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Humanizing the ICU experience with enhancedcommunication

Avicenne ICU's initiative

Decisions to limit therapy (DTLT) are routine for ICU physicians. Although breaking bad news is one of the most difficult tasks clinicians face, ongoing communication is even more crucial as families (not necessary following a legal or genetic definition) of critically ill patients have heightened communication needs. Supporting families during the process of shared decision-making from the pursuit of cure/recovery to the pursuit of comfort/freedom of pain is a key concern for our ICU. Communication, including announcements, but also listening to families requires time and training. As few physicians had received formal training in how to deliver bad news, Avicenne ICU, with the help of a newly appointed psychologist, has developed specific training.

The early years of critical care medicine were defined by remarkable diagnosis and innovation, but were also associated with substantial suffering for patients and families, who were kept out of the units with strict visiting policies. Professionals expressed major concerns that clinical care might be impeded and that family members might become too emotional and out of control, exacerbated by a lack of availability of nurses to assist them. Communication was not a priority at that time, as physicians and nurses were focusing on technical skills (remember that in the 1940s, polio patients were ventilated by hand!)

Meanwhile, ICUs still remain synonymous with hope. "Resuscitation" as a word feeds immortality fantasies and sometimes leads families to request unreasonable CPR or invasive organ support for their loved ones.

For some years, the presence of family members has been discussed. There is an increasing recognition of their important role in the ICU, and high family-centred care should now be considered a basic skill for ICU clinicians. Recommendations include a more open visiting policy, and family conferences to promote ongoing communication and trust between family members and clinicians and thus lower the risks of anxiety, depression, and post-traumatic stress symptoms.

Intensive care is the ultimate symbol of state-of-the-art medicine. Despite efforts and innovation, death remains an outcome for 1 patient out of 4. About half of the deaths occur after a decision to limit or withdraw life-sustaining treatment.

Being ethical is at the centre of all discussions, and in France decisions are also regulated by law (Claeys-Leonetti law, February 2016). Withdrawing life support is a shared decision-making process that highlights the switch from a curative strategy to palliative care.

Withdrawing life support in ICUs may sound paradoxical for clinicians who traditionally have seen their goals as curing disease and restoring health and function. These goals must expand, when necessary, to also include assuring patients of a "good death."

When the decision is made, the announcement is a critical time for all actors

The announcement of a decision to limit therapy crystallises communication issues and puts a strain on each protagonist's coping mechanism:

- Weakened families go through emotional roller coasters because of anticipating the separation. Denial, *psychic sideration* (freeze response) are frequently observed.
- Breaking bad news is one of the most difficult tasks that physicians face. They sometimes feel a sense of failure in their mission, prompting them to use various coping methods such as avoidance, distancing or intellectualisation, keeping their distance to block their own feelings.

Between distressed physicians and confused families, the whole tragic situation can become a source of conflict, especially with a lack of or inadequate communication.

When DTLT are made, technical skills become less essential, but there is a risk of losing sight of the humanistic skills of medicine. It becomes even more important to stay with the patient, and to enhance communication with relatives. Listening and explaining are keys to alleviate their anxiety and help them enter the mourning phase.

Enhance communication to improve relationships: our programme

The appointment of a new psychologist in our ICU has been an occasion to step back and focus even more on high family-centred care with the objective of humanizing the ICU experience for all.

We noticed that communication could be improved with benefits both for families and doctors. Taking into account that few physicians had received formal training on this matter,

despite its crucial role today, we decided to develop our own training sessions focusing on breaking bad news.

The programme has been developed jointly by a doctor (Guillaume Van der Meersch) and the psychologist (Anne Rocher) with real cases. All medical residents and students who work in our unit attend a training session. The objective is to raise awareness and understanding of psychological ways of coping, and also to experiment in a secure and benevolent environment.

There is no good way of breaking bad news, but some can be less devastating than others. We talk about feeling and showing empathy, using the right words when appropriate and limiting jargon. We insist on the importance of body language and on making eye contact, and overall we focus on opening up to their own feelings, to also be open to families' feelings. We also take time to discuss how some situations impact our young doctors. Giving them the opportunity to experiment, to share and discuss these subjects is greatly appreciated. We also have noticed that families remain satisfied with the care they receive even once a decision to withdraw life support has been made.

Showing empathy, actively listening, learning how to demonstrate compassion, while delivering accurate and consistent messages helps to develop positive interactions and contributes to improving family-centred care.

Studies in different ICUs have shown that improving communication has a significant impact on lowering what has been termed "post-intensive care syndrome family" PICS-F (see aftertheicu.org/what-is-fics), reducing anxiety, depression and post-traumatic stress symptoms (Scheunemann et al. 2011; Gerritsen et al. 2017).

Although it is endless work, the "hospitality label" of our unit will ultimately highlight the human and highly emotional work, realised in the shadows every day by our physicians, care assistants and nurses who address the needs of families with bereavement counselling.

Psychologist in intensive care

As a non-medical third party, the psychologist can help to foster another type of speech, around patients. He/she can be in turn a partner of the announcement, a facilitator, an interpreter between different psychic realities, and even sometimes a mediator.

In the ICU, the psychologist is a bridge between worlds, his/her role is to facilitate the work of all actors and help each one find his/her role when facing end of life.

Taking care of the soul as we take care of the body requires taking into account the psychological and relational dimension as well as the medical technique. Speech and oxygen are both essential to life. ■

References

Gerritsen RT, Hartog CS, Curtis JR (2017) New developments in the provision of family-centered care in the intensive care unit. Intensive Care Med, 43(4): 550-3.

Scheunemann LP, McDevitt M, Carson SS et al. (2011) Randomized, controlled trials of interventions to improve communication in intensive care: a systematic review. Chest, 139(3): 543-54.