

The "Dying" art of communication in the intensive care unit

Madam, Someone once said that 'two monologues do not make a dialogue'. This is very true especially in the intensive care unit where often the families of patients who are dying or critically ill wait for the physicians to communicate information, comfort, solace or hope to them. Instead they come away with a feeling of being run over by a train and their questions left unanswered in a haze of technical jargon. I am an Intensivist, I see patients who are near death every day and I see their loved ones clinging to hope and wanting to hear only the good news. I am torn at every meeting with them to give them false glimmers of good outcomes that may remain elusive. In this day and age of modern medicine, even death has shades of grey- there is no black or white. One can keep a patient 'alive' or 'not dead' by pharmacological and mechanical intervention and yet a time comes when the sad truth has to be faced and someone has to make the decision not to prolong the misery anymore. Studies have shown that providing relatives of patients who are dying in the ICU with reading material on bereavement and using communication that includes longer conferences and more time for family members to talk may lessen the burden of bereavement.¹ Other results indicate the necessity of improving the ICU environment to promote the need for proximity and privacy for dying patients and their families. There is a risk of underestimating the needs of patients without a next of kin at their bedside at the time of death.^{2,3} But in a time when time is money and physicians are over extended in terms of providing service, is it practical to spend hours on end every day with families of each patient? As doctors we learn early on in our career to separate ourselves to some extent emotionally from death and sorrow. Empathy has its spectrum and varies from person to person but no where in the curriculum of a medical college or a residency program is 'the art of communication 101' taught. West etal⁴ describe how Palliative care consultants play an increasing role in assisting critical care clinicians

with end-of-life communication in the intensive care unit (ICU). One of the ethical principles these consultants may apply to such communication is nonabandonment of the patient. However this is new and often the team approach works better. Families feel close to the physician who has admitted the patient from the start. This may be the ER doctor, the primary care doctor or general practitioner or the surgeon who operated on the patient. Intensive care physicians often enter the picture at a much later stage⁵ and may not have the trust of the family member, especially when being the harbinger of ill tidings. Nurses play a crucial role. Families often spend hours at the bedside of a dying patient with only the nurse there to offer solace and a shoulder to cry on. Often they become a part of the ordeal.

Despite all this insight, I still see death and sorrow on rounds and the confused faces of those at the bedside still leave me bewildered as to how a physician is to make the process of dying better and bearable for them.

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Références

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