Communication as a basic skill in critical care

"Be sincere, be brief, be seated!".[1] Communication is a cultural resource of enormous value and an institutional medical activity.[2] Communication may be defined as an information exchange, but it is also the whole ensemble of relationships among involved individuals, and between them and their natural environment. Communication can be both verbal and nonverbal: The latter represents up to 65% of the human communication. Nonverbal communication uses an analogic code (while verbal communication uses a digital code), often transmitting more than we would like to share by images, gestures, and postures.

Ever since the introduction of the process of informed consent, "communication" has become important in the health system, because it involves individual rights and life quality expectation. A further dilemma is added to this process by the fact that nearly 95% patients dying in Intensive Care Unit (ICU) are unable to express their willingness regarding invasive therapies.[3] When it is impossible to communicate directly with the patients, that is, whenever the patient is unconscious or unable to cooperate, to interpreter patients' wishes and opinions about end of life decisions, physicians may ask their family, in order to take shared decisions[4] with them. This approach requires the capability to inform the family about the meaning and consequences of any single decision and the consciousness that everyone is aimed to fulfill and respect patients' wishes.

The dialog between patients' relatives and friends on one side and physicians and nurses on the other side is necessary to guarantee autonomy for taking decisions that reflect patients' inclinations, but this dialog is only possible when communication is efficient, that is when messages and news are transmitted in a comprehensive way and family can further elaborate the received information. The physician transmitting the information should speak in a clear and easy way, and the one who is listening (the relative) should give feedback to the former. A communication without feedback is not efficient: Mathew *et al.*[5] reported in the previous issue of JOACP, that 71% of people who formally received information about the clinical course of their loved one had not understood either diagnosis and prognosis or treatment. In 2000, Azoulay *et al.*[6] published that 50% of relatives experienced inadequate communication with physicians. Failure of communication may have several reasons: The use of language, cultural disparities, inappropriate setting and severe stress experienced by the families of patients admitted in ICU.

Mathew *et al.* showed that elderly relatives had more difficulties in comprehension: They hypothesized this could be attributable to reduced access to web-based research. Clarity of explanation is fundamental for an efficient communication: Data have to be essential, as the contents have to be linear and coherent with the cultural level of those receiving the message.

To excuse physicians who too often indulge in a technical language, we should remember that they spend the most part of their lives in the ICU, which is a separate world, full of peculiar experiences and technical apparatus (as mechanical ventilators and vital signs monitors) which simply have no role in "normal" life. Moreover, communication skills are rarely taught to medical students.

Curtis *et al.*[7] suggested that doctors should prepare meetings with families as they organize any other invasive medical task, verifying the most important data and taking care that their own feelings do not hinder the relationship with patient's relatives.

The physician should start from the topics that are relevant for every family and be conscious that relatives' idea of illness and perspectives may be very different from his/her own. The doctor too has to receive information and understand the news about the patient's expectations, things that families probably know better. The physicians have the duty to verify that the information exchange has happened and has been correctly given and received, especially when delicate and irreversible decision should be taken on the basis of that very exchange.

There is an evident ethical implication in achieving an effective communication. Behind the contents of communication, there is also its quality since the ethical aspect is associated with a social and affective dimension. Communication has rational and emotional elements operating at the same time[8] and the intensive care physicians should take into

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consideration the feelings of those they are informing. The emotional aspect of communication may be saved even when information is poorly understood. The patient's relative should be granted the feeling of respect and understanding for their problems. Mathew reported a good satisfaction score from the families, even if they did not understand well the patient's condition.

Rescue culture and severity of illness live together in our ICUs, small and crowded environments are the settings of short, difficult conversations: We now need to learn how to remove obstacles to efficacious communication for the sake of patients and for our professionalism.

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