcomes.

Fallowfield L and Jenkins V. Communicating sad, bad, and difficult news in medicine. Lancet 2004; 363 (9405): 312-319. PMID 14751707
How to talk with families

Once it is clear that there is little hope for survival, you should schedule a meeting with the family, who should be informed in clear, easily understood language that their relative is dying. Make a distinction between your capabilities and intentions: what you want to do is cure the patient, but you are unable to do this. The family should be allowed to absorb this information before you begin discussions of treatment withdrawal.

What you can do

- Break bad news early and clearly. Use no more than a few introductory sentences.
- In the case of death of a patient, use the word dead or death.
- Show compassion.
- Ask open-ended questions (beginning with ‘How’, ‘What’, ‘Where’ and ‘When’) that allow the family to elaborate on their concerns.
- Use time to reflect (see Task 4) and identify/acknowledge what family members are feeling.
- Summarise (see Task 4) to demonstrate that you are aware of what relatives have communicated.
- Encourage the family to ask questions, and give them the information they ask for, checking that your explanation has been understood.
- After the family has had sufficient time to respond to the bad news, address what will happen in the near future and solicit their preferences.

In general: talk less, listen more (increased time given to family vocalisation is associated with increased satisfaction).

You may find the mnemonic BAD helpful:
Break bad news, Acknowledge the reaction, Discuss the near future

Occasionally, a patient in the intensive care unit must be told of the death of a loved one. Breaking bad news in this unique situation is addressed by the Rev. Lisa Watson in a review article (see below).


Where to talk with families

Bad news should be delivered to families in a private room whenever possible. The lack of a comfortable, private space for discussions and conferences is a serious drawback for families of critically ill patients. A room for families should have enough space and chairs to accommodate several people; coffee and water; tissues, blankets and a telephone; and a window and bed if possible.

Q. Your 61-year-old patient with bacteraemia, Mr Swenson, dies just as you are about to leave work for a weekend skiing trip. You meet his wife in the elevator and tell her that it looks like her husband has finally died. You explain that you have to leave the hospital on important business, but the nurse will make the arrangements. Mrs Swenson starts to ask a question, but you interrupt, saying that the physician on call can help her. Name four things you did wrong in handling this situation.

A.
1. You broke the news of the patient’s death in a public place.
2. You showed no compassion, and in fact treated the death as inconsequential.
3. You left the follow-up to someone else without first briefing them.
4. You discouraged the wife from asking questions.

Requesting organ donation

Families’ hospital experiences significantly affect whether they decide to donate organs. Non-donor families have a poor understanding of brain death, are less likely to feel they were given sufficient time to make a decision, and are more likely to feel that the person making the request was insensitive to their needs. A systematic review of 20 observational studies and audits by Simkin et al. found that ‘the main factors associated with reduced rates of refusal were the provision of adequate information on the process of organ donation and its benefits; high quality of care of potential organ donors; ensuring relatives had a clear understanding of brain death; separating the request for organ donation from notification that the patient had died; making the request in a private setting; and using trained individuals to make the request.’

A 2009 study found no increase in consent rates for organ donation when relatives were approached by the clinical team and a donor transplant coordinator together (collaborative request) rather than by the clinical team alone (routine request).
Simpkin AL, Robertson LC, Barber VS, Young JD. Modifiable factors influencing relatives’ decision to offer organ donation: systematic review. BMJ 2009; 338, b991. PMID 19383730

ACRE Trial Collaborators. Effect of “collaborative requesting” on consent rate for organ donation: randomised controlled trial (ACRE trial). BMJ 2009; 339, b3911. PMID 19815583

Recommendations of the European Donor Hospital Education Programme include:

- Allow the family time to absorb the news that the patient is dead before making the request. Organ and tissue donation are preferably discussed on a separate occasion than the one in which the death of the patient has been conveyed.
- Make the request clearly and explicitly.
- Give information in small amounts.
- Describe the most important things first.
- Use simple language.
- Check that what you say has been understood.
- Give the bereaved time alone (15 minutes to half an hour or longer) to consider what you have proposed.

See the following reference and the PACT modules on Ethics
Organ donation and transplantation


**Family satisfaction with care**

Meeting the needs of patients’ families is an essential aspect of ICU care. Satisfaction of proxies is a major criterion in the assessment of quality of care and of compliance with accreditation requirements. Often relatives are not satisfied with the emotional support they receive, with the provision of understandable, complete, and consistent information, and with the coordination of care. Poor communication is frequently cited as the main cause of dissatisfaction with care.

In a study by Stapleton, specific clinician statements during family meetings—such as assurances that the patient will not be abandoned before death, will be comfortable, and will not suffer—and the support for families’ decisions about end-of-life care, are associated with higher family satisfaction.
Practical issues regarding conducting meetings with the family:

- Choose a comfortable and private location
- Know the patient’s name
- Verify that you are speaking with the relatives of the right patient
- Know the names of the other staff members attending the meeting
- Introduce all people present
- Provide enough chairs for all attendees
- Ask all staff to turn off their pagers or cellular telephones
- Know the topics you plan to discuss
- Allow time for questions
- Identify a person for the family to contact if further questions arise after the meeting, and provide the contact information
- End the meeting by summarising decisions made and further steps to take.

One simple intervention which can be used to assess family satisfaction with care and to demonstrate better care for relatives is the Family Satisfaction with ICU Care (FS-ICU), a standardised questionnaire which is available in many languages (http://www.criticalcareconnections.com).

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<tr>
<th>Factors associated with family dissatisfaction</th>
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<tbody>
<tr>
<td>✷ Receiving contradictory information</td>
<td>✷ Showing respect and compassion for the dying patient and the family</td>
</tr>
<tr>
<td>✷ Different nurses assigned to the patient on two consecutive days</td>
<td>✷ Inclusion in the decision-making process</td>
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<tr>
<td>✷ An unwelcoming waiting room atmosphere</td>
<td>✷ Staff facilitation of family consensus</td>
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<tr>
<td>✷ Low frequency of physician communication</td>
<td>✷ Quality, quantity, consistency, completeness, and timeliness of information</td>
</tr>
<tr>
<td>✷ Being informed of the patient’s death by telephone</td>
<td>✷ Involvement of the family doctor in the provision of information</td>
</tr>
<tr>
<td>✷ Not being a native of the country where the hospital is located</td>
<td>✷ Information provided by a single junior or senior physician with whom the family can develop a relationship</td>
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<td></td>
<td>✷ Time allowed for communication of information</td>
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<td>✷ Daily telephone updates on the patient’s condition</td>
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<td>✷ Receipt of an information brochure</td>
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<td></td>
<td>✷ Discussion with a nurse 24 hours after admission</td>
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<tr>
<td></td>
<td>✷ Requests for organ donation made by healthcare professionals who have positive attitudes about donation and about their role in the procurement process</td>
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</table>

For family members, quality of care is not limited to merely treating the patient for an acute illness. In a Canadian survey of relatives of patients who died in the ICU, satisfaction with care correlated more significantly with how providers
treated the family than with how providers treated the patient. The authors inferred that, as it becomes evident that a patient will die, more support and compassion need to be directed to the family.

Many recent articles focus on using family satisfaction data to improve the quality of patient care.


Meeting the needs of families does not guarantee that they will be satisfied with every aspect of ICU care. However, it is very likely to improve the ICU experience for everyone involved.
3/ Communicating with co-workers

In the ICU, although a single physician may have overall responsibility for a patient, numerous staff members are involved in the patient’s care. In order to provide optimum care, these team members have to communicate.

Working in a multidisciplinary team

A multidisciplinary team may include not only physicians from a wide variety of specialties and various levels of seniority, but also nurses, respiratory therapists, pharmacists, dieticians, physical therapists, social workers, ethicists, and the chaplaincy staff. In general, a physician leads the team. In the view of the Society of Critical Care Medicine: ‘The effective critical care medicine (CCM) attending is like an orchestra conductor, directing various staff to integrate their diverse talents toward one goal.’ Unlike the conductor, the CCM attending will also at times act as a member of the orchestra – using his/her technical skill to contribute directly to the overall performance.

Clearly assigning roles and tasks

Each member of the multidisciplinary ICU team has an important role to play. These roles should be clearly defined, and team members, patients, and family members should all be aware of the division of responsibility. The team leader has an important influence on the interactions in the team. (For further information about leadership, see the PACT module on Organisation and management.)

Although clarification of roles is an important aspect of daily work, it is particularly important in stressful situations, such as resuscitations. Tasks should be clearly assigned, and a single person should not be asked to perform multiple tasks simultaneously. This coordinated team approach should apply to all aspects of the patient’s ICU stay.

Some aspects of patient care – particularly those involving communication – may be handled by more than one team member (a physician, a nurse, a social worker, a chaplain). It is important that the team members give consistent messages. Particularly when a shift changes, it should be clear which team member will take over responsibility for communicating with the patient and family.


Q. What forms of communication could you use to ensure that team members are aware of the division of responsibilities?
A. **Oral** – Clarify jobs regularly in team meetings; explain your role when introducing yourself to patients and families.

**Written** – Post a job diagram in the ICU; include job descriptions in a family information brochure (see Task 2).

**Improving patient handovers**

There is considerable recent literature on staff handover of patients. Of more than 300 articles cited in a non-peer-reviewed review article by Cohen and Hilligoss, most were published since 2000. In the United States, interest in handovers has increased since 2006, when the Joint Commission on Accreditation of Healthcare Organizations introduced a requirement for hospitals to ‘Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions.’

(http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/06_npsg_cah.htm)

Many articles describe negative effects on patient safety due to loss of information or miscommunication during patient transfers. Checklists and standardised processes have been developed to improve information transfer, but are not yet completely reliable.


**Note**

A study in Scotland found that open communication among the members of the ICU team predicted how well patient care goals were understood. One important aspect of open communication was providing ‘a safe atmosphere where team members feel they can speak up.’
Advantages of teamwork

There are many advantages to working effectively as a team:

- Improvements in efficiency, outcome, and the cost of care for ICU patients.
- Error reduction.
- Increases in morale, better job satisfaction, and less time missed from work because of illness.
- Moderation of the detrimental effects of fatigue on performance.
- Fewer and shorter delays.
- Higher consent rate for organ donation.
- Retention of quality, committed nursing staff.

A study in the Netherlands found that nurses' perceptions of their relationships with doctors and hospital management were directly correlated with their attitudes towards their patients and patients' perceptions of the quality of care received. For further details see the reference below.

Barriers to teamwork

There are also barriers to working as a team:

- Egos (leading to issues of control and competition)
- Maintenance of a strict hierarchy
- Different values, cultural norms, and beliefs
- Different ideas of the proper focus of care
- Disagreements over the major goals of therapy

Intra-team conflict

A 2009 study of conflict in 323 ICU's in 24 countries found that the majority of reported conflicts involved intra-team disputes. One of the primary general behaviours perceived as causing conflicts was poor communication within the ICU team. Eighty percent of nurses and 84% of doctors stated that informal debriefing and discussion were the best ways to resolve conflicts within the team.
It is important that intra-team conflicts be resolved before they are apparent to the patient and family. In the opinion of researcher Elizabeth Chaitin and co-workers, ‘families view healthcare providers as an integrated unit, without appreciating the unique differences between individuals and treatment teams.’

Intra-team conflicts, whether among members of the ICU team or between the ICU team and consultant specialists, send confusing messages to family members and may lead to suboptimal management. Conflict between the members of a team often ends with inconsistent information being given to families.


Promoting cooperation and collaboration

By working as a team, ICU professionals can benefit from each other’s strengths, knowledge, and experience. Cooperation and collaboration require acknowledgment of the existence and value of different perspectives and a willingness to solicit input from various members of the team.

In an article in Chest, past presidents of the American Association of Critical-Care Nurses and the American College of Chest Physicians presented 16 characteristics of a working environment promoting communication and collaboration and nine strategies that can be implemented to improve communication and collaboration in a critical care unit.

McCauley K, Irwin RS. Changing the work environment in ICUs to achieve patient-focused care: The time has come. Chest 2006; 130 (5): 1571-1578. PMID 17099040

Being aware of different perspectives

Much has been written about the differences in how physicians and nurses view patients. Commonly, physicians have been described as focusing on curing patients, while nurses focus on caring for them. These stereotypes may still hold or may have been modified by changes in training and roles.

How nurses and physicians interact with each other and with patients can influence attitudes about teamwork. When asked to rate the quality of interaction between specialties, healthcare workers often have very different
opinions of how well they cooperate. In one study, only 33% of nurses rated the quality of collaboration and communication with physicians as high or very high. In contrast, 73% of physicians rated collaboration and communication with nurses as high or very high.

Would you describe the relationship between physicians and nurses in your department as hostile or collegial? Why? Ask some nursing colleagues what they think, and compare your perspectives. What effect does this relationship have on patient care? Make a list of steps that can be taken to promote communication and talk to colleagues or the clinical director about implementing them.

Physicians in different specialties may also have different perspectives. In another study, 62% of surgical staff rated teamwork with anaesthesia staff highly, but overall only 41% of anaesthesia staff rated teamwork with surgical staff highly.

The perception of poor teamwork by one team member, even if incorrect, is enough to change the dynamics within that team. Nurses and physicians may benefit from training in conflict resolution, effective methods of asserting opinions and knowledge and in listening skills.


Q. Some health care professionals uphold a ‘covenantal ethic’ – a promise to the patient to battle death on their behalf – while others subscribe to a ‘communal ethic’ – a commitment to the best possible allocation of scarce resources. How might these different perspectives affect communication between the two groups?

A. These different perspectives can lead to confrontation and miscommunication. For example, surgeons and intensivists are likely to disagree when a surgeon requests and is denied an ICU bed for their patient, when a patient is discharged from the ICU before the surgeon feels the patient is ready, or when a decision must be made regarding a shift from cure to comfort care. Because of their different perspectives, surgeons and intensivists can give very different messages to families as to the odds of a patient’s survival. This can lead to confusion, distress and disagreement over whether a patient should receive heroic or comfort care. Thus, it is very important that any decisions about patient care are discussed by the whole care team, aiming at a consensus within the team, and that communication with relatives is well coordinated.

Finally, it is important that there is a formal agreement outlining who is principally responsible for a patient, so that there is some sort of mechanism to follow in case of disagreement.
Soliciting input from other team members

www.noogenesis.com/pineapple/blind_men_elephant.html

In the past, it was more common for the treating physician to be the prime decision-maker, with little or no input from the patient or relatives, other healthcare workers, or even colleagues. However, many intensivists now believe that difficult ICU decisions should not be left to an individual physician but rather should be based on team discussion, with input from all members of the team involved in the patient’s care.

An exchange of information between healthcare providers of different degrees of status is particularly important for effective teamwork in the ICU, because research shows that individuals lower in a hierarchy are often not asked for relevant information that only they have.

Since medical and nursing personnel are often trained to communicate differently, it is helpful to use tools that provide a common structure for communication. One such tool is SBAR: describe the Situation, provide clinical Background, provide a potential Assessment of the problem, and offer a Recommendation for what needs to be done.


Q. What kind of unique and valuable information might a non-physician team member provide? Give some examples.

A. Nurse – The degree of pain the patient is experiencing, unique understanding of patients’ experiences and wishes.
   Chaplain – Specific religious rules e.g. when dealing with dying patients and death.
   Social worker – Social background of a patient.

A survey of physicians working in Portuguese ICUs showed that fewer than 15% of respondents involved nurses in decisions to withhold or withdraw treatment. (The percentage increased among physicians with more than 10 years of clinical experience.) Nurses’ belief that physicians inappropriately exclude them from decisions about patient care is one of the causes of intra-team disputes.

When reviewing working relationships and interactions, remember that local culture and customs may determine the approach to patient care.

Corser WD. The contemporary nurse–physician relationship: insights from scholars outside the two professions. Nurs Outlook 2000; 48: 263-268. PMID 11135138

A nurse involved in the care of a young terminally ill patient was not included in doctors’ ethical discussions of the patient’s care. As a consequence, she was not able to understand the reasoning behind the decision to continue treating the patient. Further members of the nursing team agreed with her opinion, leading to a major dispute among members of the ICU team. The conflict was finally settled when a formal discussion was organised with the help of a mediator. Early involvement of the nurse in the ethical discussions might have prevented much animosity.

Improving the quality of care

Profiting from rounds

Besides having educational value, rounds in the ICU are used to communicate the patient’s status to the entire team and to establish goals and care plans. Communication during rounds is system-based. Bedside presentations should proceed in the same order for each patient, covering the major physiological systems.

Researchers Dodek and Raboud conducted a study in which they implemented ‘an explicit approach’ to clinical and educational responsibilities and reporting during bedside rounds. They identified several components of successful rounds, among them:

- Timely, succinct and accurate exchange of information
- Consistency of information
- Explicit short-term and long-term plans
- A balance of teaching and clinical service
- A problem-oriented approach

Dodek PM, Raboud J. Explicit approach to rounds in an ICU improves communication and satisfaction of providers. Intensive Care Med 2003; 29: 1584-1588. PMID 12898001. Full text (pdf)


Decreased length of stay, earlier identification of problems, increased collaboration and improved communication have all been associated with interdisciplinary rounds.
Using the survey questions designed by Dodek and Raboud (see reference above), evaluate the communication of information for the next five patients you visit during rounds. What was done well? What could be done better?

**Setting goals**

Care in the ICU is goal-oriented: when the goals have been met, the patient is well enough to be transferred to a less intensive level of care. However, there is not always consensus between physicians and nurses regarding the specific goals of care in the ICU. Pronovost et al. reported on an intervention designed to shift the focus of rounds from provider-centred to patient-centred care. A daily goals form was developed to facilitate communication by requiring that the care team explicitly define the goals for the day. Although at baseline fewer than 10% of residents and nurses understood the daily goals, after implementation of the form the percentage had risen to greater than 95%, and ICU length of stay decreased from a mean of 2.2 days to 1.1 days.


Q. What role might communication play in reducing ICU length of stay through implementation of daily goals?

A. By promoting communication between ICU staff members and between staff and families, the goals form could enable staff members to streamline their care by clarifying tasks, care and communication plans. It could also lead to earlier agreement in decisions to change from interventive to comfort care.

**Creating guidelines for care**

Clinical practice guidelines have been documented to increase treatment effectiveness, healthcare provider accountability, order standardisation, evidence-based decision-making, and resource use efficiency. They increase the satisfaction of healthcare professionals, contribute to improved clinical outcomes, and encourage clinician cooperation within the ICU.

A multidisciplinary team in Minneapolis, Minnesota, developed guidelines for resolving disagreements over plans of care between healthcare providers, among family members, or between providers and family. The policy outlined principles for resolving disagreements, the chain of command to follow, and a list of ‘triggers’ that signalled the potential need for a conference.

Tracy MF, Ceronsky C. Creating a collaborative environment to care for complex patients and families. AACN Clinical Issues 2001; 12: 383-400. Review. PMID 11759357
Planning for disasters and pandemics

Natural disasters, terrorist attacks and pandemics can place severe strain on intensive care services, especially when infrastructure has been damaged. Regardless of whether the increased need for services occurs suddenly—as in a mass disaster—or gradually, as in the case of a pandemic, proactive planning can help.

The medical community’s experience with the severe acute respiratory syndrome (SARS) has led to recommendations for how to treat patients when hospital capacity is exceeded. A communication plan should be developed in advance, outlining how communication will be handled with hospital administrators and staff, other hospitals and patients’ families. Communication training should be included in standard emergency training of ICU clinical staff.

Experience from one hospital in Israel has shown that for mass casualty incidents, designating a case manager to accompany a patient throughout diagnostic and therapeutic triage can 1) reduce chaos, 2) improve information transfer, 3) lead to improved interprovider, provider-patient and provider-family communication and 4) improve efficacy, timeliness and continuity of care.


Dealing with problems

Proactive planning may reduce problems and errors, but it cannot eliminate them. Healthcare leaders should encourage their workers to openly discuss patient safety issues. Team members recognising a problem should be able to communicate their concerns to persons in authority.

Handling errors in the ICU

Research in the USA suggests that between 44 000 and 98 000 patients die each year having suffered preventable errors. Many patients admitted to the ICU suffer a potentially life-threatening adverse event. Errors occur frequently, with rates as high as 1.7 per patient per day. Yet many healthcare workers state that they are not encouraged to report safety concerns and errors are not handled appropriately at their hospital.

Causes of errors

An estimated 85% of errors across industries result from failures in communication. Communication may be impaired between patient and healthcare team, between family and healthcare team, in the shift-to-shift report, between units e.g. patient transfers, between medical services and physician staff, and between members of the healthcare team.

Link with PACT module on Patient Transportation
Ambiguous verbal or written communication is especially common in connection with medications. There may be illegible handwriting; orders missed by doctors, nurses, or other staff; or verbal orders. In a system with several distinct processes – ordering, transcribing, dispensing, administering, and monitoring – there may be several steps that could fail.


Wu AW, Huang IC, Stokes S, Pronovost PJ. Disclosing medical errors to patients: it’s not what you say, it’s what they hear. J Gen Intern Med 2009; 24(9):1012-1017. PMID 19578819

As part of a quality control project at the Ostschweizer Kinderspital in Switzerland, a member of the hospital’s nursing staff noticed that two medications with very different properties produced by the same pharmaceutical company were distributed in very similar packaging. The hospital contacted the pharmaceutical company, and within weeks the colour of the package of one of the medications was changed to help avoid medication errors.

**Barriers to discussing errors**

There are a number of reasons why ICU professionals may be hesitant to discuss errors. These may include personal reputation, threat of malpractice, high expectations of the patient’s family or society, threat to job security, expectations or egos of other team members, and possible disciplinary actions by licensing boards.

**What can be done**

- Encourage discussions of safety.
- Institute a confidential reporting system that documents medical errors.
- Focus on solutions (‘What can we do so that this doesn’t happen again?’) rather than placing blame (‘Who is responsible for this?’).
- Encourage team members to acknowledge the effect that stress has on their performance.
- Expect employees to share accountability.
- Encourage teamwork within and between disciplines.
- Select leaders based on their ability to coordinate activities, to learn from error and to recognise that others can contribute to problem solving.
Learning from mistakes

In 1999, the Institute of Medicine in the USA released a report focusing on medical errors in the hospital setting. It emphasised that the majority of errors do not result from individual recklessness but from basic flaws in the way health systems are organised.


In the aviation industry, much progress has been made to create a culture that deals effectively with error. In medicine, however, there is still substantial pressure to not admit publicly to mistakes. In a study comparing aviation and medicine, over half of the intensive care staff members surveyed reported that they find it difficult to discuss mistakes.


Study newspaper reports of a well-publicised medical error that occurred in a hospital. Are any reasons given for what went wrong? Does key information seem to be missing? Did lack of communication play a role in the tragedy? Come up with a hypothesis for what might have happened and make suggestions for how such an error might be avoided in the future.

Q. How can discussion of mistakes help improve safety in the ICU?

A. Awareness of a problem is the first step to solving it. By discussing mistakes without placing blame, ICU team members can pool their knowledge of a situation and identify potential solutions for processes and procedures in need of improvement.
4/ DEVELOPING YOUR COMMUNICATION SKILLS

Reflection and learning

Few healthcare professionals are naturally talented communicators; the majority have to learn. This learning does not just occur through sheer experience or by being told what to do; it is usually acquired through extensive training and deliberate practice.

Being aware of one’s own strengths and weaknesses with respect to communication, combined with insight into how best to learn new practices and critical self-reflection on performance, will lead to improvements in communication.

See the PACT module on Teaching and learning


Awareness

The ability to sense messages from our store of emotional memory – our own reservoir of wisdom and judgment – is the basis of self-awareness, and self-awareness is the vital foundation for three emotional competencies:

- Emotional awareness (the recognition of how our emotions affect our performance, and the ability to use our values to guide decision-making)
- Accurate self-assessment (a candid sense of our personal strengths and limits, a clear vision of where we need to improve, and the ability to learn from experience)
- Self-confidence (the courage that comes from certainty about our capabilities, values and goals)

Q. Self-awareness and reflection enhance the quality of communication. Give reasons for this.

A. Through reflection and self-awareness you will become more aware of what is happening in consultations with patients and families. Understanding your own strengths and weaknesses as a communicator will enable you to keep the lead in discussions and to avoid panicking when something unexpected happens. You will more quickly evaluate situations and come up with possible solutions.
Intuition and empathy

Intuition or ‘gut feeling’ is an important aspect of communication. In order to have a real relationship with your patients, their families, and colleagues you need to be able to sense their feelings, understand their perspectives and take an active interest in their concerns. The ability to empathise with others is strongly related to our self-concept, our self-esteem, our self-awareness and our self-control.

For more information about intuition and empathy, see the following reference.


Effective communication requires not only mastery of communication skills, but also the ability to adequately interpret a situation and to recognise which skills will be effective with a particular person at a particular time.

Signals

We communicate both verbally and non-verbally. Non-verbal behaviour, such as body posture, gestures and intonation, makes up more than 80% of human communication. It is very difficult to prevent yourself from non-verbally expressing what you think or feel. For successful communication, your non-verbal behaviour should underscore the message that you give verbally.

Levels of communication

Communication involves both sending and receiving information. Every message has two levels of information: the content level and the context level. The content level refers to the verbal information contained in the message. The context level guides us in interpreting the information once it is received; it is the extra information that allows us to read between the lines.

Intonation, volume, choice of words (paralinguistic aspects), facial expression and body posture are the channels through which we can read the information on this second (context) level. If both levels are in accordance, behaviour is congruent. Lack of congruence promotes confusion and erodes trustworthiness.

Q. How can lack of congruence erode trustworthiness?

A. 80%-90% of human communication is non-verbal. You cannot hide body language. Patients and their families will pay far more attention to the context of your message than to its content. If you say something different from what you really mean, this will be evident in your non-verbal behaviour. The result is that other people will question the truth of your words.
Communication styles

There are two distinct styles of communicating with patients or families: the doctor-centred (‘directive’) approach and the patient-centred (‘explorative’) approach. Both styles are necessary, but the order in which they are used can be quite crucial.

In the directive style, the doctor gathers information to test his/her hypotheses, gives explanations or provides information he/she thinks is important for the patient. In the explorative style, the patient’s perspective – his/her thoughts, emotions, attitudes and behaviours – is the focus of attention. In order to find out about the preferences, values, thoughts and feelings of patients or family members, the explorative style is more appropriate. Physicians should choose the style with which they are most comfortable or with which they are most experienced, based on their personal preferences and skills.

A study by Beckman and Frankel found that doctors interrupted a mean of 18 seconds after patients began their opening statements, and only 23% of patients were allowed to finish after the interruption.


Communication skills

There are a number of communication skills from which the physician can choose. Among them: attentive listening, asking questions, paraphrasing, reflecting, explaining, checking understanding, summarising, concreteness, and structuring. Most of these skills are basic to every interaction; some are needed in specific situations to ensure that communication is effective.

Attentive listening

Attentive listening is one of the so-called non-selective listening skills, which means it needs to be used throughout the encounter. Attentive listening consists of verbal and non-verbal behaviours: ‘hums’, short attentive silences, and so-called minimal verbal encouragers (Yes ... ? So ... ? And ... ?); a relaxed posture, slightly bent towards the other person; an interested facial expression; stimulating eye contact; minimal non-verbal encouragers such as nodding; supportive gestures. The purpose of attentive listening is to create an atmosphere in which the other person is encouraged to speak freely. The verbal and non-verbal encouragers should not be used too often or suggest restlessness, as they may distract the speaker from their story.
**Asking questions**

There are two kinds of questions: open-ended and closed questions. Both types of questions are necessary in communication. Open-ended questions are best used when you want to explore; closed questions can be used to acquire specific information.

**Open-ended questions**

Open-ended questions give others freedom to formulate an answer in their own words. For example, ‘How are you feeling today?’ Focused open-ended questions may start with ‘How’, ‘Who’, ‘Which’, ‘What’, ‘When’, or ‘Where’. Beware of using questions starting with ‘Why’ which may be very threatening and difficult to answer. They often lead to rationalising, and may give the other person the impression that they are being called to account.

Open-ended questions can be used at various points in an interaction. At the start of an interaction they invite the other person to talk, and thus they show that you are interested in the other person’s point of view. Used during the conversation, they are helpful if you want to know more about a certain topic, if you do not understand what the other person just said, or if you want to introduce a new topic.

**Closed questions**

Closed questions are answerable with ‘yes’ or ‘no’ or a brief response. For example: ‘Is there any shortness of breath?’ or ‘How old are you?’ or ‘How high was the fever?’ They originate from the frame of reference of the person who is asking the questions. This poses the risk that they may be suggestive, and also that the person asking the questions will pay less attention to the answers because they are busy thinking of follow-up questions. In order to avoid sounding like a cross-examiner, use closed questions sparingly.

**Paraphrasing**

Paraphrasing is restating, in your own words, the most important issues in the verbal message the other person has given you. If a patient tells you that he/she has pain in his/her neck, limbs, lower back and stomach, and also suffers from headaches, you might paraphrase: ‘So you have pain almost everywhere in your body’. If you phrase this statement as a question, raising your voice at the end (tentative mode), you encourage the patient to elaborate.

Paraphrasing has several goals: to show understanding, to check if you have correctly understood what you have been told, and to present the other person’s information in a more concise manner. You can also occasionally literally repeat what has been said, but this should not be done often, in order to prevent ‘parroting’.

**Reflecting feelings**

Reflecting is used to draw out the unspoken feelings underlying the words or behaviour of another person. It is important to use your own words when reflecting feelings, and to express them in a tentative way. The intensity of your reflection should mirror the intensity of the other person’s feelings: e.g. when a
relative is very angry, it is not appropriate to reflect this with ‘you seem a little agitated’.

There are three steps to follow in applying this skill. First, you must recognise the feeling(s) the person has. Second, you have to find words to communicate your understanding. And third, you have to communicate your thoughts to the other person. A reflection of feeling can start with ‘You seem to feel ...’ or ‘I get the impression that you feel ...’ Try to avoid saying: ‘I understand that you feel ..., because you may not really understand. If, for example, you have never lost a child, to say that you understand the parents’ sorrow does not sound sincere.

The aims of reflecting feelings are to communicate understanding, to invite the other person to elaborate on their feelings, and to show the other person that you are listening. If used too often, reflection may either be threatening or give the impression that you are employing a technique.

Q. Why do many people find reflecting feelings a difficult skill to apply?

A. There are at least five reasons why reflecting feelings is a difficult skill:
   • You may be unsure that you are capturing the right emotion, and it feels unprofessional to make mistakes.
   • It feels redundant to express your understanding verbally.
   • You believe you should understand why a person has certain feelings. This is not true: you only need to mirror what you see and hear.
   • You believe that once the other person starts talking about feelings it will be very difficult to get back to other issues.
   • You worry that talking about the other person’s feelings will elicit your own feelings, which you fear you may not be able to control or which you don’t want to show.

Ley P. Communicating with patients. Improving communication, satisfaction and compliance. London: Croom Helm, 1988

**Explaining**

Good explanations are essential for successful communication with patients and families. In intensive care units, problems often arise when the abilities of patients and relatives to understand medical information are exceeded. When you are explaining a diagnosis, treatment, or prognosis, it is helpful to separate the topics, give information in small chunks, and clarify details. Use language that is easily understood. Avoid medical jargon.

Several techniques can be used for explaining. Signposting – announcing the next message – is often useful. For example, you might say: ‘First I’ll tell you what the findings of the tests were, then I’ll suggest two different treatment plans, and after that we can discuss the options’. Another technique is to start with the most important information, as people remember best what they are told first. You can also use visual aids, such as pictures, drawings, leaflets, and videos. Output from ICU imaging might be used e.g. computed tomography or magnetic resonance imaging scans to illustrate a point.
Checking understanding

You should not only check if information has been received, but also how it has been received. Observe the impact of your words. Always check non-verbal signals. It may often be necessary to repeat information, and to summarise what you have been saying. It can be helpful to ask the patient or family to repeat what you have told them. Ask for feedback about the comprehensibility of your information, and encourage questions.

Summarising

The purpose of summarising is to structure what the other person has said. Subjects are ordered in a logical way or based on assumed priorities. Essentials are separated from side issues. Summaries give an overview of both cognitive and emotional aspects; they are to the point, formulated in your own words, and ideally communicated in a tentative mode.

Summaries are indicated after you have received a lot of (confusing) information from the other person, or when sufficient information has been gathered about a certain subject. They often mark the transition from one stage of the interview to another, or to a new subject. They can be used to list items that have been agreed upon, or at the beginning of a follow-up interview.

Concreteness

Concreteness is a skill in which listening, encouraging, asking questions, reflecting feelings and summarising are combined. It is used to ensure that you have the personal, concrete and specific information you need for a full understanding of a situation the other person has described. The aims of concreteness are to help the other person move from global statements to specific ones, from implicit statements to explicit ones and from general statements to statements that are personal.

Possible ways to stimulate the other person to be more concrete include: asking direct questions; being specific in your reactions; splitting up complex problems into smaller units and exploring each unit separately; and paying special attention to vague and ambiguous words. Concreteness can be used with an explorative as well as a directive style.

Structuring

A structured interaction is more productive, keeps the participants focused, and guarantees that important issues are addressed. Structuring is especially helpful for interactions in which important issues have to be discussed, such as breaking bad news, end-of-life decisions, and requesting organ donation.

Many techniques can be used to structure interactions, such as opening and closing a meeting, providing an agenda and a timeframe, and making sure that all subjects are discussed. Most professionals know these techniques, but it is essential to apply them in a disciplined way. If you ask participants to approve the agenda at the beginning of the meeting, it is easier to control deterioration by referring to this agreement. An effective way to start an interaction with
patients and relatives is to summarise what has been discussed previously (earlier in the same discussion or at a previous discussion).


Smith RC. Patient-Centered Interviewing – An Evidence-based Method. 2nd ed. Lippincott Williams & Wilkins, 2002. ISBN 0781732794


Q. Describe some ways you could use the communication skills outlined in this task to develop a relationship with your patient in the ICU.

A. Attentive listening – Spend some time at your patient’s bedside before rounds. Asking questions – ‘So, how do you feel about being in the ICU?’; ‘What can we do to make you feel more comfortable’.

Reflecting – ‘I can see that you’re very uncomfortable with the tracheal tube.’ Explaining – ‘The tube down your throat helps you to breathe at a regular rate. You can’t talk at the moment, but after it’s taken out you’ll be able to talk again.’

Over a period of several weeks, watch the following interactions and make notes about what you see and hear:

- Television interviews in which people are invited to speak about their experiences or about their specialty
- Television interviews with politicians
- Your colleagues, in consultations with patients or with families

Write down the main differences between these interactions in terms of the skills described in this Task. What can you say about the structure of these interactions, the kinds of questions being asked, the options for answering? Note the non-verbal behaviour of both parties in the interaction: what happens on the content and the context level? Which of the people do you consider good communicators (interviewers/interviewees), and why? What can you learn from their behaviour? Make a list of dos and don’ts for yourself.
CONCLUSION

Today the care of severely ill and injured patients is centred in specialised hospital intensive care units using technology that was scarcely dreamed of just a few decades ago. Survival rates have climbed steadily, but advances in medicine have also brought new challenges. Today's ICU physicians must treat patients and deal with families with whom they have no previous relationship, but who arrive in the ICU in need of both physical and emotional support. In order to meet the needs of patients and their families, you must be aware of those needs.

Multidisciplinary care has become standard in the intensive care unit. A successful multidisciplinary team is one in which roles are clearly assigned and members work together to improve the quality of care they provide to their patients. Each healthcare provider in the team possesses specialised knowledge and technical skills, and a unique perspective. To cooperate, team members must understand each other's roles and responsibilities. To collaborate, they must appreciate each other's perspectives. To function as a multidisciplinary team, they must be able and willing to communicate.

Increasingly, physicians are recognising the importance of communication in medicine. They are learning not only how to communicate, but what, when, and where to communicate.

In this module, you have been given much information on communication in the ICU. This information won't help your patients if it remains in your head! You have to use it. And not just once or twice, but on a daily basis, until you don't even have to think about what you're doing. Communication, like any skill, takes practice. Now is the time to start practising!
PATIENT CHALLENGES

A 16-year-old female with diabetes mellitus and anorexia nervosa is admitted to the ICU following an attempted suicide with an overdose of benzodiazepines, tricyclic antidepressants and calcium antagonists. She has a varying level of consciousness, at times drowsy, at times agitated. She has been admitted to the hospital on three previous occasions following suicide attempts. Her parents arrive; her father is aggressive and demands to take his daughter to another hospital due to his mistrust of your institution.

Links to
PACT module on Major intoxication
PACT module on Altered consciousness

Q. How should you handle the father's demands?

A. Acknowledge the father's feelings of powerlessness and reassure him that you are committed to providing the best possible care for his daughter. Explain that she needs the close supervision that is available only in an ICU, and that her condition is serious, so moving her would be unwise.

Learning issues
Handling differences of opinion
Difficult relatives
Communication techniques: attentive listening, asking questions, paraphrasing, reflecting, explaining

The girl's father asserts that it is his right to decide what happens to his daughter.

Q. Explain the rights of parents according to the laws or ethical principles (beneficence or autonomy) underlying the medical approach to the patient in the relevant country

A. A system emphasising beneficence might assume that physicians will make most decisions, based on the patient's best interests, and that family members may be informed rather than involved. In a system emphasising autonomy, physicians are more likely to include families in the decision-making process.

Involving the family in decision-making
PACT module on Ethics

You explain to the father that his daughter has a right to care which is most appropriate at the time. He scowls, but agrees. Soon afterwards, however, you observe that the daughter becomes very agitated whenever her father is around.

Q. How should you determine the patient’s needs in this situation?

A. Suggest that the parents take a break in the hospital cafeteria. Ask the patient how she feels about having her parents around.

Learning issues
Meeting the patient’s needs
Shortly after the parents return to the room, the patient develops severe cardiac arrhythmias and acute hypotension. You decide to try an electrocardioversion. You again ask the parents to leave.

Q. What are reasons for and against allowing family members to witness resuscitation?

A. There is no general consensus as to whether relatives should be present during specific interventions in the ICU or during CPR. Studies on the presence of relatives during resuscitation show that most family members strongly favour being given the option to remain, and that witnessing resuscitation is a positive rather than a negative experience for them. Although the majority of doctors and nurses oppose the practice, and a 2009 study found that family presence negatively affects staff performance, another study showed that allowing family members to remain can create a rapport between the family and the staff. In the present case, however, relations with the father are already difficult.

The parents leave the room. The patient is successfully electrocardioverted but needs to be intubated due to worsening level of consciousness. The parents confront you in the hallway and ask what is going on.

Q. When, how, and where will you inform them about your diagnosis and prognosis?

A. Whenever possible, conferences with the family should be conducted in a private room with enough space and chairs for everyone to sit down. You should be careful not to promise that the patient will recover, and provide information about possible outcomes, both positive and negative. Bad news should be delivered in language that is simple and unambiguous.

During the night the patient again has severe arrhythmias and develops ventricular fibrillation. She is again successfully resuscitated. The nurse responsible for the patient wants to talk with you about the ethical repercussions of repeatedly reviving a patient who ‘obviously wants to die’.

Q. Why should you discuss the issue with the patient’s nurse? Who else might you involve in the dialogue?
A. Involving members of the clinical staff in discussions promotes a good working environment. Inviting the nurse to communicate her concerns will send the message that she is part of the team and will help her deal with the emotional distress she is feeling. A discussion may offer you a new perspective on the patient. You can hold a quick meeting and invite any of the staff involved in the patient’s care, including the senior ICU nurse manager. A consultation with an ethicist or the hospital’s ethics commission (if time allows and such arrangements exist) may be useful if opinions remain divergent.

**Learning Issues**

Working in a multidisciplinary team
Promoting cooperation and collaboration

When you come in to work the next morning you learn that, due to an error, the patient has received a much greater amount of insulin than intended and has suffered an episode of severe hypoglycaemia. She is deeply comatose. Even without her problems due to drug intoxication, you suspect that she has a poor prognosis as a result solely of hypoglycaemic brain damage.

**Q. How do you handle this situation? With whom do you discuss the error and what do you focus on?**

A. If your hospital has a protocol for handling serious errors, follow this. Inform the ICU senior clinician and clinical director. The hospital director, legal department, and communications department may also need to be informed. Talk to the people who were involved in the patient’s care, and reconstruct the events. Record facts rather than emotional reactions. Do not place blame. Instead, use this as an opportunity to discuss what went wrong and how to avoid such errors in the future.

**Learning Issues**

Dealing with problems
Breaking bad news

**Q. What do you tell the parents now?**

A. Above all, be honest. Explain that a mistake was made. Outline the consequences it may have for their daughter. Apologise. If necessary, refer the parents to the hospital’s ombudsman or equivalent. Most errors and systems errors require corrective action at an organisational level. Families may still take legal action in the event of disclosed negligent error, but failure to disclose, failure to apologise, and above all, failure to demonstrate contrition and corrective action for the future, will make the situation much worse for all participants.

**Learning Issues**

Handling errors in the ICU

A 43-year-old female is admitted to the ICU because of subarachnoid haemorrhage. She is comatose, intubated and mechanically ventilated. While you are examining the patient, she suffers a significant fall in oxygen saturation. At the same time, the nurse tells you that the patient’s husband is waiting anxiously outside the unit.

Link to
PACT module on Acute brain ischaemia
Q. What are your priorities and how do you proceed?

A. Treating the acute fall in oxygen saturation is your first priority. Your second priority is to acknowledge the needs of the patient’s husband. Ask the nurse to allow him into the room so that he sees his wife and the activity surrounding her. Depending on the policy of your ICU, you can allow him to stay in the room, or suggest that he makes himself comfortable in the waiting room. He should be told that his wife’s condition is critical, and that when she is more stable you will speak to him.

**Learning Issues**
Explaining, checking understanding
Providing information
Involving the family in patient care

When you have an opportunity, you introduce yourself to your patient’s husband. You discover that he speaks a language you are unable to speak.

**Learning Issues**
Overcoming communication barriers

Q. How do you deal with this situation?

A. Assess whether the husband also understands your language, and if so, how much. If your hospital has a list of personnel with special knowledge of the language, make contact with that person. Is there another family member who can come to help translate? Do you have any printed materials in the husband’s language, such as specially designed dictionaries or word lists? Make a special effort to speak in simple terms and to check whether he has really understood what you have said.

**Learning Issues**
Communicating effectively - What you can do
Providing information

Q. What should you communicate to the husband?

A. His wife’s status, including diagnosis, prognosis, and the next steps of treatment. Your role and the role of other team members directly involved in care of the patient. Basic information about your intensive care unit, if it is available in printed form.

**Learning Issues**
Checking understanding, explaining
Providing information

A few hours after admission to your ICU, the patient is still drowsy but haemodynamically stable. Angiography and coiling of an aneurysm of the anterior communicating artery have been successfully performed by the neuroradiologist. The patient is extubated during the night. During the morning report, the resident from the night shift tells you that ‘the patient was alert during the last two hours. She is breathing spontaneously and has no haemodynamic compromise. She is afebrile and has no neurological focal deficits. Her pulse rate is in the normal range, and she has a normal arterial blood pressure.’ At later clinical review however, you see that the patient is rousable but confused.
Q. What changes can you make in your department’s approach to rounds that will ensure that the important information is communicated?
A. You can propose implementing an explicit approach to rounds requiring documentation of the status of each organ system. Is there a structured approach to handovers between teams and shifts? Consider including a flow chart for rounds in the resident’s manual. Is the patient examined prior to rounds? Could the patient’s condition have deteriorated in the interval between assessments? Is there a medical problem list? Is the resident aware of the patient’s key problem? Is there a clear plan for the following 24 hours? Is there a clear long-term plan?

Dodek PM, Raboud J. Explicit approach to rounds in an ICU improves communication and satisfaction of providers. Intensive Care Med 2003; 29:1584-1588. PMID 12898001

While you are standing at the patient’s bedside the neurosurgeon enters the room, and without talking to the patient he triggers pain by squeezing her left toe.

Q. What is your action?
A. Having recently read the PACT module on Communication, you are aware that, even if a change in the clinical status of the patient is the main concern for the neurosurgeon, a more appropriate first action would be to greet both the patient and the team members present at the bedside. Addressing the group, you say something to the effect of: ‘I just learned in PACT that …’

Over the following two days the patient’s clinical status fluctuates. Overall she remains confused but without focal neurological deficits. Transcranial Doppler ultrasonography does not show signs of cerebral vasospasm.
On the third day the nurse calls you because of acute dilatation of the left pupil. You arrange for a cerebral computed tomography, which reveals rebleeding. She is sedated, intubated and ventilated for the procedure. The neurosurgeon arrives and claims that the bleeding is due to inappropriate management of blood pressure.

Q. What factors influence how you will respond to the neurosurgeon’s criticism?
A. Your action depends on several factors. Is this the first time such a claim has been raised, or do you have frequent problems with such patients? Are interactions with this particular surgeon frequently difficult?
**Learning Issues**

Promoting cooperation and collaboration

**Q. How do you respond?**

A. Postpone dealing with this issue until any clinical intervention required by the change in the patient’s condition have been completed. Then discuss the facts with the neurosurgeon objectively. Remind him of the frequency of secondary bleeding in such patients.

**Link to**

PACT module on Acute brain ischaemia

Four hours later the patient is polyuric. She does not show any motor response to pain, and many brainstem reflexes appear to be absent. None of her relatives are present, but the nurse says that the patient’s husband phoned a few hours ago and was told that his wife was clinically stable. He asked to be informed of any change. With the help of an interpreter, you telephone the husband.

**Q. What do you communicate?**

A. Providing appropriate, timely information is essential. Through the interpreter, you tell him that his wife’s clinical situation has markedly deteriorated and suggest that he come to the hospital as soon as possible.

Several hours later, brain death is confirmed according to guidelines in your hospital and jurisdiction. In the meantime, the husband and two of the patient’s four children have arrived at your unit and are at the bedside.

**Q. How do you break the news that your patient is brain dead?**

A. As a first step, you refer to your last contact with the relatives and explain that the patient’s situation deteriorated quickly. Then, using simple language, explain that although everything possible was done, it has now been confirmed that the patient is 'brain dead’, which means that her body is able to function only with the help of machines and her brain is no longer able to control what her body does. Answer any questions in an honest and direct way, and then allow the family members time to be alone. Remember that the grief process may include shock, desperation and confusion, a period of searching and denial, followed by anger and ultimately acceptance and reintegration.

**Learning Issues**

Breaking bad news

**Link to:**

PACT module on Ethics

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Given the clinical course of the patient, organ donation should be considered. Until now, organ donation has not been discussed with the relatives of your patient.

Q. When is the appropriate time to talk to the relatives about organ donation?
A. First the family must be allowed to absorb the news that the patient has died. They should have time to be with their relative. Also, they should have the opportunity to meet with a member of the clergy if they wish to do so. However, there is limited time for these processes if organ donation is to remain a possibility. If you and the other caregivers feel that the family members have understood the death and that appropriate time has passed, you may again meet with them to discuss the issue of organ donation.

Several hours pass, and you feel that the family can be approached.

Q. You will need a family meeting. Who should attend it, when and where should it be held, who should lead it, and what should be discussed?
A. The meeting should be scheduled at the earliest time convenient for the family. It should be attended by the patient’s husband and children, any other close family members identified by the husband, other ICU team members as needed e.g. nurse, clergy, social worker, as well as someone qualified to discuss organ donation. The meeting should be held in a private room and led by a senior physician. Use simple language, be patient, and show understanding. The family should be given ample time to ask questions and to discuss the issue of organ donation among themselves, as they need to reach a consensus on what the patient would have wished in this circumstance. Support their decision once it has been made.


On reflection, while working in the ICU you need to communicate with patients, family members, and co-workers. The adverse consequences of ineffective communication with patients and families include dissatisfaction with care; difficult behaviour; uninformed or no consent for procedures, research studies or organ donation. Ineffective communication with co-workers can result in errors, negative attitudes, bad working environment, a blame culture and failure to learn. Good communication has been shown to improve the process of patient care.