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# Contradictions and communication strategies during end-of-life decision making in the intensive care unit☆,☆☆

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**Abstract**

**Purpose:** The aim of this study was to identify inherent tensions that arose during family conferences in the intensive care unit, and the communication strategies clinicians used in response.

**Materials and Methods:** We identified 51 clinician-family conferences in the intensive care unit from 4 hospitals in which the attending physician believed discussion of withdrawing life-sustaining treatments or delivery of bad news would occur. The communication between clinicians and family members was analyzed using a dialectic perspective.

**Results:** The tension of choosing whether to "let the patient die now" versus to "not let the patient die now" was the central contradiction within the conferences. Under this overriding theme were 5 categories: killing or allowing to die; death as a benefit or a burden; honoring the patient's wishes or following the family's wishes; weighing contradictory versions of the patient's wishes; and choosing an individual family member as decision maker or the family as a unit as decision maker. In response to these contradictions, clinicians used 2 clusters of communication strategies: decision-centered strategies and information-seeking strategies.

**Conclusions:** This study offered insights into end-of-life decision making, prompting clinicians to be conscious of the contradictions that arise and to use specific strategies to address these contradictions in their communication with families.



## 1. Introduction

The course and nature of dying have changed dramatically in recent decades. Today, more than 1 in 5 (22.4%) Americans die after being treated in an intensive care unit (ICU) [1]. Most deaths of patients in the ICU are preceded by a decision to limit life support [2-7]. Family members and clinicians usually make end-of-life (EOL) choices because less than 5% of patients in the ICU are able to communicate or have decision-making capacity at the time decisions are made [3,8]. Communication about EOL care often guides

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decision making concerning medical interventions the patient receives at the end of life [9,10]. Research to date has shown promising outcomes from communication interventions such as ethics consultations, planned family conferences, or structured communication programs [11-16]. Improved communication between the health care team and the patients' family appears to decrease the length of stay in the ICU and hospital for patients who ultimately die [12-16] and reduce the occurrence of disagreement among clinicians and between clinicians and family members [12]. Despite these benefits, little light has been shed on what actually occurs within the black box of communication about EOL decisions in the ICU. To better understand communication with families, a study was conducted consisting of 51 family conferences in the ICU where the issue of foregoing life-sustaining therapy was raised or where bad news was delivered [17]. With the goal of providing guidance to clinicians around EOL communication, this manuscript reports the findings of an analysis of the clinician-family communication during the conferences using the dialectical perspective, a theory of communication that focuses on contradictions and the strategies that are used to manage contradictions. The findings offer a description of specific clinician communication strategies used in response to tensions that are inherent in EOL decision making.

## 2. Materials and methods

### 2.1. Study settings and participants

Data used in this analysis were part of a larger project that used a naturalistic, exploratory design and was conducted in 4 hospitals in Seattle, Wash, between 2000 and 2002. Results from the project have been published previously including a description of 2 frameworks for describing and understanding family-clinician communication in the ICU and identification of the relationship between the proportion of physician speech and family satisfaction with communication [17,18]. After approval was received from the relevant university and hospital institutional review boards, family conferences were identified for inclusion in the analysis. Conferences were eligible if the physician conducting the conference believed the issue of forgoing life-sustaining therapy would be discussed or the physician planned to break the bad news. If any person who planned to be present at the conference declined participation, conferences were considered ineligible.

Of 111 families eligible to participate, 17 families were not approached at the request of the attending physician or nurse caring for the patient. Because of concern of potential litigation, another 2 were excluded for risk-management reasons. Twenty-four families approached by the nurse caring for the patient refused to speak with the study staff. An additional 17 families spoke with the study staff but declined participation. Of the 111 families eligible to participate, 51 (46%) participated in the study. Only 2 conferences were excluded because of refusal on the part of a clinician (one physician and one nurse refused to participate). Eligible conferences were audiotape-recorded after written consents were obtained from all conference participants including multidisciplinary clinicians (physicians, nurses, social workers, and chaplains) and patients' families (family members and friends). Data collection procedures and characteristics of study participants have been described in detail elsewhere [17].

### 2.2. Theoretical framework and analytic approach

The analysis reported here applied an existing theoretical framework, the dialectical perspective [19] to an existing data set using a directed approach to qualitative content analysis. The dialectic perspective has been used by social science researchers to examine interpersonal relationships and relational communication [20-22]. The theory proposes that the universe and reality are organized around contrasting and opposing forces that are inseparable while simultaneously, oppositional [23,24]. The dialectical perspective has 2 main concepts: contradictions and the communication strategies used to manage them. Contradictions, also referred to as dialectical tensions, are aspects or forces of a single issue that are opposite yet mutually defining, unified, and inseparable [25]. The existence of one side of a contradiction presupposes the existence of the other [26], such as subjective-objective or life-death. In this analysis, a contradiction was defined as points of view or issues that are opposite yet mutually defining. A contradiction does not necessarily represent conflict between participants. Indeed, both sides of a contradiction may be presented by one individual. Identification of contradictions in this analysis was limited to those that addressed some aspect of EOL decision making in the ICU such as killing versus allowing to die. Communication strategies within the dialectical perspective are actual practices that people use to manage contradictions [22]. From the dialectical perspective, the focus is not on trying to solve contradictions but rather to recognize the continuing choices that each person has to make in response to these opposing forces [25]. Given the nature of family conferences, the physicians leading the conferences were typically the spokespersons and did most of the communicating with the families. As a result, the strategies used and reported primarily reflect physicians' communication in these settings. Using the dialectical perspective, this analysis identified (1) contradictions that were manifested in clinician-family communication about EOL decision making or delivering bad news during family conferences in the ICU and (2) the communication strategies that were used by clinicians to manage these contradictions.

### 2.3. Data analysis

This analysis used a directed approach to qualitative content analysis where an existing theory or prior research