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Family—clinician communication within critical care settings: Unravelling the complex and valuing the hidden

Joseph C. Manning, RN, PhD^{1,2} and Jos M. Latour, RN, PhD^{3,4}

¹School of Health Sciences, The University of Nottingham, Nottingham, United Kingdom. Email: joseph.manning@nottingham.ac.uk

² Nottingham Children's Hospital and Neonatal Services, Family Health Division, Nottingham University Hospitals NHS Trust, Nottingham, United Kingdom.

³ Faculty of Health and Human Sciences, School of Nursing and Midwifery, Plymouth University, Plymouth, United Kingdom. Email: jos.latour@plymouth.ac.uk

⁴ Faculty of Health Sciences, School of Nursing and Midwifery, Curtin University, Perth, WA, Australia. Email: jos.latour@curtin.edu.au

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Internationally, advances in medicine and technology have led to a growing repertoire of interventions that can save or prolong the lives of critically ill infants and children. Key developments include: resuscitation practices; continuous monitoring methods; ventilation devices and strategies; and artificial organs [1]. Interventions have also been developed to support parents and enhance communication between families and pediatric critical care professionals. In neonatology the Newborn Individualized Developmental Care and Assessment Program (NIDCAP) has proven to be beneficial in supporting both infants and parents [2, 3]. A range of communication strategies have been developed and tested, such as audio-recording parent—physician consultations, and the use of infant progress charts, videos or web-links [4]. Despite increased treatment efficacy, moral and ethical challenges remain [5] which add significant complexity when navigating, negotiating, and communicating treatment pathways with parents and families.

Much existing literature appears to have focused on characteristics [6], experiences and outcomes of interactions [7], or the testing of strategies to enhance clinician—family exchanges [8,9]. Studies have indicated that communicating within the confines of often time-limited and demanding critical care events and environments can be stressful and evocative for both professionals [5] and families [10]. Furthermore, the consequences of having ineffective communication and relational abilities are significant, with more negative health outcomes, dissatisfaction with care, and increased malpractice claims being reported [8,9]. Further to communication deficiencies, information provision in neonatal and pediatric intensive care units has also been associated with low parental satisfaction rates. Daily exchanges about their infants' health and wellbeing status, as well as the provision of unequivocal information by nurses and physicians, have been rated as

unsatisfactory by parents [11,12]. Therefore, it is fundamental that pediatric critical care physicians, nurses and health professionals recognize the significance of their communication in the quality, outcomes and the experiences of care by parents.

Amongst the growing body of literature, there appears to be a dearth of information regarding the content of dialogical encounters between clinicians and families within neonatal or pediatric intensive care settings. Boss and colleagues [13] offer an important and novel contribution to the field in this issue of *Pediatric Critical Care Medicine*. Their single center, prospective study explores the composition and delivery of evocative or distressing news during family conferences in the Neonatal Intensive Care Unit (NICU). Data were collected by audio-recording 19 family conferences between a total of 31 family members and 23 clinicians. These data were subsequently analyzed using the Roter Interaction Analysis System (RIAS) [14], a process which involved coding, structural measurement, and the assessment of language complexity and personalization. Their results identified that the family—clinician dialogue was composed predominantly of physician contributions, with over half of the content focusing on the delivery of biomedical information. This is striking, as physicians might want to deliver as much information as possible in a limited time frame while parents might have the desire to express their questions or concerns. Interventions to reduce this effect and come closer to a more comprehensive communicative partnership have been developed. Work by Weis and colleagues [15] developed and tested a person-centered communication intervention to reduce parental stress in the NICU. This so-called Guided Family-Centered Care intervention has scheduled nurse—parent dialogues with semi-structured reflection sheets, while using person-centered communication techniques. Although the authors were not able to demonstrate a reduction in parental stress, the intervention

might help clinicians to step back, thereby empowering parents to more actively contribute to the content of family conferences.

In order to meet the complex and often diverse needs of critically ill infants and children (and their families), pediatric and neonatal critical care is delivered by multi-disciplinary teams. Findings from the study by Boss and colleagues [13] identified that the presence of others (non-physicians) during family conferences did not increase parental contributions or content relating to psychosocial aspects of care. Specific information regarding the composition of professional groups attending each of the conferences was absent from the paper, making any conjecture about potential professional roles and influences impossible. However, it does illuminate an issue regarding the configuration of conferences, and whether they ought to, as a minimum requirement, include both a physician and a nurse. This standardization could ensure a level of support, advocacy and continuity for the family. Furthermore, although psychosocial information and parental contributions were reported as scarce during these encounters [13], this does not automatically imply that these were neglected during the NICU admission. Information pertaining to communication outside of the family conference encounter was not captured. It is therefore unclear whether opportunities for parental contributions or discussions around psychosocial information were provided. Moreover, understanding participant perceptions, experiences and satisfaction following the conferences were not explored as part of the study. Therefore, judgements in relation to the consequence of the content and delivery of the communication cannot be made. Collectively, this indicates that there may be scope in further research that triangulates these various types of data (similar to that presented in the Boss et al. study [13] with experiential

and satisfaction data) in order to provide insights as to the perceived outcome of the communication from the standpoints of those involved.

The findings of Boss et al [13] enrich understanding as to the focus, content and interplay between clinicians and the family during conferences in the NICU. However, it is widely reported and accepted that the majority of communication is composed of non-verbal cues, interactions and tone [16]. In the limitations of their study, Boss et al [13] recognize that their data collection method and analysis did not encompass communication that was not verbalized or measurable. Subsequently, it could be argued that findings from this paper illuminate only part of a complex and multifaceted phenomenon. It is without doubt that ethical, methodological and practical challenges may inhibit the exploration and comprehension of complex phenomena, like communication, within critical care environments. However, as critical care clinicians and researchers, we need to look for, and value, the hidden, the complex and the unsaid. Certainly, within a climate of growing focus on personalized health care, in which decision making and actions seeks to comprehend the individual in the broadest sense, including biomarkers, patient/family preference, coordination, and enablement [17], it is fundamental that these subtle nuances are understood. Just as the laying a hand on a shoulder can say thousand words, critical care clinicians and researchers must learn to attend to and value the subtle, understated and tacit in the experiences of their patients and families.

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