COMMUNICATING AND CONNECTING WITH PATIENTS AND THEIR FAMILIES

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Connection with patients and families is an essential part of critical care. Dr Brené Brown, in her recent book, Daring Greatly: How the Courage to Be Vulnerable Transforms the Way We Live, Love, Parent, and Lead,1 sees connection to others as a central truth of human life: “The surest thing I took away from my BSW, MSW, and PhD in social work is this: Connection is why we’re here. We are hard-wired to connect with others, it’s what gives purpose and meaning to our lives, and without it there is suffering.” Our physical connection with patients during clinical care is intimate and focuses on assisting them in meeting the challenges of critical illness. We also connect with patients and their families through our communication with them.

Communication with families is sometimes viewed as a means to an end. It becomes a mechanism for getting things done—a way to make difficult but necessary decisions about care. In our health care system, families are expected to act as surrogate decision makers for critically ill patients who are often unable to speak on their own behalf. This communication between providers and families is a delicate dance, and many complex issues are enmeshed in the relationship.

Clinicians have their own beliefs about patient autonomy, best care, and family responsibilities. Family members vary in their knowledge of patient wishes, their willingness to act, and their understanding of the surrogate role. Relationships within families vary, from highly supportive to overwhelmingly dysfunctional. Preferred decision making styles run the continuum from passive to assertive. The stakes in decision making communication are high. We recognize the crucial effects of health care decisions on the patient, the family, and the clinicians, but do not always appreciate the consequences these decisions may have on the health care system and larger society.

Beyond Family Conferences

Family conferences have become a standard mechanism for making decisions about subsequent care. As early as 1980, family meetings were proposed as a way to improve patient and family coping and enhance patient care in trauma and critical care units.2 When first described, family conferences focused primarily on information sharing and emotional support.

Over subsequent decades, most of the literature about family meetings in the intensive care unit (ICU) focused on end-of-life and palliative care decision making. As the focus shifted, outcome measures of family meetings were increasingly judged by their impact on continuance of futile
Most patients survive their ICU experience, but little research has targeted the communication needs of these patients and their families.

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Communication with families does not belong to a single profession. Care is provided by interdisciplinary teams and communication should be interdisciplinary as well. Many research studies have focused on physician communication or nurse communication, but few have examined interventions to improve communication of the team with families. Gay and colleagues state, “Almost universally, it is the bedside nurse who develops the closest relationship with both the ICU patient and the family.”

In their qualitative study of nurse communications in the ICU, Slatore and colleagues identified a theme of a key role for the nurse in serving as a translator or intermediary between physicians and patients/families. However, they further identified that nurses made a distinction between topics that they were and were not willing to discuss with patients and families. Additional research is essential to explore aspects of disciplinary cultures that aid or hinder efforts to support families as an interdisciplinary team.

Conclusion

Critical illness presents unaccustomed challenges to patients and their families. Connection and communication have the potential to improve their experiences. All members of the interdisciplinary team are important in this endeavor. Our focus on end-of-life communication has been important, but it is time to expand our knowledge of family communication and support to encompass the needs of all our patients, regardless of prognosis. Research that tests new models for communication among clinicians, patients, and families is imperative to improve outcomes.

The statements and opinions contained in this editorial are solely those of the coeditors.