NURSES AS INTERMEDIARIES: HOW CRITICAL CARE NURSES PERCEIVE THEIR ROLE IN FAMILY MEETINGS

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Background Nurses’ involvement in family meetings in the intensive care unit is central to supporting consistent communication and shared understanding within the care team and with patients and patients’ family members. Evidence suggests the existence of major barriers to the effective participation and contribution of nurses during family meetings.

Objectives To characterize the nature and extent of nurses’ involvement in family meetings in the intensive care unit, including identifying barriers to nurses’ participation and opportunities for involvement.

Methods Meetings with focus groups of nurses at a Veterans Affairs medical intensive care unit were recorded, transcribed, and qualitatively analyzed by using the constant comparative method.

Results Thirty critical care nurses participated in 6 focus groups. Three major themes describing nurses’ involvement in family meetings were identified: nurses can play multiple roles in supporting conduct in family meetings, nurses face critical barriers to fully realizing these roles, and nurses end up as intermediaries in family meetings. Subthemes pertained to being well positioned to act as the patient’s advocate, yet feeling undervalued and underempowered to contribute important information in family meetings, often resulting in mixed messages about care preferences, prognosis, or goals of care that nurses did not feel able to address during the meeting.

Conclusion Nurses are positioned to play essential roles in family meetings, but their full involvement remains unrealized. Communication training and greater attention to nurses’ empowerment and to facilitating the nurse-physician relationship in the context of family meetings most likely would increase appropriate involvement of nurses in the meetings. (American Journal of Critical Care. 2016;25:33-38)
Structured family meetings in the intensive care unit (ICU), whereby members of the providing care team meet with the patient and/or the patient’s family to discuss the patient’s condition, prognosis, treatment preferences, and options, are an important aspect of patient-centered care. Evidence suggests that ICU family meetings decrease family stress, increase care consistent with expressed wishes, and lead to higher ratings of the quality of dying in the ICU. Several critical care professional societies support routine structured family meetings in the ICU.

Guidelines emphasize that family meetings should be interdisciplinary, including at least an ICU physician and an ICU nurse in addition to the patient and/or the patient’s family, to ensure that multiple perspectives contribute to shared understanding and consistent communication within the care team. Patients and families report that interdisciplinary communication and collaboration are key aspects of good end-of-life care, and improved communication between nurses and physicians in critical care has been associated with better patient outcomes.

Despite recommendations for interdisciplinary ICU family meetings, evidence of poor communication and collaboration between nurses and physicians in the ICU suggests the existence of major barriers to successful involvement of nurses in family meetings. In a study of nurses in 4 adult ICUs, nurses identified the need for better communication among physicians, family members, and nursing staff, highlighting concerns about physicians not listening to nurses’ input on patient care. In another study, Thomas et al. found that compared with ICU physicians, ICU nurses were less likely to rate collaboration and communication with physicians as “high,” that more input into decision making was needed, that nurses’ input was not well received, and that nurse-physician disagreements were not adequately resolved. Such issues within the ICU care team most likely spill over into family meetings, further hindering consistency in communication and patient-centered decision making.

To better understand the nature and extent of nurses’ involvement specifically in ICU family meetings and to identify opportunities for improvement, we elicited ICU nurses’ perceptions of the nurses’ roles in family meetings and the nurses’ perspectives on barriers and facilitators to participation in these meetings.

Methods
Setting
This qualitative, cross-sectional study of ICU nurses’ experiences and perceptions of ICU family meetings was conducted in the 26-bed general ICU at the Portland Veterans Affairs Medical Center, Portland, Oregon. The study was approved by the institutional review board of the Greater Los Angeles Veterans Affairs Medical Center.

Participants and Data Source
A multipronged approach was used to recruit a convenience sample of ICU nurses for 6 focus groups offered at various day and evening times during a 1-week period. First, information sheets describing the nature and purpose of the study were distributed via e-mail 1 month and again 1 week before the scheduled focus groups. Interested nurses could respond to the e-mail by selecting a focus group to attend. The information sheets were also posted with sign-up sheets in break and conference rooms in the ICU. In addition, immediately before each scheduled focus group, 2 study investigators walked through the ICU reminding nurses of the focus group and inviting the nurses to join if interested. All participants provided verbal consent to participate at the start of the focus group.

Evidence suggests there are barriers to successful involvement of nurses in family meetings.
Nurses could play multiple, critical roles before, during, and after family meetings.

Data Collection and Analyses
On the basis of existing literature and a consensus-focused discussion, 3 members of the research team (S.C.A., T.J.P., and K.A.L.) developed an initial draft of a semistructured, open-ended focus group guide to facilitate an exploration of nurses’ roles in and perspectives of participation in ICU family meetings. Questions in the guide were refined on the basis of input provided by 2 experts with extensive research and clinical experience in conducting family meetings. Questions covered how family meetings were scheduled and conducted; how nurses participated in the preparation, conduct, and follow-up of family meetings; what the nurses would like to change about the roles they described; and what challenges the nurses faced in participating in family meetings. The lead investigator (S.C.A.) facilitated all focus groups, and a second investigator (H.S.B.) took detailed field notes during each focus group meeting. All focus groups were recorded and lasted 40 to 60 minutes. Because of a risk of identifiability, demographic information was not collected from the participants.

Recordings of focus groups were professionally transcribed verbatim. With the focus group guide as the framework, an initial codebook was developed. Two investigators (S.C.A. and H.S.B.) first independently read and coded a single focus group transcript and then met to refine the codebook to reflect any new codes. A similar process was used for 2 additional focus group transcripts; after that no new codes emerged and a final codebook was agreed on. The investigators then used this final codebook to independently code all 6 transcripts and had regular meetings to discuss new codes or any coding conflicts. Coding discrepancies were resolved through discussion and consensus. After all transcripts were coded, codes were compared within and across transcripts to develop larger categories, and identified relationships between these categories were used to develop a set of themes that integrated the data. All qualitative analyses were conducted by using ATLAS.ti, version 6.0.15, software (Scientific Software Development GmbH).

Results
A total of 30 ICU nurses participated in the 6 focus groups. Three major themes and several subthemes pertaining to nurses’ experiences, roles, and challenges associated with ICU family meetings were identified (see Table).

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<thead>
<tr>
<th>Primary theme</th>
<th>Subthemes</th>
<th>Content of discussion</th>
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<td>Expectations about scheduling and organizing</td>
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<td>Nurse as advocate</td>
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<td>Nurse as translator</td>
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Theme 1: Nurses Can Play Multiple Roles in Supporting Family Meetings
Nurses described being in a position to play multiple, critical roles before, during, and after family meetings, including coordinator, advocate, and translator. This playing of multiple roles occurred mainly because the nurses viewed themselves as the single member of the clinical team who was consistently present with the patient and the patient’s family, as well as routinely in contact with other members of the health care team and services. For example, in discussing her role as coordinator, a nurse said, “Nursing is really the hub of coordinating everything, just because we have contact with all the different services, so usually [we] are the coordinator for the meeting.”

Another nurse described how the amount of time nurses spent with patients and patients’ families by the bedside allowed the nurses to serve as advocates during the family meeting by contributing relevant information shared only with the nurses: “I think that’s the role because you’ve had a chance to have a relationship with that family member that the physician just doesn’t have. They just don’t spend that amount of time with them to be able to establish that.”

Nurses could play multiple, critical roles before, during, and after family meetings.
Nurses also described how the relationship they developed with patients and patients’ families over time positioned the nurses well to translate and reinforce information given to the patients or family members by physicians: “A lot of times people come in and say stuff and then [the family] looks at us for the interpretation of what they’re saying. Because they know us and we speak the language that they’ve gotten used to hearing.”

**Theme 2: Nurses Face Barriers to Fully Realizing Their Roles in Family Meetings**

Despite the multiple roles that nurses identified related to supporting family meetings, many nurses also described various barriers to fully realizing these roles. They described logistical barriers, such as a lack of resources, to setting up the meeting: “We’re short a person who would be making all those arrangements, would be making [the meeting happen]. . . . and it’s not the nurses doing it because they don’t have the time.”

Nurses also described feeling undervalued and underempowered to effectively contribute during the family meeting. Nurses who described feeling undervalued highlighted situations in which their input was not actively solicited by the physician: “During the meeting, I am taking notes. Sometimes the doctors will be like, ‘What do nurses think?’ but routinely I think the doctors just talk to the family.” Although nurses sometimes could not attend the meeting because of their duties of patient care, in some instances, nurses reported not being invited by the ICU physician to attend the meeting at all.

Nurses described feeling underempowered to speak up in a family meeting when their contribution might contradict what a physician was communicating to the family: “If the doctor was painting a really rosy picture that we’re going to do this and we’re going to do that and I know this [is just] a terrible situation, I wouldn’t feel that I was allowed to say, you know, this poor man is dying.”

Sometimes nurses who felt underempowered in family meetings held expectations about the role of a nurse that limited the nurses’ ability to fully participate in the meeting. For example, they thought that topics such as prognosis or palliative care were not within their responsibilities or area of expertise to broach with patients, even if the nurses knew the information needed to be communicated: “It’s not appropriate for us to be telling them this stuff. Sometimes the doctors put it on the nurses, and it’s like, whoa, whoa, whoa, this is your job. I may know it, but it’s not my place to tell them. And that’s something that needs to be addressed by the physician. And a lot of times it is not. Everything is left unsaid.”

**Theme 3: Nurse as Intermediary—Holding Information But Lacking Power**

Nurses often felt “caught in the middle,” or the “middleman person” as a result of being a consistent presence among the patients, patients’ family members, and the care team but simultaneously limited in the capacity to fully participate in family meetings. This scenario most often played out when a nurse held relevant information about care preferences communicated by a patient or the patient’s family before the meeting that was not similarly communicated during the meeting: “There’s some patients who tell us they don’t want to continue to do these kind of treatments. . . . And then when they come to meetings, they say things are going great, thank you for all of your treatment. We get stuck with hearing all the complaining, but none of the communication of this is what we really want. So some of the frustrations that we tend to voice are being the ones that are in the middle.”

Another nurse described the dilemma posed by hearing mixed messages about prognosis conveyed by physicians during scheduled weekly family meetings: “And sometimes doctors will tell them one thing and then the next week it seems like they tell them another thing. And then the next week they give them false hope on another thing. And we’re sitting there scratching our heads and pulling out our hair going, oh God, what do we do now?”

For the subthemes of feeling undervalued or underempowered in the family meeting, nurses typically described not being able to address such discrepancies in communication during the family meeting. Mixed messages from physicians often resulted in a conflict over goals of care that was a particular concern to nurses: “In certain cases there is a huge disconnect in goals of care . . . amongst the teams a lot of times. Different doctors have different opinions. So, there can be a disconnect between what they say to the family. Then the goals of care will change and it seems like we backpedal sometimes.”

**Discussion**

Nurses have an important role to play in ICU family meetings, by sharing information about the patient’s condition, advocating for the patient’s wishes, and helping patients and patients’ families understand the care plan.19 Interdisciplinary ICU family meetings are strongly recommended to address the concerns of patients and patients’ families and clarify goals of care.10 Our findings suggest that despite being in a position to play multiple,
important roles pertaining to family meetings, optimal involvement of nurses in these meetings is limited by several factors. Our findings reflect and are similar to larger challenges ICU nurses face in their daily practice and communication with patients, patients’ families, and physicians. Recent efforts to improve nurses’ participation in family meetings have focused on end-of-life care, training in communication skills, and education; however, greater attention to empowering nurses within the interprofessional team and to strengthening the nurse-physician relationship may be needed to engender sustainable improvements in the way family meetings are conducted.

A more proactive approach to involving nurses in family meetings may be necessary to facilitate nurses’ participation and maximize the potential for family meetings to increase the quality of ICU care. Like nurses in other studies, the participants in our study thought that physicians did not actively solicit nurses’ input during family meetings. In addition, nurses reported that they often heard conflicting messages on care preferences or prognosis during the family meeting but did not call out these discrepancies during the meeting. These findings highlight a major gap in the conduct of family meetings, whose purpose is to facilitate consistent messaging and align understanding between participants about the patient’s condition, prognosis, and goals of care. Creating a designated time and space during ICU family meetings for nurses to contribute relevant information, address any unspoken wishes the patient may have expressed separately, and highlight potentially conflicting information communicated between participants may increase nurses’ involvement. The designated time might be during the meeting or immediately before the meeting (eg, the premeeting huddle) when the nurse and physician share information, develop a plan for the meeting, and align communication.

Nurses’ expectations of their role in family meetings may pose an important constraint to the nurses’ full involvement in these meetings. The nurses in our study reported a belief that it was not within their role to broach topics such as prognosis or palliative care during family meetings, even when the nurses knew such information needed to be communicated. Clear and consistent communication about prognosis and other difficult topics during the family meeting is central to ensuring that patients receive timely and appropriate preference-concordant care throughout the course of care and particularly at the end of life. Although our findings suggest that nurses view these topics as outside of their role and scope of practice, other investigators suggest that nurses prefer greater involvement in communication related to advance care planning. Moreover, physicians generally think that nurses are competent to communicate with patients and families about prognosis, goals, and end-of-life treatment preferences. Helping nurses reset their expectations about their roles in family meetings may help increase effective involvement of nurses in the meetings.

Greater empowerment most likely is a necessary and critical component of any effort to increase nurses’ involvement in ICU family meetings. Nurses reported feeling underempowered to speak up during family meetings, particularly when their input contradicted information a physician was conveying. Nurses also said that they often did not address mixed messages about prognosis or conflicts about goals of care during family meetings. Nurses have previously reported moral distress in situations in which they perceived that inappropriate care was delivered as a result of the mismatch between prognosis and care and in situations in which they did not agree with decisions made by physicians. Often this moral distress is associated with nurses’ inability to take corrective actions because of systems-level constraints or the perceived inability to influence end-of-life decision making. Attention to empowering nurses in the ICU to become active participants in the family meeting within the context of the interprofessional team may decrease unspoken and unaddressed conflicts and consequently decrease moral distress and burnout of nurses. Furthermore, such empowerment may lead to greater shared responsibility by ICU physicians and nurses, a change that may be an appropriate goal in the context of the interdisciplinary family meeting.

Because our study was done at a single center, the generalizability of our findings is limited. Because our recruitment strategy was designed to maximize participation across day shift and night shift nurses, we have some selection bias in our study sample. However, we think that the information collected across shifts provides a deeper understanding of nurses’ perceptions of their participation in family meetings. Finally, observing nurses’ participation during family meetings was beyond the scope of this study; these data most likely would further support our nurse-reported findings about nurses’ involvement in ICU family meetings.

Nurses are uniquely positioned to play essential roles related to ICU family meetings, yet nurses’ full and effective participation remains unrealized. In
addition to moral distress and burnout among ICU nurses, limited involvement in family meetings most likely has an adverse effect on the decision making and satisfaction with ICU care of patients and patients’ family members. Efforts to improve nurses’ expectations of their role, to empower them to contribute, and to create the time and space necessary for them to fully participate may successfully increase nurses’ involvement in ICU family meetings.

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REFERENCES


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