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Communication with Families in the ICU

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Effective communication is key when working with ICU patients' family members

Introduction

Effective communication with the family members of critically ill and injured patients is a very important aspect of what we do as intensive care professionals and has significant implications for patient care, family members and the ICU team. The ICU environment can be overwhelming for the families of critically ill patients, introducing high levels of stress, anxiety and depression, and few family members are prepared for the ICU experience (Buchman et al. 2003). In this setting, the ICU team must communicate information regarding the patient's diagnosis, prognosis and treatment, even engaging family members as surrogate decisionmakers for their sick or injured relative. Often, communication with families involves difficult discussions, including end-of-life issues or organ donation (Williams et al. 2003).

Why Communication is Important

The importance of establishing a good line of communication with the family is often underestimated. Early discussions with family members lay the groundwork for establishing their understanding of their sick relative's wishes and values. This often leads to involving them as surrogate decisionmakers, in collaboration with the ICU care team. Azoulay and Sprung have emphasized this two-step model for establishing a family-physician relationship predicated on early and effective communication of information, followed by obtaining family input with regard to decisionmaking and meeting specific needs of critically ill patients (Azoulay and Sprung 2004).

Studies of ICU team communication with patients' families have demonstrated a number of positive effects on meeting family needs and facilitating their coping process with the stress induced by a critical illness in a family member. These effects include improving the effectiveness of communication and decreasing conflict between families and the ICU team (Way et al. 2002). Markers used to evaluate the quality of information provided to families include evaluation of comprehension of the information, satisfaction scores and the prevalence of anxiety and depression in family members (Azoulay and Pochard 2003). Effective communication may have an important impact on limiting the incidence of posttraumatic stress in family members (Azoulay et al. 2005). Additionally, effective communication can also ease the transition from curative to palliative care and reduce the use of futile therapies (Lilly et al. 2000).

Forms of Communication

It is important to recognize that the information provided to families comes from different members of the care team and can occur in a variety of settings. The source of information may impact the families' comprehension of and overall satisfaction with communication. Communication can occur in a formal setting, such as a scheduled family meeting. This is perhaps the best studied of communication formats, since the encounters are held at pre-determined times and are amenable to obtaining family permission to collect data. Furthermore, formal, scheduled communication allows for more preparation and integration of team beliefs and concerns prior to the session, thus avoiding conflicting information. Communication, however, most frequently occurs in a more casual manner when family members are present at the bedside. This is the most common format for communication and carries the highest risk of miscommunication, as less preparation is done. Written communication through descriptive brochures is another common method of communicating information concerning the ICU environment, physical resources of the hospital and support resources available to family members (Azoulay et al. 2002). As technology becomes available, this sort of general, predetermined information can be made available through web pages accessible both on-site through an intranet and off-site through the Internet.

Aspects of Communication

Team members' communication styles depend on their skills and preferences and their ability to be good listeners. This, in turn, may be influenced by the context in which the discussion is taking place, the anticipated content of the discussion and preconceived attitudes about healthcare. The fact is that many physicians do not like to be the bearers of bad news and may not, in fact, be very good at relating it. From the family perspective, the timing and frequency of communication of information (including prognosis) is important in determining satisfaction, and the frequency of communication often needs to change throughout the course of an ICU stay, especially as it prolongs (LeClaire et al. 2005). The duration of interactions with the team also affects the family perception of satisfaction, and these sessions should be carried out in a non-hurried manner. Too often, the healthcare team uses the communication session only to get its point across, despite the fact that allowing family members a greater opportunity to speak during family conferences has been associated with increased satisfaction (McDonagh et al. 2004). Satisfaction is also highly associated with the completeness of information received, along with compassion and respect shown to patient and family members (Heyland et al. 2002).

Family members often have differing views about the quality of information provided by different members of the care team. Nurses are more often viewed as compassionate, concerned and informative (Buchman et al. 2003). Surprisingly, for physicians, the experience level of the provider speaking with the family seems to make little difference, as house officers can be as effective as senior physicians and fellows in communicating with families (Moreau et al. 2004). Bedside communication may be improved through utilization of a goal sheet, as this provides consistency to the information and keeps everything framed as goals. It also offers the opportunity to discuss and explain why goals are sometimes not met and the implications for outcome.

Limiting Factors

Factors that can limit the effectiveness of communication relate to both care team and family dynamics. Since critically ill patients are often unable to make decisions for themselves, their interests are represented by their family. Communication with the family is critical, regardless of whether the physician or the family serves as the primary decisionmaker. The extent to which families want to participate as surrogate decision makers varies significantly, with a predominance of physician-driven decisionmaking employed throughout Europe, and patient/family autonomy favored in North America (Azoulay et al. 2003; Azoulay et al. 2004).

Failure to recognize the expectations of the family can undermine communication efforts from the beginning. Members of the care team may miss opportunities to listen and respond to the needs and values of the family or explore the specific wishes of the patient (Curtis et al. 2005). The nature of multidisciplinary intensive care models may also introduce barriers to communication when information is provided by a variety of members of the care team and there is lack of consistency with the information conveyed to the family.

For the family's part, cultural differences also influence expectations and the preference for involvement or non-involvement in decisionmaking. The educational level of the family may interfere with their ability to comprehend information or their comfort with seeking answers to their questions. As mentioned previously, anxiety may be heightened by a lack of adequate information and may impact an individual's ability to understand further communication from the ICU team. In some cases, family members may not know the wishes of their relative and therefore be unwilling to make decisions on their behalf. Often, historic family interactions can influence decisionmaking, as well. Language and cultural differences are among the most common barriers to communication, as elements of uncertainty may occur with communication through interpreters, and some things just do not translate well between languages and cultures (Norris et al. 2005).

Conclusions and Recommendations

Recommendations for providing information about critical illness to family members include scheduling structured meetings between the health care team and the family, designating a specific clinician to coordinate communication for the ICU team, providing information in an open, unhurried fashion in simple terminology and emphasizing the expected quality of life related to the clinical situation (Nelson et al. 2005). Ensuring adequate visiting hours for family members and providing comfortable surroundings along with quiet areas to meet with family members without interruption can improve the frequency and quality of communication and the satisfaction of family members. Interdisciplinary progress notes have also been advocated as an effective tool to avoid miscommunication and clarify pertinent information (Whitmer et al. 2005).

It should always be remembered that while communication is an art, skills can be honed. Listening is crucial, and its importance must be stressed if the wishes of the patient and their family are to be appreciated and respect for their values, belief systems and culture maintained. Finally, further research is needed to determine aspects of communication with families in the ICU environment that can be improved to increase satisfaction with care and avoid the consequences associated with inadequate communication.

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