Improving Healthcare Provider Communication in End of Life Decision Making

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Introduction

End of life decision making in the critical care setting is a complex and stressful event for all involved, including family members, patients and the healthcare team. Communicating end of life needs is a skill that requires education and supervised practice. This article describes a quality improvement project that was designed to improve communication structure during EOL decision-making. A gap analysis prior to the project revealed lack of formal education for this skill leaving healthcare providers uncomfortable and dissatisfied with current practice. The analysis also identified lack of structured family meeting guidelines in place which led to inconsistent meetings and documentation of plan of care leaving healthcare providers feeling frustrated and dissatisfied with outcomes of meetings.

Significance

Every year, 5 million patients are admitted to critical care settings, with mortality rate as high as 40% [1]. Various patient factors, such as altered levels of consciousness, sedating medications, and impaired cognition often render critically ill patients unable to make their own health care decisions, leaving family members to be their surrogates in many decisions, including End- Of-Life (EOL) choices [2]. Effective communication in this setting requires a skill that many healthcare providers have not received formal training [3]. As a result, communication between health care providers and patient surrogates about life-threatening issues in patients with acute COMMUNICATION 3 critical illnesses is often inadequate [4]. Family members have been dissatisfied with communication for decades, leading to dissatisfaction of the care of their family members [5]. Poor communication leads to psychological symptoms during the critical care stay and may persist after hospital discharge. Family members suffer from anxiety, depression, complicated grief and stress. This complex of symptoms affects quality of life and has been identified as the Post Intensive Care Syndrome-Family, also known as PICS-F by the Society of Critical Care Medicine (SCCM) [2-4]. To have effective communication one must be clear and use language appropriate for the audience. Potential barriers should be identified prior to family meetings which may include any of the following: current emotional state, stress level and educational level of the family member. The team must also identify any religious and culture preferences and consider how these may affect communication [6]. Often providers are unaware how roles in religion affect EOL choices [7]. Effective communication can improve family experiences and family satisfaction and may affect the timeliness of decision-making for the dying patient [8]. Providing a family meeting in a structured format is one method to deliver a consistent framework for conducting the family meeting in a critical care setting [9]. A structured format, such as a checklist used in this project, can provide a more comfortable, standardized approach to address difficult communication situations and can offer education and experience for providers. The chart documentation following the family meeting should mimic the structured tool, which allows other members of the healthcare team an understanding of plan and goals of care, especially when not present in the actual meeting. This understanding will lead to ongoing continuity of care in the critical care environment and should lead to decrease the occurrences of families receiving mixed messages from the team. COMMUNICATION 4 following an education session and explanation of the recommended communication format, the survey results of the project demonstrated the following:

– Participants obtained adequate basic education on end of life communication (with 90% improvement rate, P=0.015).

– Participants had improved level of comfort regarding end of life communication (with 52% improvement rate, P=0.165).

– Participants had improved level of confidence when faced with having to communicate bad news (with 72% improvement rate).

– Chart documentation had improved consistency with use of wording from the communication guidelines.

Not addressed in the article remains the interest of ethical principles involved with EOL decision making and the removal of life sustaining therapies. The principle of autonomy allows the patient the right to make their own decision in healthcare, including sustaining of life supportive therapies, as long as the patient demonstrates capacity. In the critically ill patient, this is often not the case, leaving the family as the surrogate decision maker. Not only does the healthcare team need to make recommendations which will help guide the decision, they need to allow sufficient time for the family to make that decision. There are three ethical principles which commonly surface at EOL discussions. These include withdrawing vs. withholding therapies, differentiating between the terms killing vs. allowing to die and the doctrine of double effect. Withholding therapy is considered a passive act whereas withdrawing is considered active, it is important not to make distinctions between the two and the decision should be based on burden vs. benefit. In legal terms, removal of life sustaining therapy is within the right of the patient/surrogate and therefore is not an act of killing. The healthcare team should use the verbiage, allowing for a natural death. The principle of double effect explains the tolerability of COMMUNICATION 5 an action that may cause a serious harm, such as hastening the dying process, as a consequence of promoting some good, such as providing adequate analgesia to prevent pain and suffering [10].

Conclusion

Although healthcare providers are trained to treat and cure disease, death is unavoidable. Historically, education regarding difficult conversations and especially end of life decision making has been minimal or absent in the formal setting. Family members face uncertainty while their loved one is in the critical care setting and this leads to stress and anxiety, leaving the family member vulnerable. Healthcare professionals need to continue to be the advocate for the patient and family, even at end of life. We need to take responsibility to provide clear and effective communication at all times, especially at end of life. By providing a structured format, such as a communication guideline can be a strategy to help improve this skill and improve overall satisfaction for all involved.

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