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Effective Communication

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Recent research is informing on the impact of poor communication skills in intensive care practice. Dr Todd Dorman reviews the sources and consequences of ineffective communication and recommendscorrective strategies.

Effective communication is of central importance to sound management in the intensive care unit (ICU). In the ICU as in many areas of medicine, communication skills have not historically been emphasized. Traditionally, medical school or residency curricula have not formally addressed communication. However, the negative impact of poor communication and the benefits of effective communication have been explored recently with increasing frequency. The results of this body of work overwhelmingly support the central role of communication skills in improving aspects of patient care, staff relations and administrative functions. To this end, the Accreditation Council for Graduate Medical Education has recognized the importance of communication where it has been defined as one of six competencies to be incorporated, taught, measured, and evaluated by residency training programs and the residency review committee (Gadacz 2003).

Types of Communication

Communication can take a number of forms. Options for communication have been expanded by technology. Examples of various modes of communication include written forms such as written notes in the medical record or physician's orders, verbal communication including face-to-face discussion, telephone conversation or voicemail, and electronic communication such as e-mail or text pagers. One must consider inherent potential problems when certain technologies are relied upon for communication. With e-mail, voice-mail, and text pagers there is often no way to confirm if a message was received in a timely fashion. Also, the type of paging system in use is important in determining response times during times of crisis (Moss et al. 1999).

Frequent Communication Patterns in the ICU

A variety of communication patterns can exist in the ICU. The types of relationships involved may influence the frequency of use of various modes of communication and have significant implications for the importance of different communication styles and skills to achieve the goals desired. Patterns include communication between the healthcare team and the patient or patient's family.

This may take the form of physician, nurse, or other allied health consultant discussing issues with the patient or a family representative. Other important patterns include communication between members of the healthcare team. This can include communication between:

• a physician and nurse

• physicians on the ICU team with the possibility that physicians may be equal, superior or subordinate in a hierarchical system

• nurses who may also be in an equal, subordinate or superior role

• the ICU team and various primary services or consultants.

Sources of Ineffective Communication

It is widely believed that physicians tend to overestimate the strength of their communication skills. Limitations in interpersonal and communication skills are perhaps the single issue interfering with effective communication across all patterns mentioned above. The causes for poor communication skills are multi-factorial. Some personality styles and managerial styles may be deleterious to effective communication including overly domineering, insensitive or overly passive personality traits. Lack of recognition that poor communication is a problem may lead to lack of attention in listening to the other side of a debate or understanding the concerns of the other party. This may be especially true when

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discussing clinical conditions with patients and their families (Gadacz 2003).

Studies have documented that while on rounds in the ICU the care team spends a significant amount of time in direct communication. However, a significant number of interruptions occur (Alvarez and Coiera 2005). These interruptions may come from outside the team or within.

The time spent dealing with interruptions approaches one third of all time spent in direct communication. It is clear that some interruptions are necessary in the efficient care of patients, but it is not known if excessive interruptions interfere with patient care. Frequent interruptions are known to have the potential to disrupt working memory and generate error.

Several studies have reinforced the notion that difficulties remain in communication across hierarchy, especially when subordinates attempt to provide information and suggestions to superiors (Coombs and Ersser 2004).

Thomas et al. (2003) surveyed physicians and nurses in the ICU and noted significant differences in their perceptions regarding teamwork. The core issues involved aspects of communication. Nurses relative to their physician counterparts believe that it is more difficult to speak up if they perceive a problem with patient care, disagreements regarding what is best for the patient are not appropriately resolved, input from nurses about patient care is not well received, and more input from other ICU personnel is needed for sound decision-making. A survey examining how providers work together in the neonatal intensive care unit identified communication as an important group influence specifically noting the importance of skill and style of questions, documentation and sharing of information, integrity and accountability, along with communicating across hierarchy as key elements (Thomas et al 2004). Sexton et al. (2000) surveyed attitudes of operating room and ICU teams regarding error, stress and teamwork as compared to aviators. Medical personnel demonstrated attitudes that were potential barriers to effective communication across hierarchies and importantly obstructed recognition and discussion of error.

Communication has also been identified as a critical element in discussing unfavourable clinical information with patients and their families. Delivering “bad news” can be very difficult for some providers. Fins and Solomon (2001) have noted the importance of using clear but sensitive language in the right setting at the right time. The burden is on the clinician to possess self-awareness regarding their own shortcomings in communication and insight to avoid undermining trust of the patient and their family. Unfortunately, this rarely happens. Sexton et al. (unpublished personal communication) have noted that ICU physicians believe they are collaborative with other healthcare team members about 90% of the time, whereas other healthcare team members believe the physicians are collaborative only 50% of the time. The difference in perception of these groups seems to be definitional. Physicians seemingly define collaboration as “the physician says and someone does it”.

Consequences or Ineffective Communication

The consequences of poor communication include increased risk of harm to patients, deterioration of working conditions leading to increased staff stress and burnout, and problems with trust and therapeutic relationships with patients and their families. Donchin et al. (2003) identified poor communication between physicians and nurses as a significant source of error. Problems were identified with both written and verbal communication. Communication and leadership have been documented as skills lacking in teams responding to cardiac arrest (Marsch et al. 2004; Pittman et al. 2001). While the impact on ultimate patient outcome is not known, empirically it is undesirable to have a breakdown in leadership and communication during times of crisis.

Communication for Improved Patient Outcome

Fortunately, communication skills can be improved if the problems are identified and acknowledged. In fact, several studies have demonstrated positive outcomes of initiatives designed to improve communication and promote an environment of safety. Pronovost et al. (2004) identified aspects of communication between team members that may contribute to untoward events. Verbal or written communications during hand-over of care, during routine care, and during crisis were identified as problematic. Team structure and leadership were also identified as potential barriers to effective communication. In response to adverse events, a Web-based anonymous reporting system was created to allow incident reporting with the potential to learn from adverse events and near misses with the ultimate goal of identifying and solving system problems.

In addition to individual awareness about personality traits and styles that may impact on effective communication, other tools may enhance communication with a positive result on patient care. Use of a daily goal sheet in the ICU has been proposed as an effective technique in ensuring all team members understand the daily goal of care, and has been associated with reductions in length of stay in the ICU (Pronovost et al. 2003). Important benefits of the strategy included encouraging interdisciplinary communication and increasing awareness of potential mechanisms of patient harm. The goal sheet can also be used to facilitate communication between the healthcare team and the patient or their family.

Conclusions

Good communication is central to effective management in the ICU. A variety of modes and patterns of communication are frequently encountered in the ICU environment. Effective communication skills are not necessarily innate. It is the responsibility of healthcare providers and managers to recognize potential shortcomings in communication and take corrective action. The quality of communication can have a profound influence on patient

care, staff attitudes and effectiveness, and implementation of administrative initiatives.

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