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THE NEED FOR FAMILY MEETING IN THE MANAGEMENT OF PATIENTS ADMITTED INTO THE INTENSIVE CARE UNIT: EXPERIENCE FROM A TEACHING HOSPITAL IN NIGERIA
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THE NEED FOR FAMILY MEETING IN THE MANAGEMENT OF PATIENTS ADMITTED INTO THE INTENSIVE CARE UNIT: EXPERIENCE FROM A TEACHING HOSPITAL IN NIGERIA

K. U. TOBI and B. I. ABHULIMHEN-IYOHA

ABSTRACT

***Objective*: To evaluate the knowledge of family members of patients admitted into the Intensive Care Unit (ICU) in terms of their patients' clinical state, reasons for admission and progress of treatment.**
***Design*: Prospective, cross-sectional study.**
***Setting*: General Intensive Care Unit of the University of Benin Teaching Hospital, Benin City, Edo State, Nigeria.**
***Subjects*: Twenty-five family members of patients admitted into the ICU were recruited. The data collected included socio-demographic characteristics, level of education, awareness of the indications for ICU admission, expectations of outcome and level of satisfaction with family meeting.**
***Results*: Fifty- six percent of family members claimed to be aware of the indication for admission into the ICU while 44% claimed ignorance. Only 24% of thefamily members who claimed to be aware were correct about the indication for admission. Among the participants, 36% were well informed about the prognosis of their patients' clinical condition. All the relatives interviewed were satisfied with the family meeting held with them.**
***Conclusion*: Majority of family members of critically ill patients were neither carried along in the management of their patients nor were they informed of likely outcome. A timely, well-planned and regular family meeting is therefore advocated in the management of critically ill patients.**

INTRODUCTION

One of the major challenges of caring for critically ill patients is the inability to communicate directly with them (1). As a result of this, critical care physicians involve patients' family members in what is referred to as "family meeting."It is a forum where the clinician meets with family members of patients admitted into the Intensive Care Unit (ICU) to discuss patients' clinical condition, progress of treatment and prognosis. It also addresses issues of matters of life and death, benefits and burdens of ICU care, the goals and values of the patients and family (2).

The benefits of family meeting in the ICU have been established previously. In fact, family members of patients in the unit have ranked effective communication with care givers as a primary concern alongside the skill and knowledge of the critical care personnel (3). Adequate knowledge about the state of their patients in the ICU has been found to improve their level of satisfaction with care (4,5). In addition, it helps to improve efficient utilisation of scare and costly ICU resources and personnel (6,7). On the other hand, failure to communicate effectively with family members has been found to be associated with adverse outcome for patients, their relatives and the clinicians (8,9).

A routine and carefully planned family meeting can enhance patients care and coping of family members. The common needs of relatives of patients in the ICU include the need to learn about the conditions of their patients, to feel useful, to express their feelings about the situation and to obtain emotional support (10). Despite these obvious advantages of improved

communication and awareness of family members, very few centres conduct a regular, stepwise and effective family meeting (11).

We interviewed family members of patients admitted into our ICU (in a series of family meetings) to evaluate their knowledge of their patients' clinical state, reasons for admission and progress of treatment.

MATERIALS AND METHODS

Setting: The Intensive Care Unit of the University of Benin Teaching Hospital (UBTH) is a seven bedded open, multi-disciplinary ward. The activities of the unit are coordinated by the consultant intensivist, ably assisted by a group of consultants and residents in the department of anaesthesiology.

Study design: It was a questionnaires-based prospective survey of the knowledge of family members of patients admitted into the ICU within the study period. For the purpose of this study, a family member was defined as anyone who stayed with the patient in ICU and took responsibility for the day-to-day care of the patient.The data collected included socio-demographic characteristics, level of education, awareness of the indications for ICU admission, expectations of outcome and level of satisfaction with family meeting. Satisfaction with family meeting was on a scale of '0 to 10', '0' meant very dissatisfied while ten meant very satisfied. Other parameters obtained were mechanical ventilation and ionotropic support.

Data analysis:Continuous data were expressed as the mean and standard deviation (SD) and were compared using the t-test. Categorical data were expressed as percentages and compared using the chi-square test. Analysis was performed using SPSS version 18.0 and statistical significance was defined as a pvalue of less than 0.05.

RESULTS

Twenty five family members of patients admitted into the Intensive Care Unit (ICU) of UBTH were interviewed. Wives of patients in the ICU constituted the majority (40%) of patients' relatives involved in the questionnaire-based interview. This was followed by husbands, mothers and sisters representing 12% each, Table 1.

Majority of the patients' relatives had tertiary education (72%), 20% had secondary education while 4% had only primary or no form of formal education, Table 2. Despite this, the level of education of relatives had no significant impact on their knowledge of the indication for admission to ICU, Table 3.

Fifty six percent of the relatives claimed to be aware of the indication for admission into the ICU while 44% claimed ignorance (Figure 1). However, only 24% of those relatives who claimed to be aware got the indication for admission correctly(Figure 2). Regarding the expectation of ICU outcome, 64% of the relatives had uninformed expectation. On the breakdown, only 36% were well informed about the prognosis of their patients' clinical condition. (Figure 3)

All the relatives interviewed were satisfied with the family meeting held with them. On a scale of 0 to 10, 48% of the relatives scored the family meeting ten out of ten, 40% scored it eight out of ten while 8% and 4% scored it seven out of ten and nine out of ten respectively. Majority (60%) of the participants wanted the family meeting to hold everyday, 32% wanted"as the need arises" while 8% wanted it every three days (Table 4).

Table1
Age distribution of patients

Age (years)	Frequency	Percentage
<20	2	8
21-25	3	12
26-30	3	12
31-35	4	16
36-40	3	12
41-45	1	4
46-50	2	8
51-55	1	4
56-60	2	8
61-65	2	8
>65	2	8
Total	25	100

Table 2
Relatives present at family meeting

Relative	Frequency	Percentage
Father	1	4
Mother	3	12
Husband	3	12
Wife	10	40
Son	1	4
Daughter	2	8
Brother	2	8
Sister	3	12
Total	25	100

Table 3
Relatives level of education

Level of education	Frequency	Percentage
None	1	4
Primary	1	4
Secondary	5	20
Tertiary	18	72
Total	25	100

Table 4
Relatives' level of education vs. awareness of indication for ICU admission

Relatives' level of education	Relatives' awareness		Total
	No	Yes	
None	1	0	1
Primary	1	0	1
Secondary	3	2	5
Tertiary	6	12	18
Total	11	14	25

P-value = 0.199

Figure 1
Relatives' awareness of the indication for ICU admission

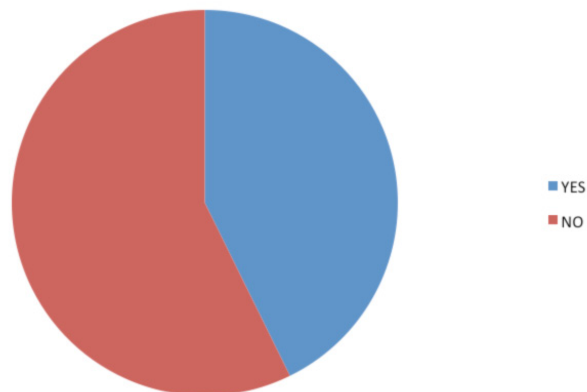


Figure 2
Accuracy of relatives' awareness of the indication for ICU admission

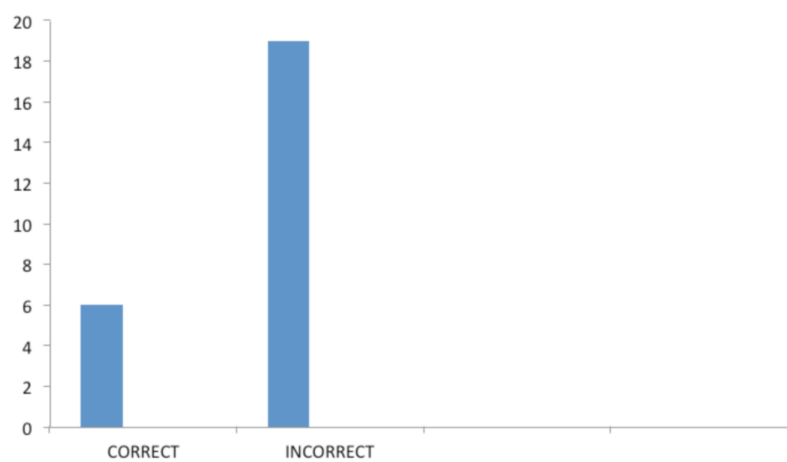
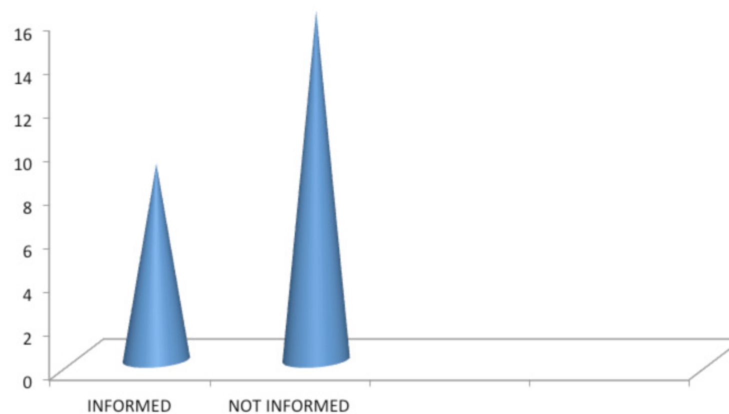


Figure 3
Relatives expectation of ICU outcome



DISCUSSION

This study revealed that although many family members claimed to know the indication for the admission of the patients to the ICU, majority of them did not; a finding which indicates that gaps exist between the care giver and the family members of patients admitted in the Intensive Care Unit of the hospital. This is in consonance with the findings of Teno *et al* (11) more than a decade ago in which less than 40% of family members of patients admitted for more than two weeks in the ICU reported that they did not have any form of communication with the doctors about prognosis and treatment.

Several factors have been observed to be responsible for failure of family meeting or forum in the critical care setting. One of such is time constraint (2). The ICU is a very busy ward both for the physicians and other care-givers. As a result of this, only very few clinicians working in the unit have the time to conduct a thorough family meeting. Although there is no consensus on the average duration of family meeting in the literature, an approximate time of 30 minutes seems to be typical (5). Based on this, an ICU physician in our centre will spend at least 150 minutes to hold family meeting every day. This is apart from preparing for the meeting and appropriate documentation thereafter.

Another barrier to effective family meeting in the ICU is the presence of multiple care givers (2). The care of the critically ill patient is usually shared among multiple specialists. In a teaching hospital setting like ours, different physicians attend to patients in the ICU apart from the primary physician and the ICU specialist. In this scenario, no physician is clearly identified to be primarily responsible for conducting family meeting. In addition, family members of patients in the ICU do not know who to discuss with about their patients. Assigning responsibility for family meeting to a particular care giver in the ICU may help to solve this challenge.

We observed that the level of education of family members had no significant impact on their awareness of the indication for admitting their patients to ICU. This is contrary to what would have been expected since effective communication requires some form of educational background. On the other hand, it shows that every family member no matter their educational background has the capacity to understand the nature of their patients' illness, the course of treatment being provided and the prognosis. For this to happen therefore, effective communication skill on the part of the care giver becomes imperative.

It is sad to note that few physicians are able to effectively communicate with family members of their patients. Inadequate training of physicians in communication skills has been identified as a major barrier to "high-quality palliative care for critically ill patients and their families" (12). In order for effective communication between clinicians and family members to occur, the clinician must be able to explain in layman's terms the often complex and difficult medical terms. In addition, he/she must provide information regarding prognosis that will enable family members make proper decision about treatment options and to prepare them in the face of a patient's death. The development of curriculum regarding effective communication in the critical care setting will help to solve this problem.

In addition, this study showed that majority of family members (65%) were not informed about the likely outcome of their patients' conditions. In a similar study, only 26% of surrogates reported that physicians discussed the prognosis for survival, functional limitations and quality of life (13). As a result of this, many family members do not have a good basis for expectation of outcome of their loved ones while in the ICU. In the study quoted earlier on (13), the authors observed that family members had higher expectations of outcome that were discordant with patients' clinical state and physicians' expectations. Decision-making regarding patients' status, instituting or withholding any form of therapy becomes difficult for the uniformed family members.

All the family members interviewed were satisfied with the family meetings held with them. Previously, family members of patients in the unit have ranked effective communication with care givers as a primary concern alongside the skill and knowledge of the critical care personnel (3). Meeting with family members of patients in the ICU has been associated with better satisfaction; increased awareness of the conditions of their patients and the feeling of being useful (10). However, the regularity and pattern of family meetings in the ICU varies widely (16). Lilly *et al* (14) had suggested that a formal family meeting be held within 72 hours of admission "for patients predicted to have a more than five days stay in ICU, a mortality risk greater than 25%, or a significant decline in functional status". Furthermore, Gay and co-worker (15) suggested that a family meeting be held to address goals of care when selected procedures are under consideration such as tracheostomy for protracted ventilator dependence or feeding tube placement after a prolonged period of critical illness. Whatever pattern that may be adopted, it is obvious that regular family meeting is necessary in the care of patients in the ICU.

Although only 25 family members were enrolled for the study, the findings that majority of family members of critically ill patients were not carried along in the management of their patients is worrisome. Family members of ICU patients often have wrong and uninformed expectations of outcome which heighten anxiety and dissatisfaction. A timely, well-planned and regular family meetings is therefore

imperative in the management of critically ill patients.

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