Communication skills in critical care

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It is 3 p.m. and you have spent the last 2 hours trying to stabilize and optimize a 72-yr-old man who you have admitted to intensive care from a surgical ward. Four days ago he had a hemi-colectomy for bowel cancer and he has now developed peritonitis and septic shock. Your review of the medical notes and nursing observation charts has left you with serious questions about the patient’s postoperative care. The consultant who performed the original procedure is out of the hospital but has arranged for the on-call surgical team to provide a review instead. The patient is now sedated, intubated, and ventilated. He has invasive arterial pressure monitoring, central venous access, and ongoing fluid and inotrope resuscitation. The patient’s wife and daughter have arrived and are anxious to be updated about what is going on. Meanwhile, another newly admitted patient is rapidly deteriorating and the nurses are concerned that he may arrest at any minute. Your colleague on the unit has recently left this patient for a belated lunchbreak without giving you details regarding this patient’s prognosis or resuscitation status.

Which communication techniques will you use to effectively co-ordinate the management of the peri-arrest situation and how will you update your colleague?

How will you approach the consultation by the new surgical team and what will you do if you disagree with their plan?

How and when will you raise your concerns about the care on the surgical ward?

What can you do to structure the family meeting so that your time is used efficiently and that the family feel satisfied?

Doctors with poor communication skills are unlikely to achieve success and are more likely to face complaints and litigation.1 Although developments in the drugs and technology of critical care receive close attention, best practice in non-technical skills is relatively neglected; this is despite the fact that attention to this area can improve measures of patient outcome, psychological recovery, and family satisfaction with the care received. The opportunity to demonstrate advanced skills in communication is a daily feature of intensive care practice: when managing clinical crises, during family meetings, and when co-ordinating complex case management with colleagues.

Communication skills curriculum

A wide variety of communication skills are important to critical care practice (Table 1).

Crisis communication

Skills for communicating in crisis situations are increasingly taught in simulators and on Advanced Life Support courses. Many of the techniques advocated have been adapted from safe practice developed for the airline industry and can make a powerful contribution to the management of a clinical emergency. An example would be the use of individual task allocation and loop closing: the response to ‘can someone draw up an epinephrine infusion?’ could either be ‘yes’ followed by no action, ‘no, I’m busy intubating the patient’ or a variety of actions by any member of the team. An alternative would be ‘Nick, I want you to draw up a standard strength epinephrine infusion immediately and bring it to me at the bedside as soon as it’s ready’.

Inter-professional discussions

Good inter-professional communication influences quality of care and patient safety. Regular

Key points

Communication skills are integral to good critical care.

A significant number of families of intensive care patients (up to 50%) may experience inadequate communication with doctors.

Clinical experience alone does not improve communication skills.

Good communication skills can be taught and are well retained.

Communication is central to quality end-of-life care.
ward rounds with documented outcomes and review of defined treatment goals between the intensive care unit (ICU) lead, nursing, and medical staff have been shown to reduce length of ICU stay. Failure of interdisciplinary communication is linked to avoidable medical mishaps. The way in which clinical disagreements with colleagues in contributing specialties are negotiated and settled has received little attention. Clear communication is central to clarifying and resolving these disputes, but little is known about how this might be taught or improved. Consultant to consultant referral to ICU is a commonplace standard with variable implementation. Ongoing contact with the referring consultant needs to be actively encouraged by intensivists to build a joint understanding of the patient’s progress and prognosis.

ICUs should have clear policies in place for handing over clinical information at the time of a patient’s discharge. This should include written and verbal communication with the receiving medical and nursing staff. In the event of a patient’s death, robust procedures should be followed to ensure that relatives, the referring medical team, the patient’s general practitioner, and, if appropriate, the coroner have been informed.

Communication with organizations outside the clinical environment requires specific expertise, and guidance should be sought from establishment staff such as the medical director and press officer when media interest is stimulated.

### Communicating with patients

There are particular difficulties in communicating with the patients who come into contact with critical care doctors. Illness severity may be such that time available for communication is limited and ability to engage in discussion compromised by clinical condition or conscious state. When conversations do take place, they are often among the most sensitive consultations that can be imagined, dealing with prospects for immediate survival or imminent risk of death. What little evidence there is suggests considerable room for improvement in these encounters. Communication at the bedside, even when the patient is unconscious or sedated, may often be recalled by critical care survivors and can impact upon long-term psychological outcomes. Medical staff should also be aware of the techniques and technology available for intubated patients to engage in communication, including the use of spelling boards, icon charts, and electronic aids.

### Family meetings

In UK intensive care practice, family meetings are commonly undertaken with a very small number of the patient’s closest relatives. In some cultures, extended family members may wish to attend the meeting and this can present a variety of challenges depending on the dynamics of the group involved.

A small number of doctors feel inhibited about what information can be given to relatives at family meetings in respect of maintaining patient confidentiality. This concern usually occurs in individuals who rate personal autonomy as their principal ethical standard. This is an extreme view and most clinicians accept that those close to the patient have a reasonable expectation to be kept well informed and included in decision-making. Many relatives hold the mistaken view that they have rights and duties as surrogate decision makers, but this is only the case when specific legislation applies, such as the Mental Capacity Act 2005 or the Adults with Incapacity (Scotland) Act 2000.

A superficial survey of family satisfaction with communication in the critical care unit can produce false reassurance, reflecting the frequency of contact with nursing and medical staff compared with the ordinary ward. Such surveys cannot be relied on to comment on the quality of communication. Closer analysis of family experiences paints a bleak picture of current standards. In a prospective study of 76 relatives of patients admitted to a French ICU for more than 2 days, 34 relatives (54%) had failed to comprehend the diagnosis, prognosis, or treatment of the patient when interviewed after routine family meetings.

Not all the impediments to good communication in the intensive care setting can be ameliorated by the doctor. A single meeting may be insufficient for a relative whose concentration is impaired by shock or anxiety and relatives may ‘shut down’ to receiving further information. Even when a doctor accurately recognizes this situation, they may lack the techniques to rescue the consultation from that point and continue to deliver information, despite realizing that it is not being taken in.

Communication may be the most important factor in end-of-life care in ICUs. Reaching agreement on withdrawal of care in acute situations is a unique challenge and significantly extends the skill of breaking bad news. The conduct and content of family meetings leading up to a patient’s death have been studied and guidance is moving from expert opinion to evidence informed practice. Studies have revealed that relatives who experienced proactive communication strategies and techniques reported improvement in the perceived quality of the death and reduced levels of anxiety and depression. Despite this knowledge, missed opportunities in the end-of-life family meeting remain common.

### Table 1 Communication syllabus in critical care

<table>
<thead>
<tr>
<th>Skill</th>
<th>Example</th>
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<td>Acting as a team leader and directing colleagues in a clinical emergency</td>
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<tr>
<td>Inter-professional discussions</td>
<td>Dealing with disagreement between clinical teams about treatment options</td>
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<td>Communicating with patients</td>
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<td>Family meetings</td>
<td>Use of communication aids with an intubated patient</td>
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<td>Initial consultation</td>
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<td>Clinical updates</td>
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<td>End-of-life issues</td>
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Communication skills training, teaching, and analysis

Doctors who work in critical care have traditionally learnt communication skills by modelling the practice of senior colleagues. This method results in a haphazard series of anecdotal lessons, which rarely challenge a trainee’s existing ideas of good or bad practice. To improve the value of this approach, an individual learning plan can be followed which would focus on particular skills during different clinical encounters. Each session should include a preview discussion and an appropriate debrief with structured feedback (such as the agenda-led outcome-based assessment system). To implement such a system, significant training of the trainers would be required.8

The gold standard teaching tool is individual feedback on videos of real meetings. This can be extended to an assessment tool where a portfolio of consultations is submitted for review by an examiner using agreed criteria. The practical and ethical difficulties of this technique have been overcome in primary care and there is an opportunity for critical care medicine to lead other hospital specialties in this area. However, mere demonstration of knowledge of evidence informed strategies and techniques are of limited value, if they become formulaic and cannot be integrated into the doctor’s individual style.

For analysis, a classification of communication skills has been proposed by the Calgary Cambridge programme. Three domains make up the communication framework: content skills; process skills; and perceptual skills. Evidence suggests that there are significant differences between competency in these skills and levels of clinical experience.

Content skills

This component is the simplest to understand and the easiest to measure and assess. It consists of what is actually said, including the language used and the information given. Most of the skills are intuitive such as avoiding technical language and using a level of explanation appropriate to the relative’s understanding.

A method for explaining common clinical scenarios such as sepsis and multiple organ failure will usually develop and improve with practice. It is likely that individual doctors develop a personal phrase book that is used on multiple occasions throughout a career.

Because of the technical sophistication of critical care interventions, some doctors struggle to maintain the integrity between their level of understanding and one appropriate for an anxious relative. A doctor is unlikely to succeed in the further skills if this relatively straightforward problem cannot be resolved.

Process skills

Process skills consist of how a meeting is structured. By using the techniques of sign posting, agenda setting, summarizing, and checking understanding, the efficiency and professionalism of the consultation can be improved.

These skills have a firm research base with improvements in outcomes such as understanding and retention of information when they are used effectively. Although some doctors develop process skills spontaneously or through reflective practice, most do not. Fortunately, these skills can be effectively taught and easily integrated into clinical practice. The doctor who has trouble getting through all they want to say or who finds the start or finish of a consultation awkward may benefit from work on process skills. Once integrated into the doctor’s personal style, these skills can radically improve the efficient use of consultation time.

Perceptual skills

Perceptual skills relate to recognizing and dealing appropriately with feelings and emotions that arise in the course of a consultation. Such feelings occur on both sides of the relationship and the first step towards improving these skills is a high level of self-awareness and a willingness to understand the attitudes and values that the doctor brings to the consultation. Experience alone is a poor teacher of process and perceptual skills and there is some evidence that these skills may actually deteriorate over a medical career.9 Since experience alone is no guarantee of good communication ability, it is unsurprising that a proportion of senior doctors continue to have serious problems in communicating with relatives, despite a high level of technical competency in other areas.

A close examination of these skills can be an uncomfortable experience. A doctor who does not accept the view of communication as a clinical skill and who believes that the ability to communicate is based on nothing more than immutable personality traits will not be able to appreciate these skills. Examining perceptual communication skills can reveal underlying problems of attitude, which might include a patronizing or condescending approach to relatives. In the only UK randomized controlled trial on the efficacy of communication skills training, Fallowfield and colleagues10 found that perceptual skills can be improved with training.

Regulatory and professional bodies are placing an increasing emphasis on the current consensus of good practice in communication skills and failure to appreciate these issues may become an issue in appraisals and revalidations.

Current evidence and future research

Although many skills developed for other specialities have direct equivalents in critical care, others do not and there will be a debate about how good practice can be transferred and adapted (Table 2). The techniques of patient-centred consultation and involving patients as partners originated in general practice but are now included in professional standards that apply to all UK doctors.
There is a growing literature to support the idea that many of the issues found to be important for effective communication in other specialist areas have equivalence in critical care as described earlier.5, 6

Quantitative studies are of little value in developing the underlying theory of communication skills; instead, rigorous qualitative work is required. Few doctors have training in qualitative techniques or the skills required to evaluate qualitative studies.

Two approaches that can be used to advance the theoretical framework are qualitative interviews and ethnographic work. A rich resource of data has been developed as part of the DIPEx project at Oxford University. This archive, which was established as a patient information resource, contains more than 40 interviews with intensive care patients and could be reanalysed with communication themes in mind. Ethnographic work, with a researcher embedded in an ICU for a period of study, could provide valuable insights into where and how communication fits into our working patterns and provide a fresh perspective on the impact of our current practice.

Summary

Competency in communication is a core clinical skill, which must be taught, tested, and practiced. An understanding of the evidence and theory of communication coupled with a commitment to cultivate and improve skills not only benefits patients and their families, it can also invigorate professional practice and provide an ongoing clinical challenge.

References

9. Aspegren K, Lonberg-Madsen P. Which basic communication skills in medicine are learnt spontaneously and which need to be taught and trained? Med Teach 2005; 27: 539–43

Please see multiple choice questions 4-6