ICU MANAGEMENT & PRACTICE

ICU Volume 7 - Issue 4 - Winter 2007/2008 - Country Focus:Canada

Communication and Decision-Making in the Intensive Care Unit in Canada

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Communication is an important issue in the Canadian healthcare system. Recent studies have shown that communication problems are the most common reason for patient complaints to Canadian regulatory agencies (Tamblyn et al. 2007), and seriously ill Canadians consider honest communication to be as important as having trust and confidence in their doctors (Heyland et al. 2006).

Communication is particularly important in the ICU. Although most Canadians are satisfied with the care that they or their loved ones receive in the ICU, many are not satisfied with the communication they have with doctors or their role in decision-making (Heyland et al. 2003). While the Canadian legal system mandates an informative model of decision-making (Emanuel and Emanuel 1992), the overwhelming majority of Canadians prefer a degree of shared decision- making (Heyland et al. 2003), and many come from cultural backgrounds in which patients are typically shielded from the burden of bad news and difficult decisions. Meanwhile, those who accept their role as decision-maker are equally disappointed by the fact that few patients and substitute decisionmakers

(SDMs) are properly informed about their diagnosis, prognosis, and alternative treatments prior to arrival in the ICU (Heyland 2006; Sibbald et al. 2007; Rady and Johnson 2004). Thus, Canadian physicians must be sensitive to the needs of a broad spectrum of cultures and beliefs.

Critical Care Response Teams – The Right Communication at the Right Time

ICU physicians typically meet their patients at a time of acute illness; often after life support (including ventilation) has been initiated. Thus, initial communication with the patient is often extremely limited, and many patients are admitted to the ICU without the benefit of informed consent or discussion. The advent of Critical Care Response Teams (CCRTs, also known as Medical Emergency Teams) has allowed ICU physicians to meet patients earlier in their illness, perhaps at a time when they can participate in discussions. This reduces their reliance on subsequent family meetings for decision-making if the patient deteriorates and ultimately requires life support. It may also result in a change in philosophy of care, whereby the patient would decide that they did not want admission to the ICU.

So far, the published literature on CCRTs has not described their role in facilitating dialogue and decision-making, but at least one Canadian study has reported that CCRTs are sometimes consulted solely for this purpose (Sibbald et al. 2007). More studies are needed in order to establish whether this is a common use for CCRTs.

Simulation Training to Improve Communication Skills

The SUPPORT trial showed that physicians communicate poorly with patients, even when given resources and a legal obligation to improve communication (SUPPORT 1995). This may be due to the fact that very few physicians have ever received formal training in communication (Nelson 2006). Simulation training may be useful in this regard. Canadian ICU trainees often use simulation to learn acute resuscitation or procedural techniques, but recent studies suggest that simulation can also be used to teach communication skills (Fallowfield et al. 2002; Lorin et al. 2006; Alexander et al. 2006).

In our institution, we have developed an educational seminar featuring simulated family meetings with standardised family members portrayed by actors. In these meetings, trainees are given challenging scenarios (e.g. two estranged siblings who disagree about a treatment decision for their aunt) that they must resolve according to the legal and ethical standards of our province. Trainees are also taught communication and conflict-management skills, which they can practice during the scenarios. These simulation sessions allow trainees to practice their skills in a safe environment, and to receive constructive feedback and evaluation from the actors and senior ICU physicians observing their performance. The

cost of developing such a session is significant, but feedback from participants at our institution has been very positive, and trainee performance scores suggest that this session is effective for improving both communication skills and legal/ethical knowledge.

In summary, communication is a core skill for all physicians, and an important part of patient care in the ICU. Communication skills are particularly important in a country like Canada, where almost one quarter of the population is foreign born, and patients have a broad spectrum of values and beliefs. In order to improve patient satisfaction with communication, we need to make better use of novel approaches such as critical care response teams and simulation training.

Published on : Thu, 15 Aug 2013