Family matters

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Writing in the *BMJ* recently, a specialist registrar described how she found herself admitted to a ward full of other women, all more than twice her age.¹ From her hospital bed she could overhear doctors talking to each other, and to their patients. "When the time came for the consultant ward round," she wrote, "it was impossible for me not to hear every word of each consultation". The lack of privacy was disturbing but it enabled the registrar, Jennifer Graves, to notice something else too. "What interested me," she wrote "was listening to these same ladies explaining to their relatives later in the day what the doctor had said. Not one of the other patients told their relatives the correct information".

After discussing the different reasons why this happened—including deafness, dementia, and hearing doctors use medical terms like saturations and UTI—Dr Graves described the lesson she learnt. "My patients are people...and taking the time to talk to them and explaining what is happening to them is crucial." She is of course absolutely right. However, this may not be the only lesson to draw from her experiences, nor even the most important one. Without wanting to diminish the value of clear doctor–patient communication, I wonder if experiences like this can teach us an even bigger lesson about the way we communicate—or more often don't communicate—with our patients' families. Regardless of whether the patients on the ward alongside Dr Graves were deaf, dementing, bemused, or simply unwell, why weren't any of them asked as a matter of routine, at the time of their admission and in private, if they wanted a family member to join in discussions with the doctors as these took place?

ABSENT FAMILIES

I've observed a number of consultant ward rounds myself in different parts of the UK over the past few weeks. Luckily this hasn't been as a patient—I've been watching how consultants teach their trainees on hospital wards as part of my job. All the consultants I shadowed were

excellent communicators and skilled teachers. They certainly avoided traps of the kind Dr Graves describes, such as not noticing deafness, or failing to check for the patient's comprehension. At the same time I noticed a consistent pattern where family matters were concerned.

For example, the ward rounds all took place very early in the morning, following the overnight 'acute take' and before normal visiting hours. This meant that no relatives were actually present in the flesh. The practical reasons for this were obvious—these were primarily 'business rounds'. However, the doctors were making crucial decisions about diagnoses, investigations, treatment or discharge. I couldn't help wondering if patients had been given the choice of asking relatives to come in early and be present for these important conversations if they wished.

FAMILY CONVERSATIONS

Although families were absent physically, they were of course often mentioned during the rounds. The doctors consistently asked who else was at home and whether they were fit and healthy. This made sense because most of the patients were elderly. It mattered whether they could be discharged at some point in the knowledge that a reasonably fit family member could look after them—or indeed if they were fit enough to look after any dependents. The consultants were also careful to think about telling families when it came to the matter of diagnosis, especially serious ones. At the same time I noted that the task of 'explaining things to the family' was often delegated, except in the most critical cases.

On the whole, consultants just asked juniors to speak to a relative, without necessarily saying how the conversation might be conducted or what areas it might need to cover. And in some cases no-one mentioned the family at all. One consultant used an impressive published checklist on ward rounds to make sure that a wide range of different aspects of patient safety and quality of care were addressed with every single patient.² It seemed a remarkably effective approach both to clinical management and to teaching. Even so, 'talking with the family' didn't appear on it.

HOSPITAL CULTURE

I want to stress that the purpose of this description isn't to criticise any of the individual consultants I saw. They were all outstanding role models. My focus here is on the wider culture of hospital medicine. This seems to dictate that it is very common indeed to speak *about* families (especially if this affects the length or cost of care) and it is reasonably common to speak *to* families (especially if you need to soften the blow of a serious or terminal diagnosis). However, there seems little recognition that family members should automatically be involved as partners in medical decision making and care at the moment when it happens and whenever the patient might want this.

At first sight there might seem to be ethical and practical obstacles to bringing the family fully on to the scene in every case. Yet family oriented care can actually lead to medical practice that is both more sound and more effective. From an ethical point of view it goes without saying that patients have a right to individual privacy and absolute confidentiality. It is this aspect that professional guidelines on decision making usually emphasise, and that doctors are often most concerned about.³ In spite of this, the vast majority of people would probably choose to bring at least one close relative into any significant conversation with a doctor if invited to do so. There is even research showing that patients from many cultural origins expect their families to be involved in medical decision making, and in some cases would prefer this to be devolved to others within the family, especially where end-of-life care is concerned.⁴ Anyone who has visited a hospital in a country where life revolves more around the family will be aware that wards are thronging with relatives, while staff accept this as a normal part of care.

FAMILY ORIENTED CARE

Within the emerging field of narrative medicine, ethicists now argue that the most appropriate medical decisions aren't simply the ones that tick the right boxes on a list of abstract principles, but emerge from deliberation with several people including the family and the network of carers as well the patients.⁵ Seen in this light, it may be unethical to assume that any patient wants to make a decision alone, without offering the choice of including significant others in the discussion as well.

The other 'obvious' objection to family oriented hospital care is that it would

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create practical difficulties and take up too much time. This objection is even thinner than the ethical one. It is hard to defend any practices designed to meet the needs and schedules of doctors without regard to what patients might wish. Besides, family conversations provide a hugely richer picture of the person, the illness, its severity, and the realistic options for care. They can lead to a more accurate assessment and more purposeful treatment. They can also pre-empt the kinds of misunderstandings and muddles that Dr Graves heard on her ward, and could avert some of the complaints, negligence claims and legal proceedings that result from communication failures alone.

SPECIFIC SKILLS

Involving family members in conversations is neither particularly time consuming nor challenging. Most doctors do it as a routine in outpatient clinics, and in GP surgeries. Many consultants set

aside specific times to meet with families on the ward to give them information. However, there is no reason why family members cannot be present at the bedside and involved in decision making at any time that patients want. Indeed, since inpatients are usually frailer and often more disoriented, there is a compelling argument for making this option freely available. For doctors who want to learn them, there are some quite specific skills for harnessing the full potential of family conversations as therapeutic interventions in their own right.⁶ If properly used these skills can even make consultations shorter, as well as empowering patients and their relatives to take a more active part in healthcare.

It would be good to think that, in the course of time, all doctors might learn family communication skills along with the ones they now learn everywhere for talking with individuals. If that happens, the kinds of misinformation—not to

mention possible medical risks—that Dr Graves witnessed from her own hospital bed should become a thing of the past.

Competing interests None.

Provenance and peer review Commissioned; internally peer reviewed.

Postgrad Med J 2011;**87**:441–442.
doi:10.1136/postgradmedj-2011-130113

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