Table 41: Hsieh 2006[224]

Study	Hsieh 2006[224]
Aim	To identify inherent tensions that arose during family conferences in the intensive care unit and the communication strategies clinicians used in response.
Population	Clinician-family conferences (n=51) 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. All conferences were led by physicians. A total of 221 clinicians, including 36 physicians, participated in the conferences. The number of clinicians in each conference ranged from 1 to 12 (mean 4.3). A total of 50 nurses participated in 41 of the family conferences (range 0-2, mean 1). A total of 25 social workers participated in 24 of the family conferences and 12 chaplains, priests or nuns participated in 12 family conferences. Finally 227 family members participated in the conferences (range 1-13, mean

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	4.5). The mean length of the conference was 32 minutes (range 6-73).
Setting	Intensive care units Seattle
Study design	Family conferences were observed and themes drawn from the discussions.
Methods and analysis	Family 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. Of the 111 families eligible to participate, 17 families were not approached at the request of the attending physician or nurse caring for the person. Because of concern of potential litigation, another 2 were excluded for risk-management reasons. Twenty-four families approached by the nurse caring for the person 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 the clinician (1 clinician and 1 nurse refused to participate). Eligible conferences were audiotape recorded. The analysis used a directed approach to qualitative content analysis where an existing theory or prior research findings influence the initial approach to the data. The dialectical perspective was used to narrow the focus of the analysis to the portions of the text that addressed communication about a contradiction (hence text was excluded that primarily focused on reviewing the person's condition and planning for future meetings). The dialectic perspective was used to identify potential initial odes for contradictions such as those that appear extensively in the ethics literature, for example, prolonging versus, allowing death or ordinary versus. extraordinary treatment. Coding was done using an iterative process. First the investigator listened to the audiotapes of the family conferences and read the transcripts throughout at least twice. Initial categories were re-examined continuously to promote clustering around common themes. After contradictions raised by either family members or clinicians were identified, the communication strategies used by clinicians in response to these contradictions were identified and coded into common themes. To ensure trustworthiness, identified contradictions and communication strategies were reviewed repeatedly by the other investigators who were experts in the content area and qualitative methodologies to validate the classification system and study findings. Other techniques sued to establish trustworthiness included prolonged engagement, reflexive journaling and interdisciplinary review and feedback. Finally, agreement was done to address dependability/reliability. After a brief training exercise, a researcher who was naïve to the data verified and matched operational definitions with specific quotes from the transcripts. The percentage agreement between the two coders was 75%.
Themes with findings	The overarching contradiction present in the conferences was the tension between to-let-die-now and not-to-let-die-now, which reflects the clinical reality that even a decision to continue life-sustaining therapy may not ensure long-term survival for a critically ill person. Surrounding this major contradiction, 5 more specific contradictions emerged from the conferences; killing vs. allowing to die, death as a benefit or a burden, homering the person's wishes or following the family's wishes, weighing contradictory versions of the person's wishes and choosing an individual

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	family member or the family unit as decision maker. Evidence for at least 1 of these 5 contradictions was found in each of the 51 conferences
	Killing or allowing to die: This contradiction centred on the issue of whether withdrawing life support is an act of taking a person's life or allowing the person to die naturally. Both sides of the contradiction were explicitly raised infrequently 93 of 51 conferences), whereas in 9 additional conferences 1 side (allowing to die) was explicitly raised. The issue of whether withdrawing life support is synonymous to killing was raised only by family members, whereas both family members and clinicians raised the opposite side of the contradiction, that is, withdrawal is allowing the person to die. The concern about killing the person seemed to make family members hesitant or unwilling to withdraw or withhold life support. Withdrawing or withholding life support was uniformly perceived by clinicians as allowing the person to die.
	Death as a benefit or a burden: This contradiction was centred on the result of death, specifically what death would mean to the patent or family members. Both sides of the contradiction were addressed in 15 conferences and 1 side was addressed in another 18 conferences (33 in total). Death was viewed as a benefit, often from the perspective of the patient, if it offered the opportunity to honour the person's wishes, end suffering, prevent lingering, end a life without quality, permit a peaceful or natural death or allow the dying person to join deceased family members. Burdens included family members not having time to digest or prepare for the death, not being able to say goodbye, not being able to pay their respects, not being able to be with the dying person anymore, other family members not being able to be involved in decision making or the person not having a chance to recover or get better.
	Honouring the patient's wishes or following family's wishes: Discussions that centred on honouring the dying person's wishes vs. following family members' wishes in decision making were raised in 44 of 51 conferences (21 conferences with both sides of contradiction expressed and 23 with 1 side). The most common presentation was that the dying person would wish to limit life support whereas family members' preferences were not to limit life support.
	Weighing contradictory versions of the patient's wishes: This contradiction could only be identified when both sides were expressed; this occurred in 1 of 51 conferences. Families and clinicians struggled with which version represented the dying person's authentic choice and hence, should be honoured.
	Choosing an individual family member or the family unit as decision maker: Both sides of this contradiction were present in 2 conferences and 1 side in 6 additional conferences (total 8 of 51 conferences).
Limitations	Very serious limitations. Family conferences represent only a portion of the communication that occurred between the clinicians and family. There

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	may have been additional formal conferences and informal discussions between the healthcare team and the family that were not captured. Communication strategies focused on in this analysis were strategies that were used to respond to contradictions directly. Other types of communication strategies are potentially useful to address contradictions. Other strategies that could not be identified in this analysis include non-verbal ones such as attentive listening, allowing denial and presenting a compassionate presence. This analysis does not assess whether different healthcare providers tend to use different communication strategies. The nature of the ICU conference makes the physicians leading the conferences in the hospitals where this project was conducted. Yet, other members of the healthcare team, such as nurses, social workers or chaplains, are also vital in overcoming challenges surrounding EOL communication. These clinicians are likely to have encountered similar contradictions around EOL decision making yet may respond with different communication strategies. This analysis could not verify the findings with participants in the study directly. The interpretation of communication is subject to the understanding of the investigators. In lieu of confirmation with original study subjects, clinical and content experts were used to validate the emerging analytical framework.
Applicability of evidence	Indirect setting. American ITU, and participants were chosen by clinicians based on their belief of potential litigation.