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Clinicians' Perceptions of the Usefulness of a Communication Facilitator in the Intensive Care Unit

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Abstract

Background—Despite its documented importance, communication between clinicians and patients' families in the intensive care unit often fails to meet families' needs, and interventions to improve communication are needed. Use of a communication facilitator—an additional staff member—to improve communication between clinicians and patients' families is the focus of an ongoing randomized trial. The clinical team's acceptance of the communication facilitator as an integral part of the team is important.

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Objectives—To explore clinicians' perceptions of the usefulness of a communication facilitator in the intensive care unit.

Methods—Fourteen semistructured qualitative interviews to assess perspectives of physicians, nurses, and social workers who had experience with the communication facilitator intervention on the intervention and the role of the facilitator. Methods based on grounded theory were used to analyze the data.

Results—Clinicians' perceived facilitators as (1) facilitating communication between patients' families and clinicians, (2) providing practical and emotional support for patients' families, and (3) providing practical and emotional support for clinicians. Clinicians were enthusiastic about the communication facilitator but concerned about overlapping or conflicting roles.

Conclusions—Clinicians in the intensive care unit saw the facilitator intervention as enhancing communication and supporting both patients' families and clinicians. They also identified the importance of the facilitator within the interdisciplinary team. Negative perceptions about the use of a facilitator should be addressed before the intervention is implemented, in order to ensure its effectiveness.

More than 5000 intensive care units (ICUs) in the United States house the most critically ill patients of our health care system.¹ These patients are often unable to make decisions for themselves and, with little or no preparation, family members are asked to act as surrogate decision makers for their loved ones in unfamiliar, highly stressful environments. In these challenging circumstances, quality communication between ICU clinicians and patients' families is a dimension of the ICU environment that enhances outcomes for patients' families, resulting in increased satisfaction with care, fewer conflicts with clinicians, less troubled end-of-life decisions, and a reduced burden of emotional symptoms both during and after the ICU stay.^{2–6} Despite the documented importance of communication between patients' families and clinicians, numerous studies suggest that family-clinician communication in the ICU often fails to meet families' needs and that interventions to improve that communication are needed.^{7–10}

A communication intervention that uses a facilitator—an additional staff member trained in mediation, attachment theory, and communication—is the focus of an ongoing randomized trial, the “ICU Family Communication Study,” being implemented at a critical illness referral center in Seattle, Washington, and serving a multistate area.¹¹ The attitudes of ICU clinicians toward a facilitated communication intervention have not been studied and are the focus of this research. Using semistructured interviews with physicians, nurses, and social workers (referred to collectively as “clinicians” in this article) who cared for patients enrolled in the ICU Family Communication Study, we describe clinicians' perceptions of the usefulness of a communication facilitator in the ICU.

Methods

Intervention

The facilitator intervention incorporated 3 components: (1) a mediation component to resolve conflicts between staff and patients' families, among patients' family members, and

among staff,¹² (2) an attachment theory component enabling facilitators to individualize communication to meet families' psychological needs,^{13,14} and (3) a communication component in which evidence-based guidelines were used to guide end-of-life care communication.^{15–17}

We used 2 facilitators: a critical care nurse and a social worker, who were research, not hospital, staff. Clinicians in these disciplines have training in communication and interpersonal skills as well as an understanding of the hospital environment upon which we built our facilitator training. Training included both didactic and role-playing exercises in a 2-day workshop; half-day refresher courses were completed annually. In addition, facilitators met regularly with investigators to review intervention cases and confirm faithful implementation of the intervention's skills and strategies. Facilitators met with clinicians to describe the study and to request clinician approval to consent eligible families.

Measures

The clinicians' interview was developed by an interdisciplinary research team that included a Master of Public Health student, a social worker, 2 critical care physicians, and an educational psychologist. The facilitators also reviewed the interview questions to ensure that they addressed the activities that they were implementing.

The interview used semistructured questions that allowed participants to evaluate the utility of the intervention generally, and then in relation to each of the intervention's 3 components. They were also asked to provide suggestions for improving the intervention (see Table).

Participant Recruitment

To identify participants who were familiar with the intervention and could provide an informed assessment, we asked the facilitators to provide a list of clinicians meeting the following criteria: (1) had interacted with the facilitators recently (in the past 6 months), (2) provided care to 1 or more patients and families who were assigned to the intervention, and (3) represented diverse perspectives, as perceived by the facilitators. All potential participants who were contacted agreed to an in-person interview. Study procedures were approved by the Human Subjects Division of the University of Washington; informed consent was obtained from all participants.

Data Collection

Interviews were conducted by a Master of Public Health student (A.H.) who had previous experience as support staff in the ICU but was not currently a staff member. Interviews were audiotaped and transcribed and lasted from 20 to 45 minutes.

Data Analysis

We used analytic methods drawn from grounded theory but did not include theory development.^{18,19} In order to develop a set of "open codes," interviews were initially coded line-by-line by 1 investigator (A.H.) and were then reviewed by the research team (n=4) to include those that were relevant and appropriate to the study's aims. "Axial coding" (ie, linking codes through circumstances, conditions) was completed by 1 investigator (A.H.)

and reviewed by a second (E.N.). Finally, recurring themes describing clinicians' experiences were identified across interviews. In order to assess trustworthiness,²⁰ these themes were co-reviewed by a member of the research team (E.N.) and reported an 80% concurrence rate.

Results

Participants

Fourteen interviews were completed in a 6-month period at approximately 30 months after the start of the intervention; they included 4 social workers, 5 nurses, and 5 physicians with critical care experience ranging from 4 to more than 40 years. Eleven of the 14 interviewees were women. Physician specialties included neurosurgery, cardiology, and pulmonary and critical care medicine. Nurses and social workers worked in 4 diverse ICUs: medical/surgical, trauma, burn, and neurological.

Themes

The interviewees identified 3 roles for the communication facilitator: (1) contributing to more effective communication between family and clinicians, (2) providing practical and emotional support for families, and (3) providing practical and emotional support for clinicians. The interviewees also provided recommendations regarding facilitators' roles and responsibilities.

Facilitating Communication Between Family and Clinicians

Interviewees reported that facilitators contributed to increased engagement between patients' families and their clinicians by sharing information *from* families *to* clinicians, and providing information *from* clinicians *to* families.

Communication From Patients' Families to Clinicians—Interviewees described the facilitators as providing significant new information to clinicians. A social worker reported that before she had even met the patient's family, the facilitator had already met the family and identified a need:

A family wanted . . . to be on a housing list and [the facilitator] didn't know how that worked, but she knew that social workers were involved. And she referred the family to me.

A physician noted that, despite having had positive interactions with a patient's mother for many days, he/she was unaware of a new issue until the facilitator brought it to his/her attention:

The mom had a big issue about the patient being moved out of his room to a different room . . . I got a heads up from [the facilitator] . . . that [the mom] was having adjustment problems with that. So that was helpful [because] that's definitely a red flag for families when patients move a lot.

Communication to Families From Clinicians—The facilitator's role in sharing information from clinicians to patients' families was seen as an opportunity to explain and

clarify the experiences of patients' families and, in a limited way, to provide information on the patient's medical status. A social worker stated:

Having another person make sure the family members understand what's going on. That's the biggest piece of it.

However, some interviewees were cautious about how much to rely on, or delegate to, the facilitators when talking about the patient's condition. This nurse stated:

...as long as it's someone in the medical field. They can explain a little bit more . . . trusting the facilitators . . . with simple things. But there are many things only the nurses and the doctors who have spent enough time with the patients and the family can help.

Providing Practical and Emotional Support for Patients' Families

The interviewees also described the facilitators as providing emotional and practical support to patients' families. In this capacity, the facilitators provided "assistance or comfort," what clinicians generally termed as "help," directly to the patient's family even when no specific information was conveyed. A nurse talked about families of critically ill patients that needed extra emotional support:

It's really hard when you have everyone talk about what would be acceptable [in] terms [of quality of life] and you have one family member who says, "I can't do this. I can't lose him. . . . And that's where I think the [facilitator] is helpful in just helping people talk through that.

Checking-in with the family was another way in which the facilitators provided important support to patients' families. A social worker explained:

The patient's been here for a very long time. And, I think it's always just helpful for any family to have somebody else that they connect with within the hospital, so, I think, in that respect, it's been very helpful.

Providing Practical and Emotional Support for the Clinicians

The interviewees described the facilitators as providing practical and emotional support to clinicians by (1) relieving clinicians' distress associated with having insufficient time to address the needs of patients' families, (2) providing trusting and collaborative relationships, and (3) modeling engagement with families, augmenting and enhancing clinicians' roles.

Time—Interviewees described having a "lack of time" and the facilitator "having the time" for certain tasks. Physician interviewees recognized that they often did not have the time to sit with patients' families; nurse interviewees mentioned that they focused on the patient with little time to talk with patients' families. As this nurse noted, facilitators were able to provide added value to the team as a resource person who "had the time" to spend with patients' families.

And it's sometimes nice to have an extra person there because I am so busy with medical care, I don't have time always even if I wanted to, to sit down and just talk.

Sometimes I can steal a few minutes, but it's always at the cost of time that I need to spend somewhere else.

A nurse commented that the facilitator “helps the family to calm them down, to answer some of the questions, detailed questions, details we cannot provide because we are way too busy.” The interviewees also mentioned how the facilitators could speed up or smooth out the communication process, “saving time” for clinicians.

A Trusted Relationship—Trust in the facilitator's role as a support person—to do a job that would enhance the effectiveness of the ICU team as a whole—was mentioned in many of the interviews. Interviewees trusted the facilitator to provide accurate, important information. A physician stated that the facilitator provided useful “information and insights into family dynamics or what particular family members are thinking about.” Another physician had confidence in the facilitator's opinion about how to approach families:

I think [it's very] helpful . . . if [the facilitator] is interacting with the family in a different way for us a get a sense of what the family's understanding of what we're telling them. To actually get a sense of what they're perceiving.

A social worker similarly indicated confidence in the facilitators' perceptions:

I think that a lot of times we'll chat and exchange pertinent information back and forth. Sometimes they are aware of some aspect of family dynamics that I may not have been aware of, to help me to know that information and be able to do a better job of working with the families.

Modeling Engagement—The interviewees also described the facilitators as demonstrating skills and perspectives that expanded their own professional role. A social worker explained:

I mean, sometimes it works out when [the facilitator] is meeting with their family, because they are coming from a different point of view, they're not coming from the point of view of the social worker . . . So I feel like we might miss something . . . when [the family] meets [the facilitator] then they may . . . be able to open up more.

A nurse similarly noted:

On a personal level and professional level, I can always be better at communicating. So I love listening to [the facilitator] give feedback and the way they go about asking questions. And talking . . . start with the small stuff. And pretty soon the deep stuff just comes. . . . So I learned a lot . . .

Several clinicians noted that the presence of a communication facilitator added an awareness of the importance of family communication. A physician stated, “If somebody thinks [family communication] is interesting enough to ask a question about, maybe I ought to think about it,” and, in this way, it becomes a “learning device.”

Clinicians' Interest in Expanding Facilitators' Roles and Responsibilities

Recommendations—Interviewees provided a number of suggestions for expanding the communication and support roles of the facilitator, including (1) entering notes in the medical chart about their interactions with patients' families so that clinicians could easily access pertinent information, (2) attending ICU rounds, (3) providing practical support for the team, including scheduling family conferences, and (4) working with families of patients who are not critically ill.

Cautions—Although most interviewees evaluated the facilitator role positively, some expressed caution. Two of the interviewees questioned the need for a facilitator because they thought that they already fulfilled the role. One social worker stated that adding a facilitator resulted in “too many cooks in the kitchen” and expressed the hope that the nurses would call the social worker directly if there were any problems with patients' families. This person thought that s/he knew how to deal with families, had the time to get the information s/he needed, and did not need additional communication input or support. One physician mentioned that the physicians and the facilitator were in “parallel roles”; the physician “did some of that stuff” him/herself.

Some interviewees worried that the facilitators might overstep their role. One clinician was more comfortable with the role of the facilitator updating the clinicians when more communication might be needed, rather than acting as an advocate for patients' families. Another interviewee, a physician, stated that s/he was not entirely comfortable with the facilitators communicating clinical information back to the families; s/he was unsure that they could do so objectively and in support of the ICU team:

One concern I would have is I think people often develop their own opinions about what should happen in a particular situation . . . What could be really harmful is if in these facilitators' communications with the family, they were to start contradicting what the team was going to say.

A similar concern was expressed by a social worker, who worried that, by expressing his/her personal opinions to a patient's family, particularly in the setting of a family meeting, a facilitator might distract, confuse, or unsettle the family. At these meetings with the medical team, s/he thought that the patient's family should focus solely on the physician's presentation. This interviewee went on to say that s/he felt that patients' families would be better served if the facilitator remained a neutral observer in family conferences.

Discussion

We explored the attitudes of physicians, nurses, and social workers toward a communication facilitator intervention for families and clinicians in the ICU. Our findings suggest that the intervention was well-received by clinicians across disciplines. The facilitator was seen as a resource for clinicians and patients' families, enhancing the exchange of information among clinicians and patients' families as well as providing separate practical and emotional support to families and clinicians.

Interprofessional relationships in the ICU are complex, and clinicians experience stressors that include emotional, communication, and collaboration issues.^{21–24} Qualitative and quantitative studies that have examined attitudes, interrelationships, and communication issues between ICU physicians and nurses report issues of trust and time affecting communication.^{10,25–29} Cognizant of the interdisciplinary aspects of their work, all interviewees consistently mentioned trust, time, and support when discussing the effectiveness of the facilitator intervention. Because successful collaborative communication—communication among all members of the health care team, their patients, and patients' families—is associated with improved outcomes for patients and their families in end-of-life care as well as with greater satisfaction among patients' families and clinicians, the facilitator may contribute significantly to these outcomes.³

Despite general acceptance of the intervention, a few interviewees expressed reservations that included overlapping roles that might result in “too many cooks” and the potential for distracting or confusing information exchange. As those concerned individuals were not limited to 1 profession, it may be individual characteristics, rather than professional training, that contribute to an individual's particular concerns. Regardless of the source of concerns, these reservations must be taken into account when introducing a new professional to the interdisciplinary team. As noted earlier, clinicians' perceptions of their own roles as potentially in conflict with those of the facilitator highlight the need to carefully integrate clinicians into the development, implementation, and evaluation of the intervention. Emphasizing the shared objectives of every member of the team and what each member brings to the team may help mitigate negative reactions.^{30,31}

This study had several important limitations. First, we interviewed only a small number of clinicians, referred by the facilitators. Although the sample was selected from a variety of disciplines and these interviewees provided critical as well as positive assessments, it is very possible that we did not have the breadth and depth of perspectives that are important to ensure that qualitative findings are appropriately inclusive and representative.²⁰ Second, we did not collect the “dose” of the intervention that each of our participants received; we therefore cannot assess whether their perceptions were based on sufficient exposure to the facilitators to provide a reliable assessment. Third, we did not explore how often clinicians actually acted on the information or truly used the facilitator for support. Therefore, these interviews cannot be used to assess the effectiveness of the intervention. These data allowed us to explore attitudes and self-reported experiences; actual behaviors and outcomes were not observed. Fourth, this study examines only clinicians' perspectives and does not incorporate the perspectives of patients' families; family perspectives are central to the effectiveness of the intervention, but clinicians' perspectives provide insights into the feasibility of implementing such an intervention. Finally, these interviews were conducted in 1 hospital from 1 region and may not be generalizable to other hospitals or regions.

In summary, this qualitative study provides insights into ICU clinicians' perspectives on the use of a communication facilitator in the ICU. Our findings suggest that ICU clinicians view facilitators as enhancing communication between patients' family members and clinicians. Facilitators are also seen as an important resource for the interdisciplinary team, providing support to clinicians as well as patients' families. Some clinicians raised concerns about

overlapping responsibilities and an increased number of team members interacting with patients' families. Although this study did not allow us to assess the effectiveness of a communication facilitator intervention, our findings can be used to guide the development of such an intervention to ensure that it meets the needs of clinicians in the ICU.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

References

1. American Hospital Association Hospital Statistics, 2011 (2009 survey data). Chicago, IL: American Hospital Association; 2011.
2. Abbott KH, Sago JG, Breen CM, Abernethy AP, Tulsky JA. Families looking back: one year after discussion of withdrawal or withholding of life-sustaining support. *Crit Care Med*. 2001; 29(1):197–201. [PubMed: 11176185]
3. Boyle DK, Miller PA, Forbes-Thompson SA. Communication and end-of-life care in the intensive care unit: patient, family, and clinician outcomes. *Crit Care Nurs Q*. 2005; 28(4):302–316. [PubMed: 16239819]
4. McDonagh JR, Elliott TB, Engelberg RA, et al. Family satisfaction with family conferences about end-of-life care in the intensive care unit: increased proportion of family speech is associated with increased satisfaction. *Crit Care Med*. 2004; 32(7):1484–1488. [PubMed: 15241092]
5. Azoulay E, Pochard F, Kentish-Barnes N, et al. Risk of post-traumatic stress symptoms in family members of intensive care unit patients. *Am J Respir Crit Care Med*. 2005; 171(9):987–994. [PubMed: 15665319]
6. Lautrette A, Ciroldi M, Ksibi H, Azoulay E. End-of-life family conferences: rooted in the evidence. *Crit Care Med*. 2006; 34(11 Suppl):S364–S372. [PubMed: 17057600]
7. Shanawani H, Wenrich MD, Tonelli MR, Curtis JR. Meeting physicians' responsibilities in providing end-of-life care. *Chest*. 2008; 133(3):775–786. [PubMed: 18321905]
8. Levy MM, McBride DL. End-of-life care in the intensive care unit: state of the art in 2006. *Crit Care Med*. 2006; 34(11 suppl):S306–S308. [PubMed: 17057591]
9. Stricker KH, Kimberger O, Schmidlin K, Zwahlen M, Mohr U, Rothen HU. Family satisfaction in the intensive care unit: what makes the difference? *Intensive Care Med*. 2009; 35(12):2051–2059. [PubMed: 19730813]
10. Studdert DM, Mello MM, Burns JP, et al. Conflict in the care of patients with prolonged stay in the ICU: types, sources, and predictors. *Intensive Care Med*. 2003; 29(9):1489–1497. [PubMed: 12879243]
11. Curtis JR, Ciechanowski PS, Downey L, et al. Development and evaluation of an interprofessional communication intervention to improve family outcomes in the ICU. *Contemp Clin Trials*. 2012; 33(6):1245–1254. [PubMed: 22772089]
12. Breen CM, Abernethy AP, Abbott KH, Tulsky JA. Conflict associated with decisions to limit life-sustaining treatment in intensive care units. *J Gen Intern Med*. 2001; 16(5):283–289. [PubMed: 11359545]
13. Ciechanowski PS, Katon WJ, Russo JE, Walker EA. The patient-provider relationship: attachment theory and adherence to treatment in diabetes. *Am J Psychiatry*. 2001; 158(1):29–35. [PubMed: 11136630]
14. Tan A, Zimmermann C, Rodin G. Interpersonal processes in palliative care: an attachment perspective on the patient-clinician relationship. *Palliat Med*. 2005; 19(2):143–50. [PubMed: 15810754]
15. Curtis JR. Communicating about end-of-life care with patients and families in the intensive care unit. *Crit Care Clin*. 2004; 20(3):363–380. viii. [PubMed: 15183208]

16. Curtis JR, Engelberg RA, Wenrich MD, et al. Studying communication about end-of-life care during the ICU family conference: development of a framework. *J Crit Care*. 2002; 17(3):147–160. [PubMed: 12297990]
17. Curtis JR, Engelberg RA, Wenrich MD, Shannon SE, Treece PD, Rubenfeld GD. Missed opportunities during family conferences about end-of-life care in the intensive care unit. *Am J Respir Crit Care Med*. 2005; 171(8):844–849. [PubMed: 15640361]
18. Glaser, BG.; Strauss, AL. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago, IL: Aldine Publishing Co; 1967.
19. Corbin, JM.; Strauss, AL. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. 3. Los Angeles, CA: Sage Publications, Inc; 2008.
20. Crabtree, BF.; Miller, WL., editors. *Doing Qualitative Research*. Newbury Park, CA: Sage Publications; 1992.
21. Gelinas C, Fillion L, Robitaille MA, Truchon M. Stressors experienced by nurses providing end-of-life palliative care in the intensive care unit. *Can J Nurs Res*. 2012; 44(1):18–39. [PubMed: 22679843]
22. Piquette D, Reeves S, Leblanc VR. Interprofessional intensive care unit team interactions and medical crises: a qualitative study. *J Interprof Care*. 2009; 23(3):273–285. [PubMed: 19387907]
23. Embriaco N, Papazian L, Kentish-Barnes N, Pochard F, Azoulay E. Burnout syndrome among critical care health-care workers. *Curr Opin Crit Care*. 2007; 13(5):482–488. [PubMed: 17762223]
24. D'Amour D, Ferrada-Videla M, San Martin Rodriguez L, Beaulieu MD. The conceptual basis for interprofessional collaboration: core concepts and theoretical frameworks. *J Interprof Care*. 2005; 19(suppl 1):116–131. [PubMed: 16096150]
25. Ferrand E, Lemaire F, Regnier B, et al. Discrepancies between perceptions by physicians and nursing staff of intensive care unit end-of-life decisions. *Am J Respir Crit Care Med*. 2003; 167(10):1310–1315. [PubMed: 12738597]
26. Carline JD, Curtis JR, Wenrich MD, Shannon SE, Ambrozy DM, Ramsey PG. Physicians' interactions with health care teams and systems in the care of dying patients: perspectives of dying patients, family members, and health care professionals. *J Pain Symptom Manage*. 2003; 25(1):19–28. [PubMed: 12565185]
27. Baggs JG, Schmitt MH, Mushlin AI, et al. Association between nurse-physician collaboration and patient outcomes in three intensive care units. *Crit Care Med*. 1999; 27(9):1991–1998. [PubMed: 10507630]
28. Baggs JG, Schmitt MH. Nurses' and resident physicians' perceptions of the process of collaboration in an MICU. *Res Nurs Health*. 1997; 20(1):71–80. [PubMed: 9024479]
29. Collins SA, Currie LM. Interdisciplinary communication in the ICU. *Studies Health Technol Inform*. 2009; 146:362–366.
30. Jones A, Jones D. Improving teamwork, trust and safety: an ethnographic study of an interprofessional initiative. *J Interprof Care*. 2011; 25(3):175–181. [PubMed: 21043559]
31. Rice K, Zwarenstein M, Conn LG, Kenaszchuk C, Russell A, Reeves S. An intervention to improve interprofessional collaboration and communications: a comparative qualitative study. *J Interprof Care*. 2010; 24(4):350–361. [PubMed: 20540614]

Table**Interview questions for clinicians**

<ul style="list-style-type: none"> • Recently you worked with _____ family who had a facilitator assigned to them as part of a study. If you had a colleague who asked you, how would you describe this facilitator intervention? • How would you evaluate the helpfulness or non-helpfulness of the intervention? <ul style="list-style-type: none"> – Probe: Ask about the opposite (helpfulness or non-helpfulness) if they don't mention it. – Probe: If person discusses helpfulness to family, inquire about helpfulness to team, and vice versa. – Probe: Do you see differences between families who have received the intervention and those that haven't? • Under what circumstances do you feel that an intervention like this should be initiated? • How could this intervention be improved? <ul style="list-style-type: none"> – Probe: What do you think the main issues were in decision making with this patient and family? Did the intervention address these? – Probe: What do you think the main issues were in communication with this patient and family? Did the intervention address these? • This intervention is based on 3 components: (a) improving communication about decision making with family members and supporting family in the decision-making process; (b) adapting our communication approaches to individual family members' needs; (c) and using the principles of mediation to help resolve conflicts that can occur in the ICU. I'd like to ask you about each of these 3 components. In what ways did the intervention help: <ul style="list-style-type: none"> a. improve communication about decision making with family members and support for the family in the decision-making process? b. adapt your communication approaches to individual family members' needs? c. mediate any conflicts within the family, within the team, or between the team and the family?
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