

## A Good Night

by Laura Miller-Smith and Diane M. Plantz

**A**nother morning has arrived in the pediatric intensive care unit. The rooms and halls, more dimly lit through the night as we feign appropriate diurnal patterns, brighten with light and activity. More staff arrives, abuzz with stories about their children, their family, an exciting football game or a good meal, stories from their precious hours away from the unit.

The turnover begins. I hear the expected question, from physicians, nurses, and respiratory therapists alike: “How was the night?” This question has become almost a greeting in medicine, a way of saying, “How have you been?” But there is a tension in the question. Whereas in the layperson’s life, close contact with death is rare, in the hospital, morbidity and mortality are common, and a “bad” night typically means an even worse following day. There are certainly nights that do not allow for a positive or even neutral retort. But more frequently than not, the question is answered simply: “It was a good night.” The greeting is given and returned along with the reassurance that the day will start well for the oncoming team.

In medicine “a good night” can mean many different things:

- The child is no longer in shock.
- The infant with pneumonia was able to wean off the ventilator.
- The adolescent with terminal cancer died a peaceful death.
- I was able to complete all my charting before morning.
- There were no unexpected deaths.

Those are all “good nights.”

On this morning, I enter Josie’s room as the nurses are giving sign-out. The parents have also just arrived, nervous and anxious about Josie’s condition. They listen attentively to any noise in the room—noise from the monitors, the ventilator, the nurses’ conversation—searching for any news on their daughter’s condition. As the nurse conveys the shift’s events to her coworker who will now be caring for Josie, I hear the standard phrase: “It was a good night. Josie remains on a paralytic and hasn’t moved. We haven’t had to adjust her ventilator. Her blood pressures have been stable, and her epinephrine infusion hasn’t changed. She’s responding to her diuretics and is now making urine.”

When the nurses exit, I start examining Josie. Listening to her lungs, I notice a small picture above her bed. It is of a small, beautiful smiling baby, with a purple bow highlighting her black hair. Not the same picture I see in the hospital bed in front of me. I see a very sick, if not dying, infant. She is puffy from her kidneys’ shutting down. Her skin is cold and mottled with a purple and pale marbling, something we see in patients close to death. She does not move, as she is sedated. Her chest rises and falls unnaturally in the precise cadence that her ventilator demands. Large tubes come out of her chest, dark red in color from her life’s blood flowing through them to a machine that is doing what her body cannot—keeping her alive. It puts oxygen in her blood stream and circulates it through her body.

I pause, considering that my evaluation to this point has been peripheral, and then, in the time-honored way in which clinicians cross the social barriers we humans have erected, I reach out to touch her hand and then her face. The touch of skin to skin can communicate much, the patient saying, “I trust you,” and the physician replying, “I am here.” Here in this intensive care bed lies a child whose puffy expressionless face shows no response to my touch, but still the communication is clear.

As her parents approach the bed, eager for some news of their child’s status, I introduce myself: “I’m Dr. Miller-Smith. I’ll be Josie’s doctor this week.”

Her father blurts out, “So she had a good night?” He seems to be grasping for the positive light that these words have evoked. Her mother is holding Josie’s limp hand and crying softly. Clearly, she is understanding and physically feeling her daughter’s reality. I pause, wondering how I interpret for them this phrase everyone keeps using, “a good night.” Josie’s night was “good” because her condition did not worsen, yet she is still gravely ill.

Having just started on service, I had hoped to have time to examine and familiarize myself with Josie before having a deep conversation with her family. But I realize I must answer this question now. I tell them the truth, as compassionately as I can. I tell them that our standard of “a good night” in the intensive care unit is skewed. I tell them that their daughter is the sickest child in the hospital, the city, likely the state. I tell them it was “a good night” because their daughter is still alive, not because her critical nature and risk of dying have changed. With their growing understanding of their daughter’s condition, I see their formerly barely suppressed emotions flow into their faces. Tears roll down their cheeks, but I feel strongly at that moment that describing the last twelve hours as being favorable would be cruelly deceptive. Josie is very unlikely to survive. While I assure them that we will continue to do everything to support Josie, the reality of her prognosis must be acknowledged. Leaving the room, I wonder how many times I have used language that conveys

a different meaning than intended, at times like this, a false sense of hope.



Although we have presented this case from the perspective of one of us to call attention to the personal, individualized experience of language between a health care provider and family members, we both cared for Josie at different stages in her illness and both realized that we needed to change how we speak to families about their loved ones' health. Through our work in pediatric critical care and pediatric emergency medicine, we have come to feel that the semantics and lingo used by medical professionals are probably poorly understood. How we communicate and what we communicate are intricately tied together, more than we may realize. In training, communication is frequently taught in the context of conversations with a clear-cut beginning and ending: delivering bad news, obtaining consent, discussing test results. Published communication guidelines exist to help structure patient and physician communication. They suggest a preparation phase, allowing the physician time to plan the focus of the conversation and which words to use. When conversations are unexpected, the preparation phase may be lacking. The words we physicians use in these situations naturally influence our patients' families nonetheless, but possibly in ways we do not fully realize. The words we directly convey and the words families overhear carry multiple meanings.

Little is known about how the subtle nuances of the casual conversation among members of the medical team, overheard by family members, affect their perception of their loved one's status. The small words and phrases we throw around, when we don't know the family is truly listening—"good," "stable," "quiet"—may strongly impact their experience and expectations. A friend whose child also spent time in the pediatric intensive care unit confirmed this for us. Sitting all day, day after day, in a hospital room, all she wanted was any possible update on her child from the medical team. She would listen to

every word spoken, grasping for information, for hope. It is known that parents wish to receive more health care information than they are routinely provided. It is not unrealistic to think that they might cling to any information that is directly provided to them by the health care team, or indirectly provided through overheard conversation.

This use of confusing language occurs in every area of medicine. The surgeon informs the family, "Things went well," after a very complicated surgery. Does this mean the outcome was good or that the procedure went as planned regardless of the outcome? For a procedure as simple as an appendectomy, this wording might not be confusing, but concerning a child who just had a massive hemorrhage drained from the brain, this might mean that all the blood was removed, but the brain could still be horribly damaged.

The emergency medicine physician says that the child who was hit by a car is "stable." What does "stable" mean? In medicine "stable" can be a good thing. It could mean that time is on your side. With the bone marrow transplant patient who has one more day post-transplant, "stable" implies no infections and no unexpected problems. But for the patient who is critically ill, it could mean he or she is not changing, for the better or for the worse. And in a case like Josie's, every day the patient remains on artificial life-sustaining support without any improvement can equate to less chance for a meaningful recovery. "Stable" is not necessarily a good thing.

So why do we use these words whose meanings may be misconstrued? Maintaining hope is recognized as a need of parents with critically ill children. Perhaps our desire to throw around vaguely optimistic terminology allows us to fill this need, consciously or subconsciously, for them and for ourselves. Perhaps it is easier—both because it can be quicker and because it is less emotional for us—to deliver superficial information than to have deep conversations. Certainly our conversations with families must balance the need for accuracy and truthfulness with a focus on the potential good outcome for which we continue

to fight. Studies have shown that parents truly value the physician's ability to balance hope and realism. They want physicians to provide clear and direct information about the situation, not to provide false hope.<sup>2</sup> Terms such as "a good night" surely do not meet these expectations or needs.

These studies also reveal that parents do not put emphasis on the scheduled family conferences that medical education highlights.<sup>3</sup> They do, however, place significant value on frequent updates by the care team and on the physician's availability to answer questions at the bedside. While formal family conferences are surely important to communication, perhaps we need to focus on and take greater care in other, less formal encounters, the ones we plan to be heard and the ones that might be overheard. Perhaps we need to ensure that the language we use in these instances meets the parents' need for honesty with empathy.

As Josie's physicians, we developed trusting relationships with the family, relationships based on honesty. When their daughter passed away a week after the conversation described, at least we had not sheltered them from that possibility but prepared them for it. We continue to wonder, however, what words parents are hearing that we do not intend for them to hear. In addition, we wonder what words they are hearing that do not truly mean what they imply? How can health care providers caring for patients and families recognize that simple words like "good," "stable," and "quiet" may be misinterpreted and may affect the trust families place in our communication? As for us, we choose our words more carefully now.

1. K. L. Meert, S. Eggly, M. Pollack, et al., "Parents' Perspectives on Physician-Parent Communication Near the Time of a Child's Death in the Pediatric Intensive Care Unit," *Pediatric Critical Care Medicine* 9, no. 1 (2008): 2-7.

2. K. N. Michelson, L. Emanuel, A. Carter, et al., "Pediatric Intensive Care Unit Family Conferences: One Mode of Communication for Discussing End-of-Life Care," *Pediatric Critical Care Medicine* 12, no. 6 (2011): e336-43.