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Communication in the intensive care unit

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Introduction

An intensive care unit (ICU) is where critically ill patients are admitted and treated. The nature of critical illness demands that the patient be cared for by multiple specialists and personnel of various disciplines. Intensive care is team work that demands co-ordinated efforts among these personnel such as doctors, nurses, respiratory therapists, physiotherapists, dieticians, trainees among others. ICU experience is very stressful both for the patients and ICU team members due to prolonged working hours, necessity for close monitoring to detect life-threatening situations, frequent interactions and counselling of patients and their relatives, high mortality rate *etc.* Therefore, errors in judgement, lapses in patient care and conflicts often occur in the ICU environment. These conflicts may be either within the ICU personnel or between the ICU personnel and the patient or their relatives. This results in further increase in the stress levels. Most often, the conflicts in ICU are related to the end-of-life care issues or communication problems.[1-5] The focus of this editorial is to highlight the communication issues in ICU.

Interpersonal communication in ICU

Each patient is usually treated by multiple professionals in the ICU. Although their field of expertise may be different, the ultimate goal that they all work towards is the safety and well-being of the patient. Thus, there cannot be any scope for hierarchical or social factors to interfere in patient care. Openness and clarity in communication has been shown to clearly decrease length of stay in the ICU and improve patient outcome.[6] It is extremely important for all the personnel involved in patient care to understand the daily goals for each patient. In fact, daily goals for each patient may be filled out in a dedicated form for every care-giver's reference. If there is a question of futility of treatment and it is felt that there should be a 'do-not-resuscitate (DNR)' or 'do-not-escalate-treatment' order, it is important that all members of the ICU team are made aware of it after extensive discussion with the patient's family. It would be extremely frustrating to resuscitate a victim of cardiac arrest successfully only to be informed later that the patient carried a DNR order.

Strain in interpersonal relations among ICU personnel are mostly due to lack of trust, personal grudges or lack of proper communication.[7] Additional problems in our country such as differing religious beliefs, language barriers and insufficient staff strength further compound these issues. Lack of proper communication from the ICU doctors to other team members, especially the usually understaffed nurses (insufficient nurse to patient ratio) has been well documented to be a source for development of interpersonal ICU conflicts.[8]

Communication problems are likely to happen more often with frequent staff rotation.[8] For *e.g.*, an ICU doctor informs the attending nurse to obtain blood glucose values of a diabetic patient on insulin infusion. While the nurse is preparing for the same, she may be called for resuscitation of another patient who suffered a cardiac arrest. By the time that patient is stabilised, nursing shift hours may change and she may forget to hand over the information to obtain blood glucose values for the diabetic patient

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to the next shift nurse. When the doctor arrives to see the diabetic patient, he may find the patient unresponsive. Immediate blood glucose estimation would reveal hypoglycaemia and the doctor would blame the nurse for disobedience, negligence and causing harm to patient. In this example, despite good intention from all personnel involved, one patient suffered due to inattention which was actually a result of inadequate staff strength and partly due to rotation of duty staff. The stress perceived by the ICU doctor concerning the diabetic patient's deterioration and by the attending nurse related to attending a cardiac arrest resulted in an otherwise avoidable conflict. The doctor develops mistrust in the nurse while the nurse feels frustrated about the authority of the doctor.

Conflicts may evolve over varying length of time starting from several minutes to several weeks.[9] If they are not acknowledged and addressed appropriately, they are likely to recur resulting in poor working environment. In fact, a study found that the ICU personnel have rated the conflict intensity to be 'severe' or 'dangerous' in more than 50% instances while it has been termed 'harmful' in about 85% instances.[7] Another study found ICU personnel addressing the ICU team conflicts to be 'distressing, frustrating, time consuming with resultant work fatigue'.[8]

Interpersonal conflicts in ICU team members can often be limited by frequent team meetings and understanding limitations and expectations of individuals as well as encouraging individuals to improve their communication skills. The hospital management or administrators should optimise the staff strength wherever possible to enhance patient safety, minimise staff burnout and limit strains in interpersonal relations that occur due to lack of time to communicate effectively.

Interaction between nurse and the patient

A greater number of patients in ICU do not communicate well as they may be receiving mechanical ventilation. Patients not receiving mechanical ventilation are likely to be sedated either due to disease process itself or by the administration of sedatives and analgesics to help them tolerate the ICU environment. Thus, significant communication difficulty may exist while interaction occurs between the nurse and such patients. In fact, this appears to be the most commonly encountered problem in patient-nurse relationship in ICU.[10-12] This strain in the relationship may manifest as anger, frustration, panic, distress or reduced sleep in the ICU patients.[10,13] It has been reported that most ICU interactions between the nurse and patient last less than a minute.[10,14] Patients in ICU often communicate through gestures, sign language, writing or incomprehensible words.[15] Therefore, longer interaction time is necessary between the nurse and the patient. This will help decipher patient communications correctly and may further enable the nurse to take appropriate actions or interventions. Nurses need to make frequent and longer eye contact with the patients during interaction to help the patient gain trust during their communication. While communicative patients may start discussion with nurse easily, nurses should initiate interaction more often with patients unable to communicate verbally.[10] ICU personnel may usually recognise pain in ICU patients by observing tears or haemodynamic variables. ICU patients who are unable to communicate verbally have been found to convey their pain through alternate means such as grabbing the hand of the nurse, shaking their legs or signalling with eyes. Nurses need to be aware of these communication behaviour of the patients so as to avoid patient experiencing prolonged pain and distress.[16] Often, ICU personnel may discuss about deteriorating patient condition or limited chances of survival in front of the patients that are unable to communicate verbally. This can be extremely distressing and hurtful experience to the patient as those unable to communicate, may be able to comprehend.

Simple facilitative communication skills and alternative or augmentative communicative skills should be a part of nurse's curriculum to limit strains in nurse-patient relationship. Nurses should

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respect patient autonomy and dignity, and should make more eye contact while interacting with them. ICU personnel should avoid discussing deterioration in patient condition in front of the patients.

Interaction between ICU personnel and patient's family members

Patient's family satisfaction depends on the extent to which their expectations in patient care and outcomes are met by the ICU personnel. One of the most important reasons for dissatisfaction among family members is improper communication about patient condition and lack of their involvement in decision making. Nearly 70% of the family members visiting ICU patients suffer from either anxiety or depression. Higher stress levels were noted in younger relatives, females and relatives of young patients.[3,17] ICU personnel and family members usually interact in two ways. The first one involves a paternalistic stance by doctors (as observed in many places in India) where the ICU team decides the investigations, mode of treatment and expects the patient's family to either agree or disagree to their plan based on the patient's financial status. The second one involves the ICU personnel meeting the patients and their family, disclosing the diagnosis, management options and allowing them to decide on the plan of action based on financial needs, religious and cultural values, and the patient's own virtues in the final decision making. Either way, few of the essential needs of the family members of the ICU patients are clear communication about the patient's illness and prognosis, involvement in and information about decisions, allowance for sufficient time with the patient and frequent visits to the patient for consolation and comfort.[18]

Most ICU conflicts with family members can be minimised by allowing frequent and sufficient visiting time, being compassionate and providing emotional support to the relatives and spending more time with the relatives in discussing the patient prognosis and management. Appropriate communication with patient's family and allowing for their religious beliefs is very important in reaching a conflict free consensual decision especially while deciding on *'end of life'* care. Finally, it is also important to ensure that the ICU personnel have clear understanding of the prognosis and management principles. This would minimise contradictory information being given to the relatives of patients when they interact with different ICU personnel.

Breaking bad news: In view of the serious illness and multiple organ pathology involved in many ICU patients, morbidity and mortality are quite high in critical care units. Therefore, anxious relatives often need to be updated about deterioration in patient's condition on several occasions. This should be handled with sensitivity. It is better to designate one person from the ICU team as the spokesperson for a particular patient's family to avoid making contradictory statements and creating confusion. This spokesperson must ensure that he/she has a good knowledge of the patient's condition and its prognosis before conversing with the family. He/she must also elicit the family's perception of the condition and empathise with them. The unfavourable news may be conveyed gently and the family must be involved in important decision-making so that grieving will not be hard.

Code of conduct for trainees and trainer in ICU

ICU will have trainees who need to learn certain procedures on patients to put their theoretical understanding into practice. However, ICU patients usually have multiple organ systems being adversely affected to varying degrees. Therefore, the question of allowing a trainee to perform procedures arises invariably in ICU. Certain guidelines as stated in the Declaration of Helsinki, therefore, need to be stringently adhered to while allowing trainees to perform procedures. Patient's autonomy should be respected. The procedure must be performed by the trainee under strict supervision of an experienced trainer who should be able to take over the procedure if there is difficulty or discomfort to the patient to minimise complications. The procedure to be performed should be a definite requirement for the benefit of the patient and should not be performed merely to let the trainee have a feel of the procedure. The trainee should be allowed to learn or perform only those procedures that they are most likely to use

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in their future *i.e.*, only a trainee doctor in intensive care should be trained to perform percutaneous tracheostomy or central venous catheter insertion. The trainee should be proficiently knowledgeable theoretically about the procedure to be performed prior to attempting the procedure.[19]

In essence, interaction in ICU is a complex and dynamic process that is highly stressful and therefore, vulnerable for development of conflicts. Improved communication by frequent team meetings between ICU personnel, more eye contact between nurses and patient, and interactions facilitated by the nurses can minimise conflicts. Similarly, proper communication with the patients, allowing patient's family to visit patients more frequently as well as allowing for their religious and cultural background in decision making will enable development of good will and trust and contribute to better outcomes.

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