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Ten practical strategies for effective communication with relatives of ICU patients

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Introduction

> 'People do not care about how much you know unless they know how much you care.'
> Attributed to Theodore Roosevelt

Intensive care units (ICUs) manage critically ill patients at high risk of death or morbidity. For relatives of ICU patients, the experience can be extremely difficult, both during and after the ICU episode. Up to 70 % of family members (irrespective of patient survival) may develop psychological problems such as depression, anxiety, sleep disruption and post-traumatic stress disorder [1–7] known as 'post-intensive care syndrome-family' [4]. Poor communication experiences may contribute to preventable adverse psychological outcomes [3, 4, 7]. In this article we review the impact of critical illness on relatives and provide ten practical strategies to optimise communication with ICU relatives.

The impact of critical illness on relatives

ICU admission may be sudden and unexpected. The complex ICU environment is unfamiliar and frightening, and may be perceived as dehumanising or burdensome. Distressing psychological symptoms among relatives of ICU patients occur most frequently during the critical illness and decrease over time, but may persist for many years [2, 4]. Non-modifiable risk factors include pre-existing mental illness [8], female gender [5, 6, 8], spouse of ICU patient [6, 7], admission diagnosis (e.g. unexpected severe trauma) and patient death [3]. Compounding and potentially modifiable risk factors may include fatigue, concerns regarding adequacy of clinical care [8], perceived role in end-of-life issues [3], and inadequate communication [3–5].

Optimising communication with relatives

Essential principles for effective communication include kindness [9], 'treating others as you would wish to be treated', and 'wherever possible, treating others as they wish to be treated'.

Moving beyond these fundamental precepts, practical strategies that can be readily implemented into daily communication are needed [10]. Communication skills are not necessarily innate, and are not always enhanced by

Table 1 Summary of practical strategies for effective communication with ICU relatives

Communication strategy		Practical implementation
1	Trust matters	Ensure access for relatives to be with the patient Allow relatives to witness clinical care and decision-making Demonstrate compassionate care through non-verbal cues such as touch during clinical examination and care
2	No surprises	Provide regular updates - Daily at least if things are not going well Outline prognosis early on and ensure relatives are fully appraised of significant developments
3	No solo acts	Never conduct a family meeting on your own - Always involve the bedside nurse Involve trainees so that they can learn and maintain continuity of communication after hours Ensure agreement with other specialists involved in discussions regarding purpose and content of conversation
4	Take your time	Ensure that you have enough time free of interruptions available - e.g. hand over pagers and phones Make sure key attendees are available Prepare the meeting room
5	Start the conversation	Prepare by knowing the patient's story and clinical details Ask relatives what they know Recount the journey from the beginning to give context - Gently correct misunderstandings if required Speak with authenticity and sincerity
6	Plain speaking	Avoid technical language - If using medical terms, provide clear explanations Be concise and direct Never patronise
7	Avoid playing 'the numbers game'	Avoid providing prognostic statistics as these are based on populations, not individuals Better to use meaningful 'real-world' examples from your own experience - e.g. 'I've never seen a person in this situation survive', or 'He is dying even though we have tried everything'
8	It's ok to show emotion	Relatives appreciate that giving bad news affects clinicians - Don't worry if your voice cracks or you miss-speak a little Revealing an emotional impact shows you are human - Clinicians should avoid extreme displays of distress
9	Talk less, say more	Allow relatives to speak freely about their loved one and experience - Try not to interrupt 'Actively listen' - Acknowledge concerns, elicit key questions, provide complete answers Avoid platitudes, anecdotes or personal stories
10	Outline a plan	Give a detailed outline of what will happen next Focus on actual treatments and management, rather than listing a range of therapies which will not be provided Explain that while the focus of management may change to comfort-based measures, that appropriate care will continue to be provided

greater experience [11], suggesting a need for practical strategies and training.

Ten practical strategies for communicating with relatives

1. Trust matters
   Telling relatives something that is both important and difficult to hear (especially if it is the worst news they may ever receive) requires them to trust the clinician to believe what is being said. Allowing relatives to be with their loved one as much as possible, including during ward rounds, provides insight into the process of clinical care and decision-making [12]. Opportunities to witness management of their loved one provides powerfully important non-verbal demonstrations of compassionate care and are likely to increase their trust of treating clinicians.
2. No surprises
   Most deterioration is gradual and predictable. Providing regular updates eliminates surprises so that it

will rarely be necessary to tell relatives something that they do not already know.

3. No solo acts
   Always involve the bedside nurse in family meetings to support the family and validate key messages. Relatives trust nurses and seek their reassurance at the bedside. ICU trainees should also attend to learn and provide continuity. If clinicians from other craft-groups are attending (e.g. surgeons), agree on the purpose and messages to be conveyed before the meeting commences [13].
4. Take your time
   Ensure you have sufficient uninterrupted time. Turn off electronic devices; relatives deserve the complete attention of the clinician caring for their loved one [14]. They will remember the subsequent conversation for a very long time. Ensure that the meeting space is suitable and available [15].
5. Start the conversation
   Be well prepared and know the patient's journey. After introductions are made, ask relatives what they know to learn their perspective. It is often helpful to re-tell the story, especially when complex, so that all relevant facts are acknowledged. It may be necessary to gently correct any factual errors or misinterpretations. Whilst being prepared is mandatory, try to speak in a manner that is authentic and unrehearsed.
6. Plain speaking
   Clinicians should speak plainly, concisely and clearly, avoiding medical jargon and euphemisms [16]. Correct medical terms can be used, but always provide interpretation.
7. Avoid playing the numbers game
   Statistics may be usefully applied to populations, but not to individuals. Providing a 'percentage chance of survival' for a patient risks inaccuracy, and relatives may seize on the '1 % chance of survival' as justification to continue non-beneficial therapies. Real-world honesty is more appropriate [17] e.g. 'He is dying even though we have tried everything.'
8. It's OK for families to see that clinicians are affected by communicating bad news
   To feel an emotional impact while delivering bad news is normal. For relatives, observing that this is a difficult task for the clinician reinforces the gravity of the situation and enhances bidirectional bonds of empathy, reducing a relative's risk of adverse outcomes [7]. Extreme displays of emotion by clinicians are unhelpful and risk increasing psychological distress.
9. Talk less, but say more
   Interactions in which clinicians actively listen and talk less improve the experience of relatives [18, 19]. Elicit key questions and ensure full answers are always provided. Periods of silence or uninterrupted crying may permit processing of important information or emotional distress. Try not to interrupt when relatives are speaking.
10. Outline a plan
    Describe what will occur next including all active care, symptom control and efforts to optimize dignity [20]. It is unhelpful to explain treatments that are non-beneficial or will not be offered. Offer meaningful therapeutic choices with appropriate recommendations and clearly convey that care will continue even if the therapeutic focus shifts to palliative intent: 'If all these treatments do not improve things; that means he is dying. We would talk more with you and then change our focus of care to prioritize his comfort and dignity while he dies.' A detailed outline of key palliative principles may assist understanding.

Conclusion

Expertise in communication is an expected standard for critical care specialists and poor communication may contribute to adverse psychological outcomes in loved ones of ICU patients. This necessitates an extensive skill set requiring specific training and practice to acquire and maintain. The ten practical strategies outlined (Table 1) can be readily implemented into clinical practice.

Conflicts of interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

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