The critical care doctor as communicator

Dilip R Karnad comments on H R Bawaskar's account

Being in charge of an ICU, I have some experience in dealing with situations similar to that described by Dr Bawaskar. Sudden development of a potentially fatal illness in a healthy person can be very disturbing to the relatives, especially if the patient happens to be young. In such a situation, the observations about the illness by the doctor who sees the patient first are vital. Invariably the family doctor who knows the family and their health problems over several years, is called first. When this trusted person comments on the prognosis, it is better received than when a doctor who has seen the patient for the first time talks of the possibility that the patient may not survive the illness. Diseases which could develop suddenly include cardiac arrhythmias, subarachnoid haemorrhage, polytrauma, pyogenic meningitis, malignancy presenting for the first time after widespread metastasis and severe infections like falciparum malaria.

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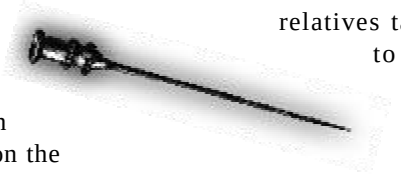
It is often not feasible for the treating doctor to talk to each of the patient's relatives. It is helpful to identify one relative who is responsible and also in a position to understand the nature of the illness. If this person is convinced about the gravity of the illness and the attempts being made to treat the patient, it is easier for this person to convey the prognosis to other relatives. Many relatives take time to be convinced that an apparently healthy person is so close to dying. How much time an individual takes to accept this varies widely. However, repeated mention of the poor prognosis by the treating doctor in an objective way could help reduce this period. Another factor which could help, or at times aggravate the problem is the consistency in conveying prognosis. Any inconsistency in prognostication by various doctors could reinforce the delusion of a close relative that the patient is not going to die, and conversely repeated and consistent statements help.



Having said all this, the job of the doctor is very difficult, to say the least. It is easy to go to the other extreme and convince some relatives that the patient is beyond all salvage. This could result in relatives denying consent to subject the patient to lifesaving treatment procedures like surgery. On the other hand, giving false hope could lead to difficulty in accepting death by the relatives. Nonetheless, the doctor must reassure the relatives that everything possible is being done to see that even if there is a small chance of recovery, the critical patient gets the best chance.

In my experience, I have not felt the need to have patients' relatives in the ICU when cardiopulmonary resuscitation is being performed. It could be a traumatic experience and many relatives could find the procedure disturbing. My personal observation is that even relatives who are medical doctors prefer to wait outside the ICU rather than be present to observe cardiopulmonary resuscitation. Hence we do not allow relatives to witness CPR in our ICU.

Another dilemma that a doctor faces is whether after death of the patient he should try to console the close relatives like a family member. If the doctor knows the family well even before the patient's illness, this may be in order. However, if the doctor has met the family only after the onset of the life-threatening illness, objectiveness is more likely to help. Other family members could lend psychological support to the aggrieved relatives. The problem may be different if there is a single relative with the patient. Here too a sympathetic and understanding nurse may find it easier to console the solitary relative who may need help with matters that they may be reluctant to convey to the doctor.

Face to Face

Medical technology allows physicians to act as if we no longer need to talk to patients. A patient comes in with back pain, and our MRI will show if it is real ("real" here means "surgically correctable"). Another presents with chest tightness and our catheters and nuclear medicine scans will tell us if the problem is in the heart or in the head. ... I do not question the importance that many medical technologies have in helping us diagnose and treat disease... Nevertheless, the benefits of these medical technologies come at a significant cost: physicians are losing the art of speaking with and examining patients, face to face, hand to abdomen, and stethoscope to chest wall....

From Doctor talk: technology and modern conversation by Peter A Ubel. *Penn Bioethics* 1998 Winter. IV(1): 1, 4.