Good communication is essential for optimal patient and family outcomes and to align treatments with the patient’s goals and preferences. Unfortunately, substantial evidence suggests that ICU clinicians are not meeting family expectations for good or even adequate communication during an ICU stay. Two studies indicate that a third to nearly half of families fail to comprehend the diagnosis, prognosis or ICU treatments (Azoulay et al. 2001; 2002). Studies of families’ perceptions indicate that poor communication may lead to anxiety and depression, and families desire more time with nurses and physicians (Pochard et al. 2005). Communication deficits may lead to mistrust, especially if the information provided is contradictory (Lautrette et al. 2007). In a recent survey of families of ICU survivors, 25 percent reported at least one episode where contradictory information was provided (Hwang et al. 2014).

Poor communication probably underlies many of the conflicts that develop between ICU clinicians and families. Conflicts contribute to stress and professional burnout and perceived conflicts are relatively common (Embriaco et al. 2007; Azoulay et al. 2009). One recent study reported that families or clinicians perceived conflict in the care of nearly two-thirds of ICU patients (Schuster et al. 2014). Curiously, when a clinician perceived that any conflict had developed between the ICU team and the family, the family shared this perception only half the time. Family’s perceptions of conflicts were missed a third of the time by clinicians, and the physician/surrogate agreement on the presence of conflict was poor (kappa=0.14). Clearly we need much better communication strategies for the benefit of all concerned (Long and Curtis 2013).

Investigators have tested a number of interventions to improve communication and comprehension of families of ICU patients. A systematic review identified 21 publications of 16 distinct randomised controlled interventions (Scheunemann et al. 2011). These included printed information, structured family conferences, additional family support measures, and ethics and palliative care rounds or interventions. On balance, evidence suggests that these interventions improve comprehension, reduce family stress, and decrease the length and intensity of ICU treatments.
Recently, investigators have proposed videos and interactive computerised decision support tools to meet varying and complex family information needs in the ICU, and preliminary results with videos are promising (McCannon et al. 2012; Cox et al. 2014). A randomised trial of diaries completed by ICU clinicians summarising, in lay terms, the events of the day (including pictures) reduced symptoms of post-traumatic distress in ICU survivors, probably by filling in key information gaps after recovery (Jones et al. 2010). A pilot study of this intervention suggested this approach also may help the psychological recovery of families, perhaps by the same mechanism (Jones et al. 2012). However, substantial deficits in communication persist in many of the superior arms of these trials suggesting more work is needed to improve communication.

ICU work rounds offer the opportunity to further involve families. Following an Institute of Medicine report endorsing “patient-centered care”, the Committee on Hospital Care, American Academy of Pediatrics and the Institute for Family-Centered Care issued a joint policy statement encouraging rounds at the bedside (2003; 2012). Furthermore, these organisations suggest that family presence on rounds should be part of standard practice to improve communication. Clinical practice guidelines for family and patient-centered care of both adults and children have also been published (Davidson et al. 2007).

Two groups have evaluated family presence on work rounds in paediatric ICUs by surveying family perceptions (Aronson et al. 2009; Stickney et al. 2014). Both showed a high degree of family satisfaction (95-98%) and comfort with most aspects of being included on work rounds. In one PICU where all parents were invited to attend but not all parents chose to do so, demographic or socioeconomic variables did not predict who chose to attend work rounds (Stickney et al. 2014). Feeling welcome was the only characteristic that predicted parent’s attendance (OR 12.2, 95% CI 2.3-64.8; p=.007). Attendees were more likely to agree that families should be invited than non-attendees (96% vs 81%). Most parents reported that they understood the content of rounds (84%), yet clinicians thought only 21% of parents understood (p <0.001). This finding strongly suggests that ICU clinicians need to recalibrate their views on the value parents derive from participating in work rounds.

Both studies noted that physicians thought that teaching was reduced or less comfortable when parents were present, and both studies indicated a higher acceptance of family presence by nurses than physicians. Parents indicated some concerns about privacy, and in one survey 93% asked that the provider return for further discussions (Stickney et al. 2014).

The published experience in adult ICUs is limited. One trauma ICU noted that families reported having limited clinical knowledge about their family member before attending work rounds. After being included in work rounds families reported that they obtained vital information, which allowed them to better understand the condition and plan of care (Schiller and Anderson, 2003). Investigators in a medical ICU evaluated the impact of inviting families to multidisciplinary rounds (Jacobowski et al. 2010). A higher degree of satisfaction was reported for frequency of communication and decisional support, though overall satisfaction was unchanged and some families felt rushed to make decisions. If attending ICU rounds educates families as ICU diaries appear to do, then psychological outcomes may also be improved (Jones et al. 2012). Of note, family presence during cardiopulmonary resuscitation (CPR) appears to ease the grieving process and reduces post-traumatic avoidance behaviour (Critchell and Marik, 2007).

Our medical ICU participated in a demonstration project funded by the Robert Wood Johnson Foundation to integrate palliative care expertise into our critical care practice (Billings et al. 2006). Open visitation was one of the many interventions that resulted. With families often present at the bedside during morning rounds it made little sense to ask them to leave (or close the door) and exclude them from our discussions. We followed the lead of our paediatric colleagues and began inviting families to our twice daily ICU work rounds. Our current practice is to clarify with the surrogate decision maker who among the family members present are authorised to hear protected medical information. We extend an invitation and assure families that participation is voluntary. For those accepting our invitation we introduce ourselves and give our roles on the team. We invite interruptions for any errors family members hear or perceive during the presentation of the history. Finally, we apologise in advance for the jargon they will be hearing and reassure families that they will have private time with us later during our usual family meetings.

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Our subjective impressions are that nearly all families choose to attend rounds when invited and appear to benefit from the experience. It is not uncommon that we receive important corrections or clarifications to the patient’s history. Some families say they found the experience engaging, and most were thankful for the time and effort the ICU team spent on their family member’s behalf. Others remarked on the team’s comprehensive approach to clinical problem-solving. Mindful that teaching has been reported to suffer from family presence, we make every effort to try and keep teaching on work rounds at a high level. Medical resident acceptance appears to be high. Our perception is that the time spent on work rounds has not increased substantially with family presence. Rather, overall rounding time appears to be less as family meetings later in the day are shorter and focused on clarifying information already presented or discussed. Further, nurses report that families appear to have a better understanding of current clinical issues such that it is much easier for nursing to help families process this information as they return to the bedside.

What are the downsides to family presence? As noted previously, physicians appear to be less enthusiastic about family presence than families or nurses and perceive less teaching (Stickney et al. 2014). The burdens this reticence places on learning and workplace stress is unknown. When the practice of allowing families to attend CPR first surfaced years ago, concerns were expressed that increased malpractice suits would result. These fears have not been realised (Davidson et al. 2007). While the impact of family presence in adult ICU rounds on malpractice rates is unknown, experts suggest that strengthening staff and family bonds actually decrease the likelihood of legal action (Brown 1989).

In summary, increased emphasis on family-centered care and persistent evidence of inadequate and inconsistent communication during the ICU stay strongly support new and improved efforts to improve family comprehension, understanding, and comfort. Growing awareness of the burden that conflicts exact on critical care providers and families further emphasise the need for better communication. Paediatric intensivists have involved parents in work rounds for many years and nearly all parents find rounds understandable and helpful. Nascent experiences in adult ICUs suggest this may also be true but solid evidence is lacking. While it is too early to know if this practice in adult ICUs will help solve our communication gaps, rounding without families appears to us to be a lost opportunity to exchange information, build trust, and make the ICU workplace more enjoyable.

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