Communication between Staff Member with Family Member Intensive Care Unit: A Grounded Theory Study

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ABSTRACT

Introduction: The patients with critical disease do not able to decide for care. Then family and providers do it. One of the most important factors improve care is relationship between family member and staff members in ICU. Creating an effective communication with patients is an essential aspect of nursing care. This study aimed to explore communication process among team members with patients’ families in intensive care unit.

Methods: Based on the nature of the research question, qualitative study using grounded approach was used for collecting and analyzing data. A total of 22 participants (10 family member, 8 nurses, 4 physicians) were selected based on purposive sampling. Sampling was terminated after saturation of emergent categories Data were collected via non-structured individual interviews, observation. Subsequently; the data were analyzed according to the Strauss and Corbin constant comparative analysis method.

Findings: Data analysis has led to discover the main category that is called “superficial and ineffective individual relationship” as a main challenge for care team and hospitalized patients families. They have used strategy is titled “effort” to solve this problem and strengthen the relationship. Extracted themes from this study include, unsuitable organizational conditions of social subclasses (social and cultural factors, inhibitory organizational atmosphere, job problems, indifference and disinterest of care team and negative features of care team), interface conditions (individual and professional values), strategies (spiritual considerations, emotional responses, cooperation, consulting, guidance and interactive training) and communication consequences (satisfaction and dissatisfaction, trust and distrust, justice and discrimination, stress and relaxation) also it needs strengthening the relationship and mutual cooperation between care team and hospitalized patients’ families in ICU (intensive care unit).

Conclusion: Although, there are numerous problems and obstacles between care teams and hospitalized patients’ families in ICU in communication process, but, there is relationship between them, regarding to individual and professional values of care team and they try to strengthen this relationship by using different strategies superficially and cooperation with each other. Thus, in order to create effective and desirable communication, we must consider policies in educational, clinical and management plans of care and cure teams in universities and hospitals, also we must consider communication as the most important factor in this process.

KEYWORDS: Communication Process; Staff Member; Family Member

INTRODUCTION

Background

Man is a social creature who interchanges feelings, attitudes, and emotions through communication and whereby meets his physical and psychological needs; in other words, communication is a dynamic process between humans which is used to achieve effectiveness, to achieve mutual support, and to achieve what is necessary for health, growth, and survival, and life without it may be soundless, lethal, and deadly (1). Communication is today considered as an art (2), and one of the fundamental parts of patient’s satisfaction, which is always observed in research findings, is the importance of the patient-curer relationship and communication (3). Communication in treatment (curing) is of great importance and is one of the main tasks to be done by the care team (4). Patients consider interaction with the care team as fundamentals or basics of their treatment (5). An effective relationship is the principal characteristic of the care-therapists and has always been under consideration as a necessity in the patient-oriented tendencies (6).

Nursing is a profession whose role is played through communication and, according to the King theory, is based on the patient-nurse interaction. This positive patient-nurse relationship plays a vital role in the quality of the nurse caring (7). All of the nursing process steps require proper and fair communicational skills which are important factors for patient satisfaction, treatment positive results, and patient’s agreement with care and treatment procedures (8). They also lead to the care team’s satisfaction and result in satisfaction by care activities (9). Besides, the current health care system always emphasizes greatly on the patients’ satisfaction (10); meanwhile, in the physicians’ profession, it is considered as a cost-effective and reliable method for getting awareness of the patients’ problems and disease diagnosis.

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Worsowics et al (2004) writes: if the communication is not done properly, the needs of the patients and their families won’t be met, their social processes will be disturbed, and their co-operations will be reduced which, by itself, can result in the increase of stress and tension in the care team (11).

Critical disease is an incident which threatens the life and appears without previous warnings and gives the patients and their families a little time for getting adapted with it (12). Critical disease is a condition in which the patient needs residence in the intensive care unit (ICU), and is known as an experience which has lots of stress-making stimuli. When a member of a family is hospitalized in the ICU, the whole family is influenced. Leski (1991) emphasizes that there are numerous evidences which show that the pressure and stress caused by critical conditions of a family member exert a great effect on the whole family’s performance; in the meantime, the family’s behavioral pattern can, by itself, influence the disease-related results (8). As previously mentioned, the existence of stress and anxiety in the family and the care team is one of the main problems in the intensive care units. Lack of communication can result in tension and stress in the individuals. Maxwell (2007) reported that lack of a relationship between the family and the care team creates a huge amount of anxiety and tension for both parties, specifically when the family member dies (9). In any case, if there is a good interaction, the family members feel that they will get the best results; on the other hand, lack of an effective relationship with the patient and his family is assumed a big source of stress for the treatment team. Therefore, some of the nurses, patients, and physicians believe that it is critical and necessary to provide the patient’s family with appropriate and correct information and to effectively communicate with the patient’s family (13,14).

McDonagh believes that despite the emphasis on communicative skills of the care team during last two decades, the structural factors have caused the communications to remain weak (15). Insufficient relationship between the care team and the patient’s family, in spite of spending millions of dollars for researches and studies in this field, has created big problems and difficulties and numerous challenges for the care team and the patient’s relatives; however, it is not always easy to correctly communicate because lack of enough time, lack of loneliness and privacy (solitude), cultural differences, and problems caused by physical and mental disabilities can create obstacles for achieving the goals (16). McCabe (2004) demonstrated that the nurses don’t provide the patient with sufficient information and are worried about their routine tasks rather than communicating and talking with the patients. Chiu (2004) not only emphasizes on the importance of the patient-nurse relationship as a fundamental part of the nursing cares but also considers it by itself as a curing and treatment (18).

Since in the intensive care units the patients with critical conditions are hospitalized and the disease pre-awareness is not specified and the patients are unable to decide for themselves, the role of the families is highlighted and gains special importance; besides, an effective communication can reduce the hospitalization period and lead to the physical and psychological relaxation of the patient and his family. Also if the families are provided with sufficient information, they will spend less painful time. Researches on the importance and problems of communication and relationship in the intensive care units have demonstrated that there have been little concentration and focus on the process of communication thus it seems necessary to perform a research on the process and procedure of communication and making a relationship.

A review on the previous studies provides a good base and knowledge for perceiving the necessity of considering and paying attention to the process of communication in the present research. An important point which is rarely seen in these studies is that there is no applicative and practical communication and relationship between the patient and his family and the treatment team; another point is that the effect of the social processes on performing such a communication has not been described in these studies. Besides, the scholars have mostly analyzed the importance and advantages of relationship between families and treatment teams in the intensive care units (19,20). This information will be useful only if the process of communication occurs. In one of these studies only the relationship between nurses and families has been described (21) but the manner and method of actual and practical execution of such relationship has not been observed and specified. Also the manner of a real relationship between nurses and physicians hasn’t been elaborated.

An important point to be considered in the present research is that a useful and satisfying relationship between patients and their families and the treatment team should be created by whom, when, by which method, and by which language? What the care team members should know when they want to communicate with the families, regarding the fact that the role of such a communication is very vital and important for decision making? With regard to the fact that in the Iranian researches on communication — particularly in Iran — have been performed superficially and one-dimensionally and all the aspects of the communication process haven’t been studied in detail, and since there are many differences between various societies and cultures and the communication is an intercultural and interpersonal subject, thus the researches performed in other cultures are not enough and sufficient for us and, therefore, based on the philosophy of the qualitative research, we can do this research through qualitative method. Consequently the researcher decided to perform a qualitative study in order to gain more information about the procedure of communication and about the approaches used by the care team for achieving a more effective communication and relationship. The present research, with a comprehensive attitude toward experiences of families and care teams, has come over the important subject of communication and eventually has provided solutions and approaches for more effective communication by presenting a theory for making a relationship.
METHOD

Continuous data comparison and ground theory method were used for data analysis (22). Ground theory is a research method which is useful for studying the phenomena which are not well known such as communication with patient’s family or gaining a new vision about known phenomena (23). The ground theory is based on simultaneousness, data collection and comparison, and formation of the concepts. In the ground theory the researcher doesn’t begin his job with predetermined hypotheses but, instead, it is by appearance of the concepts that the research method and research questions are specified (24). Since the present research is aimed to investigate the communication between the nurses and patients hospitalized in the ICUs and due to the high capability of this method in elaborating the facts, the ground theory appears to be an appropriate approach for this study. In the present research 10 patient-families, 8 nurses, and 4 physicians were chosen from two training hospitals in Kerman city. The nurses had got MA and BA degrees; the families of the patients of 3 to 20-day hospitalization in ICU were all the next of kin relatives. Data collection was done through non-structured interviews and observation. Interviews were done in the waiting rooms or the nurses’ resting rooms where, before interviewing, they were provided with some explanations about research goals, information confidentiality, and recording the interviews and then they, in case of intention to participate in the study, consciously filled in a letter of permit. The themes presented in this study are related to the finding obtained from the answers of the participants to the question “please express your experience about communication”. Time duration of the interviews was set according to the mental and psychological conditions of families and nurses free time. Time of interviews ranged from 25 to 90 minutes and the average time was 60 minutes. Another source for data collection included five observation sessions. Besides, the non-official (informal) interviews with five individuals from among nurses and families’ members at the end of the job were used as a proof of the researcher’s findings and observations. The data obtained from interviews, observations, and in-place notes was codified, by three steps of codification (open, pivotal, and selective codification) and analyzed alongside with using the continuous comparison methods and Corbin & Straus approach (1998). Data collection was stopped when data repeatability occurred. To ensure that data interpretation indicates the under-study phenomenon, review by participants, review by individuals other than participants, and triangulation or time & place-incorporation were used. Also data sampling with maximum variation increases the confirmability.

Review by participants for data confirmation has been one of the most important actions of the researcher for perceiving the data credibility (25).

Themes such as incompatible environmental conditions, interface conditions, communication strategies, and outcomes (consequences) express the communication experiences of the families and nurses.

Findings

Participants consisted of 10 patient-families, 8 nurses, and 4 physicians. The age of participants ranged from 18 to 50 years. The patients’ statuses were recognized suitable based on their consciousness score (completely conscious=suitable; Glasgow score between9-12=semi-critical; Glasgow score less than 9=critical). In the treatment team two participants were nurses with MA degrees and other participants had got nursing BA degrees. The patients’ families included individuals whose literacy ranged from illiterate to BA and all were next of kin relatives. Table-1 shows the categories formation manner.

<table>
<thead>
<tr>
<th>Quotation</th>
<th>Meaning unit</th>
<th>Code</th>
<th>Subcategory</th>
<th>Category</th>
<th>Theme</th>
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<tbody>
<tr>
<td>I think one of the reasons of nurses for not giving information to the families is their fear from physicians. If we give information to the patient’s companion he may go to the doctor’s office and tell them to the doctor, then doctor asks who has given you this information? And he will say “the nurse”. So the nurse will be blamed.</td>
<td>Nurse’s fear from being blamed</td>
<td>Physicianarchy</td>
<td>Organizational policies</td>
<td>Organizational inhibitory atmosphere</td>
<td>Incompatible environmental conditions</td>
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<td>The unit door is closed and we are not allowed to enter so we can’t communicate with the nurses.</td>
<td>Unit isolation</td>
<td>Unit no-visitation</td>
<td>Environmental &amp; physical conditions</td>
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<td>When we have personnel shortage how can we both do the unit jobs and communicate. So we can’t do the unit jobs completely. Sometimes the unit jobs are very heavy and we haven’t enough time for communicating with patients’ companions.</td>
<td>Heaviness of unit jobs</td>
<td>Human forces</td>
<td>Job (professional) problems</td>
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The most important themes of the present research included incompatible environmental conditions, individual and professional values, strategies, and consequences (outcomes) of communication each one of which, by it, consisted of some categories (table 2).

### Table 2: the themes of the categories

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<thead>
<tr>
<th>Subcategory</th>
<th>Category</th>
<th>Theme</th>
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<tr>
<td>Care team responsibility</td>
<td>Interface conditions (communication facilitator)</td>
<td>Care team’s professional and individual values</td>
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<td>Sense of duty</td>
<td>Justice observation</td>
<td>Professional’s humanitarian nature</td>
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<td>Accountability</td>
<td>Causative conditions</td>
<td>Proficiency</td>
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<tr>
<td>Not prejudging about patient and family</td>
<td>Spiritual considerations</td>
<td>Emotional responses</td>
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<td>Suppose patient and family as wise</td>
<td>Attempting to deepen the communication</td>
<td>Mutual understanding</td>
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<td>Imagining family’s situation</td>
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<td>Calmness inspiration</td>
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<td>Lack of sense of dominance on family</td>
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<td>Persuasion</td>
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<tr>
<td>Family’s participation in decision making</td>
<td>Cooperation absorption</td>
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<td>Conflict and incoordination</td>
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1. Incompatible environmental conditions: the “incompatible environmental condition” is the same as “environmental inhibitory factors”.

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Social and cultural (socio-cultural) factors: The socio-cultural factors were of people’s social determinatives in the communication procedure which have acted as obstacles of communication. In most cases the socio-cultural factors and family prejudices prevented the effective communication between nurses and families. Some of the nurses expressed that in order to avoid connection with patients’ companions they preferred to work in the intensive care units because these units are closed up and thus they have less connection with patients’ companions. The society’s negative attitude toward nursing and families’ prejudices were some of the outstanding problems mentioned by the nurses several times. They felt unhappy and distressed because the society still had a bad attitude toward nursing. They declared that those individuals who are in charge of such responsibilities have not done their duties perfectly and have understated this profession and haven’t considered it a valuable profession compared to other countries. Beside, in many cases, the nurses in the context of the society don’t introduce themselves as nurses. Such a negative attitude have caused that they can’t effectively communicate with the families. Such an issue requires a cultural reconstruction which is mostly the responsibility of the governmental and organizational policies. One of the nurses said: “I am one of those nurses who prefer to not have contact with the patient’s companion and many of my colleagues are just the same; perhaps because the society lacks a good attitude toward this profession and assumes it as a good job. Most of the people believe that a person belonging to a noble family shouldn’t choose nursing as profession and also they think that a nurse’s job is only to provide first aids and primary care activities. They think that the nurses should be from the lower social levels and thus they should be able to bear any kind of desecration.” (Nurse-7)

Cultural sensitivity: The cultural sensitivity is another socio-cultural factor which results in misconception of the patient’s companion and can act as a communication obstacle. One of the married nurses who worked, together with her husband, in one of the units said: “most of the patient companions lack a veracious and correct judgment about nurse and if they enter the unit and see that two nurses are drinking tea during their rest time (break time) they will suppose the nurses as idle and will think that the nurses are always idle and never do anything for the patients. Sometimes it is the case that a nurse marries her colleague, who is a nurse too, and thus they are very intimate but the companions may think of such intimation as an immoral relationship.” (Nurse-6)

Patient companions’ numerousness: Since the intensive care units are places where no visitation can occur and the families and relatives can’t have direct contact with the patients, the families have to bother the nurses and ask them about their patient’s status and thus the nurses get tired and disconcerted and fatigue due to consecutively giving repetitive information to the families. It may be a cultural characteristic in Kerman that when an incident occurs for a family member the sentimental relationships are increased and many of the far relatives increase the number of visitations in order to avoid discontent and vexation of the patient’s family. About this point one of the nurses stated that: “another problem is that the nurses are encountered with more than one person. That is, the maternal cousin comes, the mother comes, the paternal cousin come, and all them want to know about the patient. But they should introduce a person as the first-degree companion, for example mother or father, in order to get all the information of the patient from the nurse and then he/she can transfer this information to other relatives” (Nurse-6). One of the nurses said: “in order to avoid bothering the nurses and other personnel of the unit, it is better that a member of the patient’s family gets the whole information about the patient from the nurse and then transfer it to the other relatives” (Nurse-8).

Organizational inhibitory atmosphere: The organizational inhibitory atmosphere was another unfavorable ground of communication between the care team and families. A large number of the organizational factors prevented an effective communication. Solving such a problem requires fundamental changes in the organization; of course it is mostly related to the nurses rather than the families. Since the dominant health system in Iran is a physicianarchy system and the nursing profession when considered beside physicians’ profession fades, the nurses are understated, compared to the physicians, and thus they feel discontent of being considered as subordinates of the physicians. Nurses should always be responsible to the physicians and they have not sufficient support. They don’t receive a powerful and integrated support and may undergo interpellation and be blamed thus they don’t attempt so much to communicate and give information to the families. A nurse said: “as nurses our problem in communication is that if we give information to the family then the doctor will reproach us. I think it is due to the fear from the doctors that the nurses don’t communicate with the families; because if we give information to the families they may retell that information to the physician and then the physician will blame the nurse thus the nurses try to avoid such a responsibility and give insufficient and incomplete information to the families” (Nurse-1).

Organization’s limited support for nurses: Lack of organizational support for the nurses was another factor which reduced the nurses’ hopelessness, discouragement, and interest in communicating with families. This means that if the nurses encounter a problem with families there will be no powerful official who can support them and they don’t receive sufficient respect and support. A nurse said: “nurses are not appreciated as much as the job they do and they don’t enjoy sufficient material and spiritual advantages. They only receive some null promises which are never realized. No official seriously supports them. Their social position is a low level one. They don’t receive any fringe benefit and advantage. They don’t have any special facilities which distinguish them from other professions and jobs” (Nurse-6).

Unplanned communication: Since communication in special units hasn’t been defined properly, hospitals’ responsible and universities’ education responsible haven’t emphasized on this point, and treatment teams are not asked for explanation of not communicating with families and thus they don’t consider it as one of their duties, thus the members...
of the treatment teams do what they want; this means that the team members will communicate with the patient only if he, himself, tends to do so otherwise such a communication will not be made and nobody will ask and order them to do it.

Those who are not interested in communicating with the patients’ families can provide many pretexts and reasons for justifying it while if there is a compiled and codified communication plan it will dissolve all of these justifications. As for the nursing non-compiled communication plan one of the nurses said: “I think that there should be compiled plan in ICU for communication. For example a 15to20-minute period is not a very long time period for nurses to give information to the families. The nurse, or even the physician, should undertake such a duty. A physician who is responsible to a patient actually has some duties for which he is earning money. Right now the communication between the nurse and the patient’s companion is a superficial and unconscious one” (Nurse-6).

Weak informing: the only source from which the families can get information about their patients is the information given by the care team. It has been seen in many cases that the families are discontent and complain that the care team doesn’t give them accurate and clear information. The information given to them is incomplete and they are not convinced and are informed weakly and improperly. Since the care team doesn’t suppose giving information as its duty, its members don’t communicate appropriately with the families and don’t give them sufficient information. Most of the participants were discontent of such conditions and of course both parties had their own reasons. The families had a sense of bewilderment and complained that the care team doesn’t allocate enough time for them and don’t provide them with perceivable and sufficient information and even evade their duty of giving information. One of the patients’ sisters stated: “physicians and some of the nurses don’t correctly answer our questions and we are not convinced by their answers and don’t understand them. They talk to us in such a way that we are not persuaded that they are allocating enough time for giving us sufficient information.”

Economic approach: another problem preventing communication is the economic approach among the treatment team members. Today the financial and economic issue is the main issue in the society. Most of the nurses need to work overtime and since working in the intensive care units is too hard thus no time and energy remains for them to communicate with the families, because their principal priority is to meet their financial needs. A nurse said: “many of the nurses work in the special units only for gaining more income and work in extra shifts due to their financial problems; therefore, they get tired and spend their energy only for caring the patients thus no energy remains for them to communicate with patients and families” (Nurse-3).

Job problems

Job problems or professional problems are other factors preventing the communication. The care team members are discontent of various problems in their profession and this cause them to not have enough tendency to communicate with the patients’ families. Problems such as hardness of working in ICU, human force shortage, units’ crowdedness, and time shortage of the nurses and physicians were some of the obstacles of communication with families. Many of the professional problems of the nurses are problems which must be resolved by the organizational system.

Nurses express that the treatment team, including nurses and physicians, can’t spent their time for communicating with families due to various reasons such as time shortage, human force shortage, and increase of their work, because if they do so then their patient-related tasks will not be performed perfectly. One of the physicians said: “we are very busy and the number of patients and units is too high and thus we don’t have enough time to communicate with the patients’ families in order to provide them with explanations and information about their patients” (Physician-2).

Human force shortage: the shortage of human forces is one of the main obstacles of communication with families. As for this point, one of the nurses said: “there should be sufficient forces since shortage of forces is one of the factors preventing the communication with the patient’s family. When we are faced with shortage of human force, how can we both do the unit’s tasks and communicate with the patient’s companion; thus, evidently, a part of the unit tasks is left undone. Sometimes the unit tasks get very difficult and thus no time remains for us to communicate with the patient’s companion. As you know doing the unit’s tasks is a very difficult job but if there is enough force in the unit then we can both do the task perfectly and communicate with the patients’ families” (Nurse-3).

Speech-behavior paradox: one of the communication preventives is the paradox and conflict between speech and behavior of the treatment team. It is due to the paradox in speech of the nurses and physicians or other treatment team members that the families and patients can’t trust on them.

“The physician says something but the nurse says something else and the neurologist says something different, thus we can’t find out which one is right. There is paradox and conflict between what they say. They can at least coordinate their speech. We are bewildered” (Family-1).

Lack of motivation and interest in nursing profession: another problem is that the nurses are not interested in nursing and they don’t love their profession and are not encouraged. Some of the nurses haven’t chosen this job based on their interest. a nurse said: “I think that this problem must be solved basically. The nurses who are employed should be chosen from among those ones who love and are interested in this job. This job is perhaps the only job which requires great interest and enthusiasm because its salary is not too much and in the meantime it is a very hard job” (Nurse-2).

Negative individual characteristics of the care team: the negative individual characteristics of the care team members are other obstacles of communication. Some of these characteristics include pride, obstinacy, violence, aggression,
impatience, and fatigue. Any individual communicate with other people based on his own temperament thus there are some individuals who don’t have any tendency to communicate. Obstinacy was a negative characteristic which reduced team members’ tendency to communicate. They had an obstinate behavior toward the families and even toward their colleagues. Most of the participants have mentioned this point. Among the families, one of the participants said: “once due to suggestion of one of my friends I entered the unit, the nurses were annoyed and told me in a bad manner “when you know the fact so what is the reason of your insistence?” We really get angry. The nurses behaved obstinately and didn’t regard their colleagues at all” (Nurse-2). The nurses’ aggressiveness was another negative characteristic which caused the families’ discontent and complaint. Of course the nurses, too, proved this fact and thought that it was resulted by the nurses’ fatigue and the unit’s hard work thus they give the right to the families to be discontent. One of the families expressed: “it depends on the nurse’s temperament. A nurse is calm while another one may be obstinate and prevent the patient’s companion from entering the unit” (Family-6).

Environmental and physical conditions of ICU: the environmental and physical conditions of ICU and shortage of equipments and facilities of the unit and hospital are of other important ground factors which are mentioned by families and nurses as the obstacles of communication. In the intensive care units, due to special and sensitive condition, the families can’t easily visit their patients and stay with them or directly observe the care activities; thus, the nurse or care team is an important interface and the most important information source, and they are the only ones who can inform the families and remove their worries. A nurse expressed: “strictly forbidding visitation in the unit is not a good option. They should regard the rules and wear covers but they don’t regard the rules. They only put the gown on their shoulder and enter the unit. They should wear hat and gown thoroughly. They should the single-use dresses only once while, here in this unit, the dresses are so dirty that the patient’s companion doesn’t like to wear them (Nurse with MA degree). Shortage of facilities and equipments is one of the reasons for preventing the families from entering the unit because entering the unit requires wearing single-use shoes and dresses while the intensive care units lack sufficient equipments. The families don’t like to wear these dresses since they believe that their own dresses are cleaner than them”.

“The hospital must have sufficient equipments and clean single-use gowns and dresses but here they give us very dirty gowns to wear while these dresses have revolting odour. Are these dresses really hygienic? They, themselves, enter the unit wearing their own casual dresses and shoes but meanwhile insist that the families must wear the dirty dresses. I have seen with my own eyes that some of the physicians enter the unit with their own shoes.” (A patient’s sister)

2- Individual and professional values

The professional and individual values are factors which can facilitate the communication. Having such characteristics which are related to the individual’s values or profession the treatment team attempts to communicate. Individuals who work in the care team enter this job with some thoughts, beliefs, and values and believe in son principles. Some of these values are accountability, sense of duty, and responsibility. If the care team ceaselessly insist on these beliefs and values it will result in satisfaction of the patients, families and, most importantly, the God; also it will cause that the care team has a same view on all the patients and never discriminate between them. In such a viewpoint, all the patients have the same value and the team members only perform their humane duties and work conscientiously. They try to respect the patients’ dignity. It is the patient’s personality which is important so they respect all the patients. A nurse said: “for example Dr …., who is a neurologist, certainly communicates with the families and informs them perfectly. Even some of the physicians answer the companions’ question during walking even if they haven’t enough time” (Nurse-4).

Sense of duty is an effective factor in communication. As for this point, a nurse stated: “it is the nurses’ duty to inform the families of their rights. From a legal perspective the patients’ companions should be justified. Also the unit must have appropriate conditions”(Nurse-3). Another nurse said: “I think that it is the nurses’ duty to help the families feel calm and relaxed. When a patient is unconscious and can’t understand his surrounding, the nurses’ duty is to take the companions on his bed for a close contact and helping them to perceive the situation and conditions” (Nurse-4).

The positive individual characteristics of the care team are among the factors which facilitate the communication. When an individual decides to work in ICU, he should be evaluated in terms of his individual characteristics and temper because patience, kindness, compassion, and sufficient understanding power are among characteristics which remarkably influence the communication and can result in deep communication and intimacy and also can attract the companion’s trust.

Kindness and compassion: kindness and compassion are two of the best characteristics of the care team which families considered as important factors in communication and felt satisfied by them.

“For example they said: “we are redressing your patient, please wait a few minutes.’ They were very good persons. They answered our questions. …. The nurses worked hard. …. I am content with nurses and I hope they can help me” (Family-1).

Confidentiality: since confidentiality is one of the most important characteristics of the care team, the families believe that they can tell the physicians and nurses those secrets then can’t be told to other families. They have a full trust on them. A family said: “I trust on nurses. I talk with them. I tell my secrets to them. I feel comfortable with them” (Family-7).

Some of the other themes of this research include the communication strategies.
**Spiritual consideration**

Giving hope: when a patient has no hope to recover yet his family may tend to be provided with hope by the care team even if they feel that there is no truthfulness in their speech and it is only a null hope. A nurse said: “while giving null hope is not right yet disappointing the companions is not a good option. . . . We should tell them the truth in such a manner that they are not shocked. If we do so we have helped them to relax while, in the meantime, we haven’t disappointed them” (Nurse-3).

Recourse on religious actions was one of the researcher’s observations. The religious beliefs are highlighted in difficult situations such as being afflicted by a disease because these beliefs help the patient to accept his disease and his conditions. Therefore, performing the religious actions, providing the required facilities for performing the religious actions, and meeting the patients’ religious needs during hospitalization are necessary for those patients who cannot even do their primary and basic tasks. One of the nurses said: “all the patients are very important for me. I pity them. Once I had a patient who encountered a problem after surgery. His family stood up behind the ICU door. I vowed for his recovery and he regained his health and thus I did my vow” (Nurse-8).

**Emotional (sentimental) response**

Anxiety is one of the main problems which the families are encountered to. The patients’ main worry was related to costs of treatment and releasing and also the side effects of their disease. One of the nurses said: “here the families are always worried about both the costs and the status of their patients. For them, the life and health of the patient is more important than the costs. They always ask if their patient will regain his health and whether the services given to their patient are sufficient and effective or not” (Nurse-3). The high level of anxiety increases the families’ need to psychological supports, mutual understanding, trust attraction, and relaxation.

Mutual understanding between families and care team leads to a more effective communication. The families said: “those nurses who understand us wear our shoes and thus understand our problems and difficulties better. They communicate with us more effectively and, as a consequence; most of our difficulties are resolved” (Patient’s sister). A patient’s old father said: “nurses are of the best human beings God has created, they understand our conditions, and they understand that we are worried and sad so they will do their best for us”.

Calmness inspiration: many of the families stated that they need the care team’s consolation to achieve calmness and relaxation, and also they considered it very important. Inspiring the calmness and relaxation to the patient’s family was one of the communicative behaviors of nurses while encountering the patient’s vital requirements during the present study. By behaviors such as expressing intimacy, consolation, respect, sympathy, and patience inspired the patient to feel that he is not a stranger and this helped him to get calm and relaxed. One of the families expressed: “nurses are very good persons, they work hard, they are not ill-tempered, and they don’t shout on us. We shout on them but they say nothing to us. They talk to us very calm and respectfully” (Family-8).

Trust absorption: the families sought to trust on the nurses since trust and confidence could result in more intimacy between families and nurses and would create a desirable sense and feeling in them. A patient’s brother said: “there should be a good emotional and psychological communication. If the patient has a good status they should inform us. They told us that our patient was recovering. This was perceivable for us. They could persuade us. We had contact with two or three of the nurses who had a good behavior” (Family-3).

**Cooperation absorption**

**Family’s cooperation in decision making**

In special units, due to the patients’ emergency conditions and their need to urgent decisions, the families’ opinions and ideas are not regarded and included and decision making. In most cases they are informed and they fill in a letter of permit. When a particular action is required for a patient the families are asked to decide about it, for example about transferring a patient to another hospital. A family said: “sometimes they consult with us about what they want to do for our patient. For example, our patient needed dialysis and they talked to us and wanted our opinion.” (A patient’s sister)

Family’s cooperation in physical care: in ICUs the families are asked to help in physical cares so some the care are relegated to the patient’s family. A nurse said: “if we have enough time we ask the patient’s companion to do the gavages; consequently, the companion both learns how to do that and help us in doing the required tasks.” (Nurse-4)

Preventing the family’s cooperation is a very important and serious problem. Since the treatment team doesn’t regard the family’s cooperation in care activities and their opinions, the families have little cooperation in decision making about the patient. Preventing the families’ cooperation in decision making may be due to their lack of knowledge about treatment and care activities, and perhaps the care team members don’t believe that the families can be a part of the treatment and care process and don’t consult with the families about what they want to do for the patient thus no effective communication is created between the care teams and families. In fact the care team asks the families only to help meeting the patient-related needs. Communication with families is based on the personal belief of the care team members and they do it just according to their personal temper, conscience, and patience. The families are not allowed to interfere in decision making and physical care activities; they are not informed accurately and precisely. They are always encountered with ambiguities and are unaware of what will happen to their patient. One of the participants said: “I really wanted to know
about my patient’s status, I wanted to be with him, I wanted to know that what are they doing for him, and what will be the
outcome of their activities. I didn’t know the meaning of some of the information given to me. The nurse impatiently said
‘why do you ask so many questions? Your patient’s status is good.’” (Patient’s 20 year-old sister)

1- Interactive training: one of the ways or methods of communication is to interchange information about the patient
between families and care team. The common and primary reason for communication is to interchange the information.
The worried and stressed families expect to earn information about their patients’ status.

“Patient’s severe problems” in this category were divided into various psychological and physical problems which
resulted in communication between patient and nurses. However, such a communication sometimes may not be formed in
an actual and perfect manner. A nurse said: “during the patient’s recovery process we are mostly asked to tell the name of
disease, the patient’s recovery procedure, and about what has been done for the patient. Sometimes the patient’s
companion wants to know about the patient’s type of disease, who is the doctor, and what we have done for the patient. Of
course we often explain to them as much as we can.” (Nurse-4)

Guidance and consultation
Consultation on choosing the best treatment: one of the concepts in communication is the treatment team’s
consultation and guidance for the families for choosing the best treatment method. In order to achieve the best treatment,
the families need to get advises and consultations from the care team. In most cases the families ask the treatment team to
provide them with consultation and advise in order to achieve the best treatment and care services. A patient’s sister stated:
“we want the physician and nurses to advise and help us to do our best for our patient’s recovery. We are not skillful in
such activities thus we need the nurses’ advises.” (Family-3)

When patients are released from hospital they still need nursing cares in their houses thus most of the families sought
for a service-providing center or a nurse to do these care activities for their patients. One of the families asked a nurse this
question: “can you introduce to me a nursing services providing center? I need someone for nursing my mother.” (Family-7)

Companionship and coordination
Companionship and coordination of care team and families facilitate and accelerate the patient’s recovery and also have
positive effects on the patients’ spirits. A nurse said: “we have co-operations with families as much as possible. For example,
if a patient is hospitalized for a long time, we will let his family come to the unit and be with the patient, talk to him, improve
his spirit, and massage him because this can effectively accelerate the patient’s recovery procedure.” (Nurse-4)

Satisfaction / dissatisfaction
Another concept formed in this research is the concept of satisfaction of family or treatment team which has been
expressed in various forms. Satisfaction is an important consequence of an effective communication, and the health
system’s goal is to achieve the patients’ satisfaction. Some of the families have expressed their satisfaction of the nurses
rather than the physicians.

“I had a seventy-percent satisfaction of the nurses and physicians. …. The physicians were good. I’m informed of
my patient’s status. They don’t let me in the unit and tell that it can be harmful for the patient. The well-behaving
personnel explained everything for us perfectly.” (Family-5)

As for dissatisfaction of communication, a family said: “I really don’t know why some of the doctors and nurses
don’t regard and respect the families. They answer our questions tempestuously and impatiently as if they don’t know that
we are waiting behind the ICU entrance door bearing great anxiety and worry. It is not our fault that they are very busy;
they’d better increase and reinforce their forces and equipments. ….” (Family-6)

1- Achieving calmness / stress and anxiety
Achieving calmness or serenity is a result and consequence of an effective communication and sympathy between
families and care team. Such calmness is really a critical requirement. Many of the families expressed that the care team’s
consolations and sympathy can reduce their stress and anxiety and result in their serenity and solace. A patient’s sister said:
“ICU is a stressful and stress giving unit. I didn’t know what would happen to my patient. Two of the nurses were
good persons and consoled me. They told me ‘don’t worry; we have had numerous patients with same conditions who
recovered and regained their health.’ Thus I got calmed and relaxed. Families of the patients in ICU really need
consolation and need someone to console them.” (Family-7)

In the present research one of the principal psychological problems of the patients’ families was their stress and anxiety.
The main reason for the families’ stress and anxiety was related to the hospitalization and release costs and to the disease’s
consequences. One of the unit’s nurses stated: “here the patients and families are always worried about the costs and their
health. They ask whether our patient will recover or not. Are the provided services perfect and effective?” (Nurse-8)

Justice / discrimination
Justice is regarded by the nurses. The nurses have chosen this profession while they knew that they should act, behave, and judge fairly. The position and level of the patients and families shouldn’t influence the nurses and they should regard all the patients the same. One of the features of nursing profession is observing justice and avoiding discrimination.
Of course the Iranian nurses have such characteristic and feature. A nurse said: “due to the Hippocratic Oath we have sworn and promised to help everyone who needs our help. Of course it may happen that a companion annoys us but this annoyance can’t change our caring activities. I, myself, try to communicate with those ones who are not loquacious and inform them about their patient’s status. Many of my colleagues are so.” (Nurse-8)

On the other hand, many families complained about injustice and discrimination. They had observed that the care team discriminates between the patients. They complained that in order to achieve the best services you need to graft. They believed that you would receive the best services only in case of having a relative among the unit’s personnel otherwise you wouldn’t receive any persuading service or answer. Some of the nurses approved it and expressed that if a patient’s family has a high cultural, social, or even economic position and level, such position or level can influence the communication of between personnel and family. A nurse said: “manner of our speech and the information we give to the family depends on the family’s position and level. Even our behavior may be different. When a person with respectable personality talks to us, we, too, have to behave and speak respectfully. Of course the cultural conditions are also effective; that is, we may unconsciously be attracted toward a person who is in a higher economic level.” (Nurse-4)

**Trust / distrust**

If the members of the care team have the sense of duty, accountability, responsibility, commitment, and conscience then the patient and his family will trust on them; thus, the more trust on the care team the family has, the more cooperation with the team will occur, and this can resolve most of the problems and difficulties between family and care team and prevent undesirable outcomes and consequences.

“People should have more trust on the nurses and physicians and accept what they say.” (Nurse-4). A patient’s sister said: “the ICU is a stressful place; I didn’t know what would happen to the patients. One or two nurses were very good and consoled us. They told us ‘don’t worry, we have had too many patients like your patient or even worse, who got better and recovered.’ This relaxed me and I could trust on them.” (Family-7)

Another finding of the present research was concept of distrust against trust which was observed in many families. Some nurses believed that conflicts and paradoxes which occur or the mistakes and inconsiderations in care activities may result in the families’ distrust.

A nurse said: “people don’t trust on the treatment system, and this may be due to the errors and mistakes which occur in the hospitals and expose the patients to risk and even death. We, too, are not excepted. Those people who can afford prefer to take their patients to foreign countries or to other cities such as Tehran, but those who can’t afford eventually stay in Kerman.” (Nurse-4)

Attempting to deepen the communication was the central variable of the present research. The concept of “attempt to deepen the communication” was recognized as the main variable of the research due to having features such as numerous repetitions in data for communicating between different categories. This variable is located in the pivotal and central point and can describe and elaborate the changes and dispersion (scattering) of the data. Attempting to deepen the communication has the required features and conditions (specifications) and is qualified to be introduced as the central variable of the research. It has been recognized as the principal and main variable due to having some features such as numerous repetitions in data, capability of creating communication between different categories, and required capability for elaborating the changes in data. This variable is located in the pivot and center of the data and describes and elaborates the dispersion and changes in the whole data.

**DISCUSSION**

The present research studied the process of communication between the care team and the families of patients hospitalized in the intensive care units. On the whole, four categories, namely incompatible environmental conditions, professional and individual values, communication strategies, and communication consequences were recognized and then the relationships of these four categories with each other and with the central variable and also with each category’s subcategories were explained.

The present study’s theme was “attempting to deepen the communication” which elaborated the principal strategy of communication between the care team and the patients’ families in the field of study. In this study, which was aimed to elaborate the process of communication between the care team and the patients’ families, some features and conditions such as the care team’s belief in the importance of communication with the patient, type of the performed actions, work volume (work size), and considering oneself’s needs rather than patient’s requirements and needs, had influenced the strategies of the participants for communication. This effect was such that the care team mostly had an active role in the communicating with the patients and ceaselessly attempted to improve its communication with the patients and their families and to meet their needs. In other words, the members of the care team acted in such a way that they could, on one hand, response their own professional needs and, on the other hand, meet the needs of the patients’ families. Identically, the patients’ families, too, attempted to communicate with them. The communicative role had been defined as expressing the needs for information and care, needs which were responded by the care team.
The results of the present research revealed a remarkable part of various factors influencing the process of communication between families and care team. It is quite evident that many of these factors have indirect effects on the communication process. Some of these factors are socio-cultural factors which greatly influence the communication between families and care team and can prevent this communication from being created.

Some of these factors to be mentioned include cultural factors, society’s negative attitude toward nursing, families’ prejudices, injustice, numerosity of companions, and companions’ bothering which notably influence the communication. Many nurses believe that the society’s negative attitude toward nursing profession is one of the most important factors preventing the communication specifically among the nurses. Unfortunately, despite numerous attempts done to introduce this profession to the society, many families still haven’t a good attitude toward this profession, at least in city of Kerman, and this fact has made an obstacle in the way of communication between families and nurses. Since this factor is a completely socio-cultural ground and any society has its own specific culture, achieving a professional excellence in nursing profession requires having some characteristics and attitudes such as value-creation for oneself, maintaining and developing the professional values as meta-professional behaviors, and attempting to make this profession socially acceptable. But appearance of such behaviors is feasible and possible only in supporting environments which are created by the families and the organization’s management. (26)

Some of other findings of this research include issues related to culture and cultural variables, mentioned by the participants, and their effects on the process of communication between families and care team. Culture, in fact, determines the pattern of perceptions, behaviors, and expectations of a particular group or society and is a set of complexities (complications) which the individuals’ behaviors based on the forms dominating the society and gives that particular group a specific identity (27&28). Although numerous definitions have been presented for culture, the important point to be mentioned is that such a culture has not been formed in a vacuum environment but it is taught and learned gradually and unconsciously by the individuals during their interactions with each other and in a course of time, after being appropriately situated, dominates its expectations on the individuals’ behavior and forms their behaviors and leads them.

Process of socialization is indeed a process through which the values and expectations of a particular group are formed and transferred from a generation to the next one. Although these values and expectations are different and various, the nature of this phenomenon permanently influence various professions (29). Thus the society’s attitudes toward nursing and the public thought’s sensitivity to this profession have created a specific imagination (supposition) of this profession. This imagination or supposition, whatever it is, strongly influences the nurses and even influences their identity (30).

Patient’s unawareness of the situation and the nurse’s duties, on one hand, and lack of a clear list of duties for nurses, on the other hand, cause that the nurse’s performance lack the required integration and coherence; that is, instead of performing his duties, a nurse is forced to spend his time and energy for doing tasks which are duties to be done by other members of the treatment team. Evidently a disease and hospitalization result in tension, anxiety, and fear. The patients’ families are faced with numerous problems and worries and spend difficult and critical moments and have various and different needs and requirements (31). Therefore, presence of the patient in the ICU’s strange environment which has a structure different from the living environment (i.e. it is an environment full of tension), beside other factors such as physical pain and fear from death, results in the intensification of the anxieties and worries of the patients and families. On the other hand, lack of knowledge and wrong judgment of the patients and families about the nurse’s duties and situation may cause them to reach on an incorrect interpretation of the nurses’ role so that they may relegate all the responsibilities of their patient’s life on the nurses. Since the nurse, compared to other members of the treatment team, has more direct contact with the patient and his companion he provides direct care activities; while, having the least delay or mistake, they are blamed by the patient and his companions.

The organizational inhibitory atmosphere was another one of the incompatible environmental conditions which prevented the communication between the families and the treatment team in this research. Factors such as nurse’s professional role, care team’s job problems, physical and environmental problems, physicianarchy, nurses’ economic approach and financial conditions, care team’s lack of motivation, and care team’s negative characteristics were some of the incompatible ground conditions in the present research’s findings.

In this study, one of the findings related to the communication obstacles is the nurses’ professional problems; the nurses mention the high volume of their work as an obstacle for an effective obstacle of communicating with the patients’ families. Hardness and difficulty of nursing, shortage of facilities for the nurses, and the physical and mental fatigue are some of other obstacles and preventives which are emphasized by the nurses. Lahooti (1375) has found out in his research that lack of enough nurses, compared to the number of patients, and lack of enough time are among the most important obstacles of communication; this is an indication of compression and density of the nurses’ job. Also in this research, fatigue resulted by working overtime has been mentioned as another obstacle of communication (32). Findings of Neehan et al (1997) is consistent with the present research’s findings. In the above-mentioned research, the nurses have mentioned time shortage and the personnel’s workload as the obstacles of nurse-patient interaction (33). Low salaries of the nurses and the officials’ not appreciating the nurses have been expressed as less important factors. Lahooti’s study (1996) demonstrates that the nonsystematic relationship between officials and nurses influences the nurses’ communication with the patients (32); while, it seems that in our country the organizations that are in charge of hygienics and health have not
recognized the importance of this method and have understated it. Results of a study performed by McCabe (2004) show that the nurses can effectively communicate with the patients when they act according to a patient-oriented method not a duty-oriented one. McCabe says: “if the health services management wants to be ensured of the quality of the nursing cares for the patients, it must support and encourage the nurses to communicate with the patients based on a patient-oriented method (17). Regarding the effect of the above-discussed factors, from a particular viewpoint, it can be said that the workload or work compression prevents the nurses from having an effective communication with the patients; moreover, they have a hard job while they don’t receive sufficient advantages and are not appreciated as they deserve. In such a situation we can expect that the nurses’ relationship with the patients lacks a desirable quality and even the nurses’ temper and behavior be influenced by the conditions, as the patients, too, have stated this fact and have emphasized on the negative effect such conditions on the quality of the communication.

By performing a comparison between opinions of the nurses and the patients about the nurse-related communicative obstacles, Aghabarari demonstrates that factors such as shortage of enough nurses, high workload of a nurse in a workday, and nurses’ discouragement and lack of interest in their job are of the most important nurse-related communicative obstacles which are expressed by both nurses and patients as factors which can cause the nurses’ inability to use their communicative skills in their interaction with the patients (34).

Results obtained in Park Song’s study, too, showed that high workload is one of the most important nurse-related communicative obstacles which influence the quantity and quality of the relationship between nurse, patient, and patient’s family (4). It is evident that an effective communication is achieved when the nurses apply their skills practically not by merely having the knowledge of communication; because, based on Hawn et al, many nurses are acquainted with the communicative skills but they can’t apply these skills practically (35).

The physical environment of the ICU is another obstacle of communication. An interesting result of the present research is that the nurses’ belief in the effect of equipments shortage and non-hygienic rooms on the effective communication is more than the patients’ families. Such attitude can be attributed to the lengthy presence of the nurses in the clinical environments and their numerous experiences about the effect of equipments shortage and non-hygienic environments on their communication with the patients. Both nurses and patients assume the patient’s affliction to infectious diseases as an obstacle for an effective communication. Hence, this fact is an important issue which should absorb the attention and consideration of the nursing managements. As for this issue, improving the conditions and equipments of caring the infectious patients and retraining the personnel can help resolving and repelling this problem. Gurses et al (2000), in a study, found out that a physical environment, which is insufficient in terms of equipments and facilities, and an insufficient management can prevent the nurses from performing their professional role (36).

Another strategy for communication in this research was spiritual consideration. In critical and severe conditions, the families’ spiritual considerations and recourse on religious issues usually increases and they perceive that God is the most powerful source for recourse. Despite numerous difficulties and problems, the nurses paid special attention to this issue and tried to communicate with families and reduce their stress and worries by giving hope to them and leading their attention toward the Almighty God and encouraging them to perform religious acts and ask the God to help them.

Remembering the Almighty God helps us to become calm and achieve serenity. Of course the hope given by the care team was not a null hope and the team members always mentioned the God’s providence. By paying attention to the God’s memory, the families asked the Compassionate God to help their patient regain his health. By performing religious acts they felt that they have got closer to God.

In general, performing the religious rules is a strengthening source for the patients and accelerates their recovery. The anxiety resulted by the patient’s separation from the religious society and the patient’s failure in performing his duty toward God and people can result in longer hospitalization and consequently higher treatment costs, in addition to the negative effect on the patient’s recovery procedure. Some patients consider their disease as a divine affliction and believe that they will be rescued if they have a firm faith.

Some patients think that they have been punished by the Holy God due to their previous unethical acts and behaviors (37). These individuals believe that praying, vows, repentance, charities and alms can increase the patient’s tolerance against a disease and its consequences (38). In the Holy Quran, in Surah Al-Zumar Verse-8, God says: “when a man undergoes a forfeit or a loss, he calls upon his God and returns back toward his God.” Performing the religious acts such as praying is a common compatible mechanism which can increase the sense of hope and competency (39,40).

As a part of the comprehensive cares, the nurses’ duty is to proceed to prepare a situation for the patient to meet a clergy in order to meet his religious and spiritual needs. This part of care activities is clearly assumed as a part of the obstetric and nursing standards because the patient may have some religious and spiritual needs (41).

The American Psychology Association recommends the physicians to seek for knowing the patients’ religious and spiritual tendencies. The infrastructure of this recommendation is the fact that caring the patient is highly beyond merely curing him and embraces various needs. Most of the patients want to have their religious and spiritual observed and met (42).

Although the patients’ religious beliefs usually strengthen their morale and spirit and increases their power of resistance against disease and its consequent problems, but these religious beliefs might also influence the manner of his communication with the nurse, especially when the nurse is of the opposite gender, and prevent him from asking the nurse
for help. Hence, by having a good level of knowledge about religions, the nurse can act more successfully in communicating with the patient (43).

Another strategy mentioned in this study was emotional (sentimental) response or reaction. Humanitarianism has been recognized as one of the main measures and standards of nursing profession (44,45). The humanitarianism’s theme indicates its importance in the communications experienced by the participants. Various studies have proved the nurses’ role in creating an emotional and spiritual atmosphere for providing cares and its effect on communication with patients (46,47).

In the present research, sympathy was another strategy of communication between the care team and families. Families expressed that the physicians and nurses’ sympathy reduces their sadness and help them to calm down. They believed that they need such sympathy and asked for more sympathy by the care team. Most of the time, the members of the care team, particularly the physicians, didn’t express such sympathy so that many families preferred to have communication with nurses rather than physicians.

When encountering the patients’ needs, most of the nurses used intimate, regardful, and respectful behaviors which, by themselves, could result in the patients’ satisfaction of the manner of communication and also led to a sense of confidence and serenity so that most of the participant families expressed the nurses’ communication as a good one and interpreted this goodness with features such as on-time observation, intimacy, sympathy, applying a supporting approach, and respectful approach. Having a regardful and respectful behavior is so important that it has been studies in numerous researches. Mottram, in a research on elaboration of the treatment behaviors in the day of surgery, has assumed the following communicative behaviors by nurses as treatment communication: explanation, on-time response to patient’s need, intimacy, friendly behavior with patient, and nurse’s calmness while working, which by itself, results in the patient’s calmness (48). The nurses’ sympathy with families of the patients who are hospitalized in ICUs is one of the positive points mentioned by the care team in this research. Such meaning has been reported in McAdam et al (2009) and Norman et al (2008) too: “patients expressing high satisfaction were those ones who had been influenced by nurse’s high consideration and sympathy. Families stated that when their patient was hospitalized in the ICU they spent difficult and stressful time and needed sympathy and consolation because of not having enough information about their patient and also due to the strangeness of the environment” (49,50).

Another strategy in this research was attracting the patient and family’s trust and confidence and meanwhile maintaining the professional and personal privacy. The nurse’s belief and attitude toward the importance of communication was one of the conditions influencing the communication. Findings of Fakhr Movahedi et al showed that the nurses’ belief in the importance communication with the patient and their attempts and efforts to respond their needs had resulted in a sense of trust and confidence so that they expressed it as the nature of nursing cares (51).

Recognizing the families’ needs is another category in the communication strategies. Besides the ground conditions influencing the field, the nurses used strategies such as care activities based on the patient’s critical needs, and maintaining the professional territory in order to improve the care quality and cooperation of the patient and his family. In care activities based on the patient’s critical needs the nurses, besides recognizing these critical needs, tried to care the patient and meanwhile maintain their professional duties by using behaviors such as care considerations, informal trainings, and inspiring calmness and serenity to the patient. Shattell, too, expresses that the nurses pay more attention to patients with more needs and use more active strategies to meet these needs (52). Also Suikkala et al have considered the patient’s tendency to talk about himself and his physical status as one of the conditions which caused them to convey his need to the student of nursing (53).

Cooperation and participation of the families in caring and decision making for the patients is another finding of the present research. Families tend to know which decisions are made for their patients and what car activities must be done for them. Participation of the families in caring the patients leads to more cooperation with the treatment team; this can greatly reduce their anxiety and stress and increase their hope for their patients’ recovery.

The present research’s results demonstrated that the role clarity and re-planning the profession for improving the teamwork reduce the work pressure and creates an integration and coherence among the team members and also creates a sense of valuableness. Effective leadership, organizational support, and appropriate relationships and communications between the individuals reinforce the effectiveness. Besides, lack of transparency and clarity of the borderlines and roles of the hygienic and treatment services providers are assumed as obstacles which prevent the nurses from playing their roles effectively (54).

The treatment team’s communication and sufficient presence in the unit which, by themselves, result in information interchange with each other and with other teams especially with physicians are among the most important instances in the present research mentioned by the participants. These instances indicate various aspects of the nurses’ role in a professional relationship with the physicians.

Effective communication has been recognized as a necessary skill for a professional nurse’s performance. Studies have shown that when physicians have respectful and non-imperative approach in their communications we can observe higher satisfaction in nurses (55).

Another communication strategy in this research was informing and training the patients and their families. Critical conditions create anxiety and worry in the patients’ families and in such situations they severely need to receive information from the care team. Giving information is a method of communication with the patients’ families. Moreover
in the present research, the need for more presence and interaction of the physicians and nurses for information exchange through face to face communication has been mentioned as a factor which can improve the professional communication. Masters points out that for gathering information and having a better evaluation the nurse should have a good communication with the patient. Training the patient requires that the nurse has capability of communicating effectively with the patient so that he can recognize the patient’s needs and preferences and provide required trainings for changing the patient’s attitude (56).

In nursing basics, one of the roles of nurses is to provide the patient with information and improve his knowledge. In this research, the nurses due to time shortage and high work pressure and some other limitations couldn’t formally train the patient but in every visitation or on the patient’s release they informally presented the care recommendations; while Hanoch and Pachor state that giving information is the responsibility of the nurses (57). The results obtained in a study by Pytel showed that providing information about the remedial and diagnostic tests is one of the most important needs of the patients and companions which is done by nurses (58).

Another strategy applied by the treatment team was to communicate with the patients’ families and training them. Through training the families, the treatment team communicates with families and helps them in caring their patients. In this research, training the families was another communicative concept in the “informing” category which is classified under the “strategies” subcategory in the communication process. One of the methods through which the treatment team communicates with families is training the families about the care activities which they should do during the patient’s hospitalization or on his release from the hospital. In order to be able to care the patient, families need to be trained by the care team. Training the families both accelerates the patients’ recovery and prevents further hospitalization. The nurses, comprising 70% of the treatment team, have a valuable role in training the patients because they have more access and contact to the patients and families and spent so much time for doing the care activities; consequently, they have numerous opportunities for training and also can evaluate the educations and trainings (59). Disease and hospitalization are of issues which increase the need for help and training on this area so the concept of training the patient has been formed and is considered as nurses’ key role in providing hygienic and treatment services (60).

The “consultation and guidance” issue was another finding of the present research which is classified under the “communication strategies” category. The patients’ families want the care team to advise and lead them in decision making for their patients, choosing the best physical care and treatment, choosing the best treatment centers for faster recovery, and about what they should do after their patients’ release from the hospital, and the care team effectively advises and guides them. Consultation and guidance is performed not only in the special units but also in most of the hospitals and always positively influences the families’ spirit and satisfaction. Consultations of the treatment team may be done individually or collectively and this depends on the type of disease. Studies performed on consultation for the patients afflicted by cancer have demonstrated that consultation can reduce side effects of chemotherapy and accelerate the patients’ recovery.

In this research, providing the families with consultations and advises was unplanned and each person did it according to his temper, patience, and conscience and it was only on the patient’s release that some information about care activities was given to the families; while, consultation is one of the accepted remedial quality indices. All the patients have the right to receive appropriate consultations and advices about maintaining and improving their health level and preventing themselves from being afflicted by diseases. Consulting and advising the patients has numerous positive effects and advantages: 1) reducing the hygienic and care costs; 2) increasing the care quality; and 3) helping the patient to achieve more independence and self-sufficiency (61,62).

Another finding of the present research is supporting the patient’s family which can facilitate the communication. Supporting the family is a causative condition in the present research. Rushlan (1995) writes: “effective leadership, open communicative patterns, cooperation-based problem solving methods, compatibility between values and philosophy of various fields in the care team and organization, and presence of a committee of ethics can help and facilitate supporting the patients” (63). Drew discusses that dissatisfaction of the hygienic care system motivates the nurses to speak on behalf of the patient and positively influences their supporting role (64).

Supporting the families and patients who are hospitalized in special units was another finding of the present research which is considered as one of the professional values facilitating the communication between families and care team; so that, one of the fundamental needs of the patients and families was their need to support. Necessity of supporting the patient is rooted in the effect of disease on the individuals’ independence and decision making capability, and this puts the care team in a powerful position. In the hygienic care environments the families often feel powerless and, consequently, vulnerable; therefore, the role of care team has been emphasized as supporter in the hygienic care activities (65). Writer nurses have different opinions in describing what is called “support” in the nursing personnel. Supporting in a legal and ethical framework has been described as the philosophy of nursing profession and as words and expressions such as helping the patient to achieve required hygienic cares, ensuring and warranting the care quality, advocating and defending the patient’s rights, and acting as the interface between patient and hygienic care system (66).

The individual beliefs in the care team, too, are involved in communication. Results of the present research showed that the sense of inner satisfaction by effectiveness of cares and work conscience of the care team can facilitate playing the professional roles. Sandman and Lindhal, too, expressed that sense of commitment and conscience can encourage the care
team to care the patient and also can cause that they arrange and regularize the care programs and plans and provide the meritoriously (67).

Regarding the family’s rights was another finding of the present research. Silvane expressed that the care team must be sensitive to the patients’ rights, as an ethical factor, and respect their values (68). Regarding and observing the patient’s rights and informing the family and the patient about their right to receive perfect and comprehensive trainings and also informing the care team members about these rights actually manifest the concept of patient-orientation and the emphasis on patient enablement, of course this depends on the communication and relationship between the patient and the care providing individual. Having appropriate communicative skills and the care providing individual’s sensitivity to the patient’s needs are in fact prerequisites of covering these concepts (69).

One of the findings resulted in this research was the families’ stress and anxiety. Facing the conditions which change the life process, such as hospitalization of a family member in hospital, is one of the reasons creating anxiety in a family (70). In critical conditions that a patient is hospitalized in ICU his family experience higher levels of anxiety (71&72). Anxiety and worry are ambiguous and undesirable feelings and often lead to symptoms of automatic stimulation of the nervous system. The anguishing and agitating factors may result in a situational crisis in families if the families can’t deal with it or the social systems are unable to recognize the reason and cause of such anxiety and anxious individuals’ needs and to categorize and meet these needs (73,74).

A study performed by Sadeghi (1391) has demonstrated that the families’ anxiety can be reduced significantly by their cooperation in care activities. In other words, participation and cooperation of the family members in the daily care plan has effectively reduced the under-study individuals’ anxiety level (75).

Calmness inspiration was another positive consequence (outcome) of the present research. Despite numerous personal difficulties such as professional or family problems, the nurses attempted to inspire calmness and serenity to the patients’ families. The nurses believed that in case of calmness and relaxation the families would have better cooperation with the personnel and if we can make the families to feel calm and serene their repetitive reference to us will be reduced. The reason for the families’ numerous reference to ICU is their disquietedness, restlessness, and anxiety; hence, if we can ensure and help them to calm down most of the problems will be resolved and prevented. Fakhr Movahedi (2012) has come to the conclusion that the nurses try to inspire calmness and serenity to the patients and calmness inspiration is one of the strategies of communication between patients and nurses (76).

Conclusion
The present research’s results demonstrate that “attempting to deepen the communication” is an issue to be regarded in the communication process in the intensive care units. The communication process is changing permanently. Although incompatible environmental conditions such as socio-cultural factors, organizational inhibitory atmosphere, physical and environmental conditions, negative individual characteristics, and job (professional) problems are obstacles preventing the communication, which require organizational, cultural, and social infrastructures to be resolved, but nursing can create some communication facilitating factors due to the fact that the nursing profession is a humanly and humanitarian profession which has its own specific professional values. With regard to facilitating factors such as individual values, professional values, responsibility, sense of duty, and accountability the care team tends to have communication with the patients and families and attempt to communicate and deepen this meaningful relationship by applying strategies such as spiritual considerations, emotional and sentimental responses, trust absorption, participation absorption, consultation and guidance (advice), and giving information. As a result, this communication process leads to a series of consequences and outcomes which comprise a spectrum of negative consequences moving toward positive consequences. Some of these consequences include dissatisfaction and satisfaction, discrimination and justice, distrust and trust, anxiety/stress and calmness and serenity, and companionship and coordination. To sum up, we can call this theory the theory of “attempting to deepen the communication”.

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