The Intensive Connection

Communication

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Communication

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This module is updated and maintained by the (ETHICS) section

Latest Update

First Edition

Ethics

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Update Info

Intended Learning Outcomes

Communication Part I: Communicating with Patients

1. Adequately approach conscious and unsconscious patients
2. Deal with communication barriers
3. Correctly obtain an informed consent from an ICU patient

Communication Part II: Communicating with Families

1. Adequately provide information to family members
2. Know when and how to involve the family in decision-making and in patient care
3. Adequately transmit bad news

Communication Part III: Communicating with co-workers

1. Have improved communication skills within the ICU team
2. Perform a clear, succinct and adequate handover
3. Correctly and openly communicate about errors in the ICU
4. Explore the advantages and barriers to good team-work

Communication Part IV: Developing communication skills

1. Have effective communication strategies with patients
2. Adapt these strategies for team communication enhancement

eModule Information

Relevant Competencies from CoBaTrICE

Communication Part I: Communicating with Patients

- **7.1** Comfort and recovery: Identifies and attempts to minimise the physical and psychosocial consequences of critical illness for patients and families
- **12.1** Professionalism: Communicates effectively with patients and relatives
- **12.4** Professionalism: Involves patients (or their surrogates if applicable) in decisions about care and treatment

Communication Part II: Communicating with Families

- **12.1** Professionalism: Communicates effectively with patients and relatives
- **12.4** Professionalism: Involves patients (or their surrogates if applicable) in decisions about care and treatment

Communication Part III: Communicating with co-workers

- **12.2** Professionalism: Communicates effectively with members of the health care team
- **12.7** Professionalism: Collaborates and consults; promotes team-working
- **12.8** Professionalism: Ensures continuity of care through effective hand-over of clinical information
- **12.9** Professionalism: Supports clinical staff outside the ICU to enable the delivery of effective care
- **12.10** Professionalism: Appropriately supervises, and delegates to others, the delivery of patient care

Communication Part IV: Developing communication skills

- **12.1** Professionalism: Communicates effectively with patients and relatives
- **12.2** Professionalism: Communicates effectively with members of the health care team

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1. Communicating With Patients

1. 1. Introduction

‘What we’ve got here is... failure to communicate ...’ Strother Martin in the film Cool Hand Luke, 1967

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.

> **Note**
>
> Give clear, honest, comprehensible information in a sensitive way

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. 1. 1. The physician–patient relationship

In the past, physicians had only limited therapies and treatments at their disposal. With so few options for treating patients, there was much more emphasis on the physician-patient relationship. Over the course of the 20th century, however, the availability of many treatment options 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 ICU. 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. Furthermore, effective communication may lead to less anxiety in patients and more trust in physicians.

In the last decades, healthcare policy in many countries has increasingly focused on ‘patient empowerment’. Also, there is a trend towards using less sedation in critically ill patients. As a result of this, patients are more aware of their stay in the ICU. Nurses and physicians should be aware of this and of the consequences this has on the way a patient experiences the ICU stay. It has been shown that nurses have an important role in ‘translating’ medical information to patients and families and that this lowers feelings of depression and anxiety.

In text References

(Borza, Gavrilovici and Stockman. 2015; Chaitin et al. 2003; Laerkner et al. 2017; Sustersic et al. 2018)

References

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- Laerkner E, Egerod I, Olesen F, Hansen HP, A sense of agency: An ethnographic exploration of being awake during mechanical ventilation in the intensive care unit., 2017, PMID:28704639
- Sustersic M, Gauchet A, Kernou A, Gibert C, Foote A, Vermorel C, Bosson JL, A scale assessing doctor-patient communication in a context of acute conditions based on a systematic review., 2018, PMID:29466407

1. 1. 2. 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.

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

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

‘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 doctor or nurse, you should give information and explanations even to patients who are unresponsive.

Note

Always talk to patients even if they are unconscious or unresponsive!

Several decades ago it was found that increased verbal communication with unconscious patients leads to a proportional reduction in the incidence of 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.

In text References

(Laerkner, Egerod and Hansen 2015; Leung et al. 2018; Shaw et al. 2014; Walker, Eakes and Siebelink 1998)

Note

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.

References

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- Leung CCH, Pun J, Lock G, Slade D, Gomersall CD, Wong WT, Joynt GM, Exploring the scope of communication content of mechanically ventilated patients., 2018, PMID:29102851
- Shaw DJ, Davidson JE, Smilde RI, Sondoozi T, Agan D., Multidisciplinary team training to enhance family communication in the ICU., 2014, PMID:24105452
- Walker JS, Eakes GG, Siebelink E, The effects of familial voice interventions on comatose head-injured patients., 1998, PMID:10188435

1. 1. 3. 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.

1. 1. 3. 1. 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.

Anecdote

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, causes stress in caregivers. 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.

Note

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.

Although for most people speech is the preferred method of communication, there are other ways to communicate. Non-verbal 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, see video). A one-way speaking valve may enable patients with a tracheostomy to communicate vocally at a very early stage. Ten Hoorn et al. performed a systematic review of all studies available on communication aids in conscious ventilated ICU patients and suggested an algorithm for the selection of alternative communication methods. Next to the alternative methods discussed in this review, newer methods are being developed and should be tested in ICU patients (e.g.: tablet-based communication).

In text References

(Ten Hoorn et al. 2016; Girbes and Elbers. 2014)

1. 1. 3. 2. 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 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.

In text References

(Hamill-Ruth and Ruth. 2003)

1. 1. 3. 3. Foreign languages

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

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. In addition, most smartphones carry an application which translate the speech and written words and can be then shown to the patients/family.

Note

A family may be from a different cultural background or have religious beliefs of which you are not aware.

Challenge

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 coworkers. The next time you encounter a patient with limited language abilities, apply what you learned.

1. 1. 3. 4. 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. 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.

In text References

(Bell et al. 2016; Volandes and Paasche-Orlow. 2007)

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

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

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.

References

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- Hamill-Ruth RJ, Ruth RA., Evaluation of audiologic impairment in critically ill patients: results of a screening protocol., 2003, PMID:14501956
- Bell SK, Roche SD, Johansson AC, O'Reilly KP, Lee BS, Sands KE, Talmor DS, Brown SM, Clinician Perspectives on an Electronic Portal to Improve Communication with Patients and Families in the Intensive Care Unit., 2016, PMID:27700144
- Volandes AE, Paasche-Orlow MK., Health literacy, health inequality and a just healthcare system., 2007, PMID:18027287

1. 1. 4. 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 should not 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.'

Sometimes ICU doctors have the difficult task to discuss plans with patients with capacity about what to do when things go wrong. One of the options may be starting palliative care. Under these circumstances, the best beginning of such a conversation is an open question (e.g.: "How have you been coping with your disease?"). Most patients will have thoughts about this subject and will express their opinion and wishes without much further prompting.

> **Note**
>
> You never really understand a person until you consider things from his point of view ... until you climb into his skin and walk around in it': Character in the novel To Kill a Mockingbird

In text References

(Acebedo-Urdiales et al. 2018; Darbyshire et al. 2016)

> **References**
>
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> - Darbyshire JL, Greig PR, Vollam S, Young JD, Hinton L, I Can Remember Sort of Vivid People…but to Me They Were Plasticine. Delusions on the Intensive Care Unit: What Do Patients Think Is Going On?, 2016, PMID:27096605

1. 1. 5. 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 and support 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.

1. 1. 5. 1. 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 health care professionals 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.

> **Note**
>
> Family relationships often include elements of conflict. Family members do not necessarily view the patient's situation in the same way that the patient does. Always keep the patient's best interests in mind.

1. 1. 5. 2. 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 very often 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. This is in contrast to findings in a study on critically ill traumatic brain injury (TBI) patients, where doctors 'refused' to give numbers while families preferred to hear numbers when talking about prognosis
See the following references and the ESICM module on Clinical outcome.

In text References

(Quinn et al. 2017; White et al. 2010)

1. 1. 5. 3. 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.

In text References

(Chiarchiaro et al. 2015)

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?

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

'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.'

References

- Quinn T, Moskowitz J, Khan MW, Shutter L, Goldberg R, Col N, Mazor KM, Muehlschlegel S, What Families Need and Physicians Deliver: Contrasting Communication Preferences Between Surrogate Decision-Makers and

Physicians During Outcome Prognostication in Critically Ill TBI Patients., 2017, PMID:28685395
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- Chiarchiaro J, Buddadhumaruk P, Arnold RM, White DB., Quality of communication in the ICU and surrogate's understanding of prognosis., 2015, PMID:25687030

1. 1. 6. 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.

Note

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. Sometimes ‘difficult’ behaviour can result from coping strategies from the patient.

Regular communication can improve understanding, emphasise the limitations of medical science, establish a trusting relationship, 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
- Involving the patient’s family

1. 1. 7. 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% 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.

> **Note**
>
> Admitting the initial uncertainty concerning results of the research (clinical equipoise) is the 'only honest way for proposing a clinical trial to a patient or family.' European Society of Intensive Care Medicine Statement, 2002

In text References

(Terry 2007; Matei and Lemaire. 2013; Modra, Hilton and Hart 2014)

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 10month-old child?

For a detailed discussion of the issues surrounding consent see the e-learning module on Ethics

1. 1. 7. 1. Consent forms

Unfortunately, many 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.

In text References

(Silverman et al. 2005)

Challenge

Adapt several paragraphs of a previously used consent form, using the suggestions above to create simpler text. Prepare three questions that test the reader's understanding of key points in the paragraphs. Show the original text to four nonmedical people you know e.g. friends, family and ask them to answer the questions. Then show them the simpler text. Which test provoked the best answers? Which version did they prefer?

References

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- Modra LJ, Hilton A, Hart GK, Informed consent for procedures in the intensive care unit: ethical and practical considerations., 2014, PMID:24888290
- Silverman HJ, Luce JM, Lanken PN, Morris AH, Harabin AL, Oldmixon CF, Thompson BT, Bernard GR; NHLBI Acute Respiratory Distress Syndrome Clinical Trials Network (ARDSNet)., Recommendations for informed consent forms for critical care clinical trials., 2005, PMID:15818118

1. 1. 8. 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. 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 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 team should emphasise that the patient has clinical improved to such a state that he no longer needs critical care, and he will attain more independence in a hospital ward as well as, attempting to answer patients' questions, provide reassurance and solicit input on aspects of care that can be improved. In addition, a transfer letter written for the patient can be a solution in solving any unanswered questions regarding the transfer.

Note

One hospital that received high ratings in preparing patients for discharge required patients and families to write down any questions they had. Only after all questions were answered was the patient discharged.

In text References

(Ullman et al. 2015)

References

- Ullman AJ, Aitken LM, Rattray J, Kenardy J, Le Brocque R, MacGillivray S, Hull AM, Intensive care diaries to promote recovery for patients and families after critical illness: A Cochrane Systematic Review., 2015, PMID:25869586

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.

Note

Looking after families is an integral part of our job

2. 1. Introduction

Delivering bad news is one of the most daunting tasks faced by physicians. For many, their first experience involves patients they have known only a few hours. Additionally, they are called upon to deliver the news with little planning or training. Given the critical nature of bad news, that is, “any news that drastically and negatively alters the patient's view of her or his future”, this is hardly a recipe for success.

Historically, medical education has placed more value on technical proficiency than communication skills. This leaves physicians unprepared for the communication complexity and emotional intensity of breaking bad news. The fears doctors have about delivering bad news include being blamed, evoking a reaction, expressing emotion, not knowing all the answers, fear of the unknown and untaught, and personal fear of illness and death. This can lead physicians to become emotionally disengaged from their patients. Additionally, bad news delivered inadequately or insensitively can impair patients' and relatives' long-term adjustments to the consequences of that news.

In this course we will explore some strategies to communicate with patients and address the issue of how to “break bad news” in intensive care.

2. 2. Providing information

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. Patients are part of a wider social patient-family network. Although there might be 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.

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 that 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 or her. The information should be clear, accurate, honest, timely, and in language they can understand.

In text References

(Azoulay and Pochard. 2003)

2. 2. 1. 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. It is quite common that physicians, nurses and auxiliary treating team members have completely different perspectives of how they predict the course of the patient's disease will progress.

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.

2. 2. 2. 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.

Note

Often, medical professionals give families the same information they give each other - physiological data - rather than providing information in human terms.

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.

Warning

Half the families of ICU patients don't understand the patient's diagnosis, prognosis, or treatment. Try to explain the medical condition of the patient in such a way that both your 10-year old nephew and your grandmother will understand. Try to avoid overloading families with unnecessary details, which may be easily misinterpreted and distract families from more crucial information.

In text References

(Lee Char et al. 2010; Quenot et al. 2017; Wilson et al. 2015)

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.'

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

‘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 into the entrance of the lungs 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.’

2. 2. 3. 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.

Note

Communication is only effective if it meets the needs of the audience

What you can do:

- Communicate with the family on a regular basis, 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 like summarising, reflecting and and asking the family what they understood from your message.

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?

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

'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.'

2. 2. 3. 1. 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%.

Note

Policies designed to promote communication are only effective if they are used

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.

In text References

(Dotolo et al. 2017; Francis et al. 2017; Furqan and Zakaria 2017; Lautrette et al. 2007)

Challenge

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.

2. 2. 4. 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.

In text References

(Au et al. 2018; Curtis and White. 2008; de Havenon et al. 2015; Bruce et al. 2017)

References

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2. 3. 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. Telephone updates are a good addition to family meetings, however they cannot replace face-to-face meetings.

In text References

(Seaman et al. 2017)

2. 3. 1. 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.

In text References

(Azoulay et al. 2003)

2. 3. 2. 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.

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?

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

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.

In text References
(Ovayolu Ö et al. 2015)

2. 3. 3. 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. Several studies have shown that

allowing family members to witness resuscitations in emergency rooms or before hospital admission might be advantageous in their coping with the resuscitation. Many guidelines support family-witnessed resuscitation.

In text References

(Breach 2018; DeWitt 2015; Leske and Brasel 2010)

References

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2. 4. 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. The role of the family is dependent on cultural context, in some European countries, it is the team who makes the decisions in line with the wishes of the family. The role of the family is to represent presumed patient's wishes, so the most appropriate question to be asked is often "What do you think your mum would have wanted?". Remember that assignment of

final responsibility varies across medical-legal systems. It is very important to realize this variation, and to inform yourself how this is arranged medically and legally where you practice.

Important

Medical practice and legislation vary between countries and sometimes even regionally. Inform yourself how this is arranged where you practice.

In text References

(Azoulay, Chaize and Kentish-Barnes 2014; Chao et al. 2016; Petrinec et al. 2015; Sprung et al. 2014)

2. 4. 1. 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%).

In text References

(Cunningham et al. 2018; Nelson et al. 2017; Oczkowski et al. 2016; White et al. 2018)

2. 4. 1. 1. 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?'

2. 4. 1. 2. 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.

In text References

(Boyd et al. 2010; Zier et al. 2008)

2. 4. 1. 3. 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. A skilled physician should 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.

Note

One third of family members of ICU 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.

In text References

(Cameron et al. 2016; Graef and Sieber 2018)

Challenge

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.

In text References

(Wong, Phua and Joynt 2018; Bosslet et al. 2015)

References

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2. 5. Handling differences of opinion

Sometimes you will not reach full agreement with the family on how to proceed with care. Perhaps you will disagree over the goals of treatment, whether to continue with treatments you consider inappropriate, or who has the right to decide.

Important

Depending on differences in laws, ethical and professional guidelines, and local practice, large differences exist throughout the world. As noted previously, always consider such variability and respect laws, guidelines and rules relevant for the specific circumstances.

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.

Note

Many disputes on medically inappropriate treatment begin with unrealistic expectations on the part of the family resulting from the clinician’s failure to communicate successfully.

2. 5. 1. ‘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 medically inappropriate 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 aids 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 medically inapproprate treatments either do not have sufficient awareness of the extent or severity of the patient's illness or have been given an inaccurate picture of the patient's chances of recovery.

2. 5. 2. 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.

What you can do:

- Keep calm.
- Listen attentively 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 E-module on Ethics.

In text References

(Cook and Rocker. 2014; Curtis et al. 2012; Luckett 2017; Truog et al. 2008)

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.

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2. 6. 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.

2. 6. 1. 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 curative 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.

In text References

(Hollyday and Buonocore. 2015; Kim et al. 2016)

2. 6. 2. 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.

> **Note**
>
> Postponing the message worsens the situation for the patient and relatives

What you can do:

- If the family comes completely unprepared, use “warning shot” tactics (e.g. “I have bad news for you, we should sit down”).
- 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 and identify/acknowledge what family members are feeling.
- Summarise 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.
- After the encounter, take a deep breath and, if possible, some time for yourself.

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 the bad news
Acknowledge the reaction
Discuss the near future

> **Note**
>
> Occasionally, a patient in the ICU 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).

In text References

(McDonagh et al. 2004; Watson 2008)

2. 6. 2. 1. 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.

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.

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

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.

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2. 7. Discussing organ donation

Every patient dying in Europe should be considered as a potential donor. Regulations differ throughout countries, though. For details refer to the following e-modules:

- Ethics
- Organ donation and transplantation

2. 8. 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.

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.

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.

In text References

(Dall'Oglio et al. 2018; Frivold et al. 2017; Heyland et al. 2002; Jensen et al. 2017; Kryworuchko and Heyland. 2009; Lam et al. 2017; Pagnamenta et al. 2016; Schaefer and Block. 2009; Stapleton et al. 2006)

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3. Communicating With Co-Workers

3. 1. Introduction

Research in healthcare shows that patients frequently experience unnecessary harm as a result of preventable medical errors. These events can result in the substantial suffering of patients, as well as a high financial burden in terms of extended hospital stays and litigation costs. In the intensive care unit (ICU), the complex and multidisciplinary nature of intensive care medicine renders it particularly susceptible to the occurrence of medical errors.

Effective team communication and coordination are recognized as being crucial for improving quality and safety in the intensive care unit. Studies of communication failures in medical teams have indicated the influence that hierarchical and social factors have upon the behaviour of junior medical staff. Communication failures can emerge from junior team members being reluctant to communicate openly with senior team members because of a fear of either appearing incompetent, or of being rejected, embarrassed, or reprimanded. Attitudinal research in the US has indicated that ICU team members have divergent perceptions of their communication behaviours, with more nurses than doctors reporting difficulties in speaking-up about problems with patient care, and fewer nurses reporting that teamwork between nurses and doctors is well coordinated. Not only do such factors increase the likelihood of medical errors occurring, but also the extent to which communication in the ICU is open may influence the degree to which patient care duties are understood. Through the use of communication interventions that promote teamwork across role boundaries (e.g. ICU daily goals sheets), making communication more inclusive and explicit has been shown to increase team members' understanding of patient care plans in the ICU.

3. 2. Working in a multidisciplinary team

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. Therefore, the etymology of the word

“communication” should be remembered: communicating means “sharing, joining, uniting or making understanding common”; much of what means to function as a team or be a good leader is linked with optimal communication strategies.

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.

3. 2. 1. 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; quality of leadership includes the ability to establish a shared mental model, to coordinate tasks, to centralize the flow of information, to establish structure and to stabilize emotions. (For further information about leadership, see the e-module on Organisation and management).

Note

Give one specific task to one person at one time

Although clarification of roles is an important aspect of daily work, it is particularly important in stressful situations, such as resuscitations. It is known that, during crisis, medical teams often fail to achieve a shared mental model: physicians often fail to communicate what they are doing and why. Consequently, tasks should be clearly assigned, and a single person should not be asked to perform multiple tasks simultaneously. Practical strategies to enhance short-term medical communication imply combating mitigating language (referent to language that de-emphasizes), use of graded assertiveness (like the 5-step advocacy or SBAR) and use of closed-loop communication (confirming task completion by demanding feedback). This coordinated team approach should apply to all aspects of the patient’s ICU stay.

SBAR tool consists of a standardised prompt questions in four sections allowing effective and consistent communication between healthcare professionals. It’s a mnemotechnic word for:

- Situation: identify yourself and patient, name the reason for your communication and describe your concern
- Background: patient’s reason for admission, significant medical history (patient’s background)
- Assessment: vital signs, clinical impressions or concerns
- Recommendations: explain what you need, suggestions, expectations…

Using SBAR, important information can be transferred in a brief, concise and predictable structure (as the structure is shared, it helps staff anticipate the needed information). It was originally developed by the United States military for communication on nuclear submarines and has been adapted for use in healthcare by Dr M Leonard and colleagues (Kaiser Permanente, Colorado, USA).

Regarding other developed tools, teamwork in medical emergencies may be measured using the TEAM tool, developed from an extensive review of the literature, and validated through instrument testing. Primarily developed for cardiac resuscitation teams, the TEAM tool has also been found to be a valid measure for teams managing critically ill patients. In summary, TEAM is a training and/or assessment tool that is made up of three categories (leadership, teamwork and task management); encompassed within these categories are nine elements: leadership control, communication, co-operation and co-ordination, team climate, adaptability, situation awareness (perception and projection), prioritisation and clinical standards. The final eleven items include applicable prompts to aid rating, whilst the twelfth item is a global rating of the team's performance.

Table 1: TEAM tool. Randmaa M et al, 2014.

Categories (3)	Elements (9)	Items (11)
Leadership	Leadership control	The team leader lets the team know what is expected from them through direction and command
		The team leader maintains a global perspective
Teamwork	Communication	Effective communication within the team
	Co-operation and co-ordination	The team worked together to complete the tasks in a timely manner
	Team climate	The team acted with composure and control
		Positive morale within the team
	Adaptability	The team managed to adapt to changing situations
	Situation awareness (perception)	Monitoring and re-assessing the situation
	Situation awareness (projection)	Anticipation to potential actions

Task Management	Prioritisation	Prioritising tasks
	Clinical standards	The team followed approved standards and guidelines
Global (overall rating)	On a scale of 1-10 give your global rating of the team's non-technical performance	

In text References
(Randmaa et al. 2014)

What forms of communication could you use to ensure that team members are aware of the division of responsibilities?

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

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.

3. 2. 2. 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 (with a profound impact in patients' safety).
- Increases in morale, better job satisfaction, and less time missed from work because of illness. Health team satisfaction requires feeling supported (e.g.: administratively and inter-personally, respected, valued, understood, listened to, with a fair compensation), with a clear understanding of one's role.
- Moderation of the detrimental effects of fatigue on performance.
- Fewer and shorter delays.
- Higher consent rate for organ donation.
- Retention of high-quality committed nursing staff.

Note

> 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.

In text References

(Agency for Healthcare Research and 2018; Parker 2016)

3. 2. 3. Intra-team conflict

The observed majority of reported conflicts involve intra-team disputes, especially poor communication within the ICU team.

Intra-team conflict implies barriers to working as a team, like:

- 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

As 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, they should therefore be resolved before they are apparent to the patient and/or family.

In text References

(Van den Bulcke et al. 2016; Wujtewicz, Wujtewicz and Owczuk. 2015)

3. 2. 4. Improving patient handovers

It is important that the team members give consistent messages, especially during shift changes. It should be clear which team member will take over responsibility for communicating with the patient and family.

There is considerable recent literature on staff handover of patients. Handoff or handover is defined as the information exchange that takes place when a new clinician assumes control of, or takes responsibility for, a patient. 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.(Joint Commission on Accreditation of Healthcare Organizations)

A handover is not a unilateral transfer of information, and if poorly conducted it may degrade quality of care. Many studies describe negative effects on patient safety due to loss of information or miscommunication during patient transfers. See Brindley et al below.

Checklists and standardised processes have been developed to improve information transfer and provide accurate transmission of key facts: background clinical information, course of acute illness, tasks that need to be completed, uncertainty and anticipation of events. Cohen and colleagues emphasize the effect of handoff interaction on the mind of the receiver and their subsequent ability to make sense of the patient's unfolding episode of illness and treatment.

Simple mnemonic tools such as those listed below are unlikely to be sufficient, as they have failed to show benefits in clinically relevant outcomes and may even decrease physician accuracy:

- SBAR (previously mentioned)
- SOAP: subjective, objective, assessment, plan.
- DeMIST: details, mechanism, injuries, signs/symptoms and observations, treatment given)

In a systematic review performed by Van Sluisveld et al., effective interventions (measured by an improvement of continuity of care and decrease of preventable adverse events) included:

- Implementation of liaison nurses to improve the communication and coordination of care between ICU and ward healthcare professionals.
- Handover forms to facilitate the timely handover of complete and accurate clinical information for ICU to ward healthcare professionals.

In text References

(Cohen, Hilligoss and Kajdacsy-Balla Amaral. 2012; Brindley and Reynolds. 2011; Ilan et al. 2012; Patterson and Wears. 2010; van Sluisveld et al. 2015; Taylor et al. 2014)

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3. 3. Promoting cooperation and collaboration

As noted previously, modern healthcare is delivered by teams rather than individuals, and requires the cooperation of healthcare professionals from multiple disciplines. Failures in inter-professional teamwork and communication lead directly to compromised patient care, staff distress, tension and inefficiency. Besides, 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.

3. 3. 1. Being aware of different perspectives

How different healthcare professionals 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.

Challenge

Would you describe the relationship between healthcare professionals 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. Research indicates that communication across specialties is not as frequent as desirable. In a study, 62% of surgical staff rated teamwork with anaesthesia staff highly, but overall only 41% of anaesthesia staff rated teamwork with surgical staff highly. We need to team together, to join forces, and avoid this particular situation. Effective information between physicians reduces the risk of medication errors, unnecessary diagnostic testing and re-hospitalization rates, and is also associated with an improved quality of life for patients. Furthermore, successful communication strengthens relationships among providers, and may increase referral rates across health care settings.

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. Standardized communication protocols have demonstrated a significant increase in direct (interactive) communication events from acute care providers to primary care providers. Moreover, primary care providers confirm that interactive communication with ICU professionals is useful.This allows them to participate in the care plan during the patient's admission to the ICU. Follow-up care assistance may also take place once the patient is discharged from the hospital.

In text References

(Ellis et al. 2015)

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?

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

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.

3. 3. 2. Soliciting input from other team members

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. Salaset al proposed a model of five key dimensions of effective teams: team leadership, mutual performance monitoring, backup behaviour, adaptability and team orientation. Team

members must be willing to take other's ideas and perspectives into account; team's goals must be aligned with what is best for the patient, and they are more important than an individual's goals.

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 (Costa et al. 2016; Leonard, Graham and Bonacum. 2004). Different professional groups have different expectations concerning the content, structure and timing of information transfer, and may not understand the role and priorities of other groups. This is why team members must respect and trust each other in order to give and receive feedback on their performance; for example, nurses' belief that physicians inappropriately exclude them from decisions about patient care is one of the causes of intra-team disputes.

In text References

(Salas, Sims and Burke. 2005)

What kind of unique and valuable information might a nonphysician team member provide? Give some examples.

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

- 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.

Anecdote

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.

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3. 4. Improving the quality of care

3. 4. 1. 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. An explicit approach to clinical and educational responsibilities and reporting during bedside rounds could be implemented. Components of successful rounds could be:

- 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

Decreased length of stay, earlier identification of problems, increased collaboration and improved communication have all been associated with interdisciplinary rounds.

3. 4. 2. 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 (reference below) 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. At baseline fewer than 10% of residents and nurses understood the daily goals, but 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.

In text References

(Pronovost et al. 2003)

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

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

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.

3. 4. 3. 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 et al below).

Additionally, guidelines for family-centred care in neonatal, paediatric and adult ICU have recently been published, emphasizing critically ill patient care as an approach to healthcare that is respectful and responsive to individual families' needs and values.

In text References

(Davidson et al. 2017; Tracy and Ceronsky. 2001)

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3. 5. Dealing with problems: Handling errors in the ICU

'To err is human'- Alexander Pope

Healthcare errors occur frequently in hospitals and although not all result in actual harm, those that do are costly. Safety programs have been implemented in the last decade, providing a strong and visible attention to safety, implementing non-punitive systems for reporting and analysing errors and incorporating well-understood safety principles, incorporating all these topics in training programs.

An estimated 85% of errors across industries result from failures in communication (see reference below; US Institute of Medicine).Communication may be impaired between patient and healthcare team, between family and healthcare team, in the shift-to-shift report, between units, e.g.:with patient transfers, between medical services and physician staff, and between members of the healthcare team.

A twofold increase in preventable adverse events has been demonstrated in patients being covered by on-call physicians belonging to a team different from the daytime care team. Handoffs were implicated in 28% errors; Starmer et al demonstrated a decrease of 23% of medical-error rate and preventable adverse events (form pre-intervention to post-intervention period) after the implementation of a handoff programwithout a negative effect on workflow.

Furthermore, 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.

In text References

(Starmer et al. 2014; Institute of Medicine (US) Committee on Quality of Health Care in America; Kohn, Corrigan and Donaldson. 2000; Vande Voorde and France. 2002; Wachter et al. 2002; Wu et al. 2009)

Discussing errors is therefore crucial. Yet, 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.

In order to promote patient's safety and avoid medical errors, we may highlight some principles for effective teamwork:

- *First of all*, encourage discussions of safety and establish a confidential reporting system.
- *Voice specific findings:* the team member assuming the leadership role should encourage information sharing and ask questions as opposed to suggesting diagnoses
- *Think out loud:* all members of the team are encouraged to verbalize on-going observations; effective leadership can facilitate this process by querying the team for observations
- *Perform periodic review of quantitative information:* noted changes should be verbalized by the team, highlight the change in the status of information

- *Focus on solutions,* rather than placing the blame
- *Double-check crucial data:* all members of the team are encouraged to double-check crucial data and tasks, and verbalize any doubts

In text References

(Bion, Abrusci and Hibbert. 2010; Hunziker et al. 2011)

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.

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

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

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. For more details, refer to Crisis Resource Management e-module.

References

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4. Developing communication skills

4. 1. Introduction

The gap between the importance of communication skills in critical care and the lack of structured educational programs to improve any critical care health professional's comfort and skill in these areas is a reality that must be recognized.

Recent guidelines (see reference below) recommend that:

- Routine interdisciplinary family conferences be used in the ICU to improve family satisfaction with communication and trust in clinicians and to reduce conflict between clinicians and family members(grade 2C).
- Healthcare clinicians in the ICU should use structured approaches to communication, such as that included in the "VALUE" mnemonic, when engaging in communication with family members, specifically including active listening, expressions of empathy, and making supportive statements around non-abandonment and decision making. In addition, we suggest that family members of critically ill patients who are dying be offered a written bereavement brochure to reduce family anxiety, depression, and post-traumatic stress and improve family satisfaction with communication (grade 2C).
- ICU clinicians receive family-centered communication training as one element of critical care training to improve clinician self-efficacy and family satisfaction (grade 2D).

In text References

(Davidson et al. 2017)

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. Hence, communication skill programs give the opportunity for skills practice and feedback and must be integrated into critical care training programs.

Simulation and debriefing come into play. Increasing published references demonstrate that both strategies help promote the integration of skills learned in the simulated setting into the clinical environment and ongoing skills development. Structured debriefing of the clinical team after a potentially traumatic event can lead to process improvements and better patient focused outcomes.

In text References

(Chiarchiaro et al. 2015; Couper et al. 2013; Curtis et al. 2013; Hope et al. 2015; Roze des Ordons et al. 2017; Zante and Schefold. 2019)

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4. 2. Effective communication strategies

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 e-module on Teaching and learning

4. 2. 1. 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 (Goleman 1998).

- 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)
- Cultural awareness- (knowledge of how our culture influences health decision making, stereotyping and assumptions

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

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

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.

4. 2. 2. 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. Besides, 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.

4. 2. 3. Types and 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.

How can lack of congruence erode trustworthiness?

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

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.

4. 2. 4. 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.

(Warrillow, Farley and Jones 2015) summarised all these aspects into ten practical skills for effective communication with relatives:

1. Ensure access for relatives to be with the patients, demonstrate compassionate care through non-verbal cues
2. Provide regular updates and outline prognosis early on (no surprises)
3. Try to avoid conducting a family meeting on your own and involve other healthcare professionals, such as the bedside nurse and/or trainees.
4. Ensure you have plenty of time free of interruptions available for communication with relatives
5. Start the conversation; prepare by knowing the patient's history and clinical details, never forgetting to ask relatives what they know
6. Avoid technical language
7. Avoid providing excess numeric data, such as prognostic statistics and laboratory results
8. "It's OK to show emotion"
9. Allow relatives to speak freely
10. Outline a plan, focusing on actual treatment and management

References

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4. 3. 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.

In text References

(Engel 2010; Ley. 1988)

4. 3. 1. Attentive listening

Attentive listening is one of the so-called non-selective listening skills, which means it needs to be used throughout the encounter, creating an atmosphere in which the other person is encouraged to speak freely. 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.

4. 3. 2. Asking questions

There are two kinds of questions: open-ended and closed. Both types of questions are necessary in communication.

- Open-ended questions are best used when you want to explore. They give others freedom to formulate an answer in their own words,e.g.: “How are you feeling today?”
- Closed questions can be used to acquire specific information. e.g.: “Is there any shortness of breath?” 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, closed questions should be used sparingly.

4. 3. 3. Paraphrasing

Paraphrasing is restating, in your own words, the most important issues in the verbal message the other person has given you. 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’.

4. 3. 4. 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‘, for example “It sounds to me like you are disappointed with what Ive just told you about your fathers condition".

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.

4. 3. 5. 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.

4. 3. 6. Summarising and Concreteness

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. 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. They often mark the transition from one stage of the interview to another, or to a new subject.

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.

4. 3. 7. 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.

In text References

(Awdish et al. 2017; Roze des Ordons et al. 2015; Salmon and Young 2017; Zante and Schefold. 2019)

A communication curriculum could therefore start with knowledge about human relationships. Learning about attachment processes and adult attachment styles could help clinicians make sense of the variability of patients' presentations and appreciate, for example, that some patients' difficulties with trust can lead to detachment or hostility that is easily mistaken for self-sufficiency. Knowledge about relationships will provide information for practically-focused learning. Good communication needs clinicians to transcend generic knowledge and be curious about their patients; they must be motivated to find out about their patients' individuality. Clinicians should also be able to focus their attention on their own behaviour instead of the patient.

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

COMPLETE TASK THEN CLICK TO REVEAL THE ANSWER

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.'

Challenge

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.

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4. 4. Team communication

Regarding team communication in healthcare, many of the strategies mentioned above may be used, contingent upon the situation.

Nevertheless, we can describe several actions to overcome barriers to team communication in healthcare:

- Teach effective communication strategies (structured methods of communication such as SBAR handovers).
- Train teams together, especially using simulation (as a safe way to practice new communication techniques, allowing an increase in interdisciplinary understanding). Immersive simulation can be a powerful intervention to trigger discussion about roles, responsibilities and information sharing around patient management.
- Simulation (with appropriate debriefing) provides insights into how other professional groups think and feel, and a better understanding of how to support each other and maximise everyone's input to patient care.
- Define inclusive teams.
- Create democratic teams (each member of the team should feel valued; flat hierarchies encourage open team communication).
    - Hierarchies can create barriers to information exchange and action (e.g.: if nurses perceive themselves as lower status team members, they may be less likely to initiate action, despite being highly competent, because the legitimacy of their action in the situation may be questioned).
- Support teamwork with protocols and procedures that encourage information sharing among the whole team
- Develop an organisational culture supporting healthcare teams, overcoming the geographical and temporal challenges often faced by healthcare teams where patients and team members are spread across the hospital and belong to a number of different teams (we must recognise the imperative inter-professional collaboration for safety)

In text References

(Weller, Boyd and Cumin. 2014)

References

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