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FROM THE INSIDE

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"Not out of the woods"—a wife's perspective: bedside communication

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My silent journey started on 17 July 2010 when my husband was involved in a motorbike accident (MBA) and given less than a 1 % chance of survival by the attending doctors. On that day, without any warning or training, I became the matriarch, a single mother, a carer and a lonely victim. It is obvious that all the attention is focused on the patient and not much consideration is given to the families, who are left to deal with their own emotional and psychological trauma. Along this traumatic, yet amazing journey, I met some incredible medical staff who exhibited exceptional emotional intelligence, but I also met some thoughtless individuals who lacked what I call "bedside" communication skills. These are the skills crucial to any situation, but so important in the intensive care unit (ICU) where the families are desperate for meaningful information.

My struggle started in the ICU of a large tertiary trauma centre where Darryl was rushed to the operating theatre without stopping in the emergency department. At the time of the accident, our 10-month-old daughter and I were visiting family in Belgium and it took a gruelling 27-hour flight to be by my husband's side. On arrival at the hospital, in a state of disbelief, under intense stress, I was told in a rushed and matter of fact fashion that my husband was in a critical condition and would most likely not survive his injuries. While I understand it was the duty of this doctor to inform me of Darryl's medical status, the message could have been delivered with so much more consideration and sensitivity. It may have been another "normal" working day for this doctor, but for me it was a life-changing moment that made our future very uncertain. Darryl was not just the patient in bed 22 who was involved in an MBA; he was my husband, the father of my daughter and my soul mate. Behind a bed number there is also a person, a family and a community.

Every day I would visit my unconscious husband and try to source any information about his progress. This task may seem simple, but it was a real challenge to obtain daily medical briefs and I often found myself chasing doctors and surgeons. Darryl had ten operations during his ICU stay, numerous people were involved in his care and it was impossible to speak to all of them on a regular basis. While the intensivists were overseeing his care, there was not one consistent contact person throughout his 5-week stay in ICU that I could approach to better understand his evolving medical puzzle. Each week and depending on the time of day, new intensivists would be appointed to Darryl's case. Some were exceptional communicators and took the time to explain and some made you feel like you were an inconvenience, taking up too much of their precious time. Another layer of difficulty was added when some doctors started using medical jargon and expressions that did not make any sense for a person whose native language was not English. For example, many times I heard "he is not out of the woods" and I could not figure out the relationship between the "woods" and ICU. Physicians need to think carefully when using metaphors, which might simply

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further complicate any explanation. Trying to decrypt medical jargon and other expressions creates confusion, frustration and misunderstanding in an already complex emotional milieu. Regular meetings, preferably with the same doctor using simple words which are easily digested, would allow families to build a level of trust and have their concerns adequately addressed. These meetings need to be honest, but should aim to mitigate the stress rather than exacerbating the fear and uncertainty. After all, the person lying in ICU is not the only person that requires care.

Having good communication skills also means informing patients and their families about the possible challenges that they may face when leaving ICU. Note I use the word “may”. Always be mindful not to deliver a self-fulfilling prophecy by telling families that something will happen when it may not, but always ensure they are informed of what could occur. While my time in ICU was stressful due to the critical nature of my husband’s condition, at the same time it was a “feel safe” place where I knew that he was being looked after by the best team in the hospital. Nobody really took the time to explain the transition from ICU to the ward, where the patient no longer has the undivided attention of a critical care nurse. This was a very scary part of our journey, where we felt totally unprepared for Darryl’s move to a less controlled environment. This simple transition resulted in further unnecessary stress and anxiety for Darryl and our entire family. I would urge intensivists to take the time to explain to loved ones what to expect as they step down from the ICU. It is time to recognize a condition I refer to as *“transition shock”*. This needs to be managed, and communication and expectation management are critical to that process.

While it is obvious that all the attention is focused on the patient, it is important to acknowledge and recognize that the loved ones are those who are often left to suffer in silence. We all undertake and express this silent journey in different ways. This journey for the patient and their families can be positively changed by doctors, who have the ability to exhibit genuine compassion, provide clear “bedside” communication and who can read the non-verbal cues. This is especially true in ICU as the silent victims are emotionally distressed and are often left to make important decisions without fully appreciating all the consequences.

I would like to personally thank all the staff for the exceptional care delivered to my husband in saving his life, but in particular those who went beyond the call of duty to keep me informed in a kind and compassionate way. My plea is for recognition of the intensive care patient’s family and their real need for care, information and communication.

Epilogue

In light of this report, the ICU described in this essay is in the process of improving the transition of ICU patients to the ward, such that they will be electively followed up by an “outreach team” to ensure their continued satisfactory progress.

Compliance with ethical standards

Conflicts of interest On behalf of all authors, the corresponding author states that there is no conflict of interest.