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Communication Dynamics Between Healthcare Providers and Family Caregivers in Intensive Care Units: Implications for Clinical Decision-Making, Care Ethics, and The Quality of Nursing Practice at Yaoundé Central Hospital

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ABSTRACT

Effective communication between family caregivers and healthcare providers is critical in the Intensive Care Unit (ICU), as family members serve as essential intermediaries for most patients. Communication barriers in Cameroon negatively impact not only ethical care but also the quality of nursing care within a community. Communication dynamics between family caregivers and healthcare providers at the ICU of Yaoundé Central Hospital were explored through this qualitative exploratory study to determine how communication practices influence clinical decision-making, ethics, and the quality of nursing care. This study used purposive sampling of twenty (20) participants from the four groups and utilized semi-structured interviews for data collection and thematic analysis to identify key findings. Results of this study indicate that due to workload, time constraints, emotional distress, and lack of formal communication guidelines, communication among healthcare providers and caregivers was frequently uncoordinated. Family caregivers reported limited opportunities to become involved in clinical decision-making, which decreased their level of trust and their ability to access ethical care. Nurses acted as the primary links to communication but often had unclear roles and received inadequate training in communication skills. Overall, family caregivers and nurses believe that effective communication will improve ethics of care, trustful relationships with family caregivers, and the quality of nursing care. In conclusion, communicating in a structured, interdisciplinary manner and providing ongoing training related to ethics and communication is essential to enhance ethical, family-centered, and quality care provided by nursing staff in the ICU setting.

INTRODUCTION

Communicating effectively between healthcare providers and family caregivers is one of the cornerstones of high-quality patient care in ICUs. In addition to caring for critically ill patients with high technological demands and uncertainty of their prognosis, the ICU environment poses significant amounts of emotional distress to both patients and their families; therefore, developing effective communication strategies (both verbal and nonverbal) that convey compassion, ethics, and clarity of message is essential (Babaei, 2024). Effective communication involves more than simply sharing information; it also encompasses providing emotional support to patients and their families, making decisions collaboratively, and respecting each patient and family's values(salehmohsen Alyami *et al.*, 2024).

A number of researchers have demonstrated that patients feel a greater degree of trust in their care and have reduced levels of anxiety and increased satisfaction when their families are involved as part of the decision makers (Klaas & Baliki, 2024). In addition to these benefits, researchers have also identified that ineffective or poorly organized communication can create barriers to effective family participation in care through confusion and misunderstandings, the creation of ethical dilemmas and regret, and loss of confidence in the health-care provider. Limited communication can have a big impact on family participation in health-related decisions, decreased trust in medical professionals, and dissatisfaction with their overall care (Cussen *et al.*, 2020) . For nurses, a lack of communication can create ethical challenges to practicing nursing, increased levels of moral distress, and less overall quality of patient-centred care (Beheshtaeen *et al.*, 2024). These particular challenges are compounded in resource-poor settings due to the additional burdens of larger patient caseloads and minimal staff availability, absence of formal guidelines for communication between nurses and families thus making it more difficult for health-care providers to communicate effectively with families (Choi *et al.*, 2021)

As primary health care providers, ICU nurses play a critical role in communicating with those involved in an intensive care patient's care. They regularly serve as liaisons between treating physicians and the patient's family, interpreting medical language, and providing emotional support(de León Oliva *et al.*, 2025a). Research

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indicates that the quality of communication provided by an ICU nurse is directly correlated with providing ethical care to a patient and their family, as well as the level of family satisfaction and perceived quality of performed nursing practice(Coombs *et al.*, 2020). Unfortunately, many nurses do not receive a great deal of formal training in communication with patients' families and the ethical decision-making processes required in these circumstances; this is especially true in the area of critical care (Maghsoudi *et al.*, 2022).

Communication dynamics in ICUs, and their effects on clinical decision-making, ethical nursing practice, and institutional policy, have been sparsely researched empirically in Cameroon, specifically at Yaoundé Central Hospital, so it is difficult to improve Family Centred Care, develop an ethical framework which guides nursing care, and inform institutional policy based upon this understanding. Therefore, the overall objective of this study was to explore the communication dynamics between healthcare providers and family caregivers and examine their implications for clinical decision-making, care ethics, and nursing practice quality in the ICU of Yaoundé Central Hospital. It seeks to evaluate the experiences and expectations of communication in the ICU from the perspective of both healthcare professionals and family caregivers. Furthermore, there is a goal to identify the barriers and facilitators that impact effective communication within the ICU. In addition, the study assesses how communication influences a family's participation in clinical decision-making, as well as the ethical dilemmas that arise when healthcare providers and family caregivers communicate with each other. Lastly, it examines how these communication dynamics between healthcare providers and family caregivers affect the quality of nursing care as identified by the nurses working in the ICU.

LITERATURE REVIEW

Communication Dynamics in Intensive Care Units

In Intensive Care Units, communication is widely acknowledged as a public health and nursing issue because it affects not only the ethical and quality standards of care, but also family involvement in health care delivery systems (Herbland, 2020). Since patients in critical care environments cannot communicate themselves, family caregivers play a critical role in exchanging information with providers and making decisions (Curtis *et al.*, 2021). By improving communication effectiveness, care coordination, and family satisfaction, and creating a trusting relationship between families and health services will occur (Herbland, 2020). On the other hand, ineffective communication creates anxiety, creates psychological difficulties and generates lower care experience (Atinga *et al.*, 2024). ICU communication occurs for public health systems in Cameroon and other Central African nations where many limitations exist concerning resource availability and scarcity of health workers and work load(Amponsah-Dacosta *et al.*, 2020) . These barriers to communication may cause provider-centric and sporadic communication between health care providers and families without robust organisational support in supporting family involvement in decision-making and the communication process (Aljawad *et al.*, 2025). In addition to the impact of the organisational barriers identified in this article may be compounded by the traditional cultural norms of providing deference to the physician's authority leading to family members becoming passive players in the ICU communication process and leading to inequities in care provided because of the communication asymmetries (Saifan *et al.*, 2025a).

Communication and Clinical Decision-Making

The clinical decision-making process in ICUs consists of very uncertain choices in deciding on treatments, prognosis, and end-of-life care. Clinical nursing and public health shared decision-making models encourage transparency, accountability, and alignment with patient and family values (Abbett *et al.*, 2020). Appropriate and adequate communication will support informed consent and reduce the likelihood of conflicts between families and patients regarding occupational health care decisions (Hu *et al.*, 2025). Recent research from sub-Saharan Africa has shown that ICU decision making is still mainly conducted by the physician, with only minimal structure concerning the participation of the family and nursing staff(Korsah *et al.*, 2026). Research completed in Cameroonian public hospitals has shown that fragmented communication, as well as delayed communication between the health care team and a patient's family, has created confusion and distrust among families regarding the delivery of care and challenges regarding adherence to treatment decisions, demonstrating the importance of communication in determining the quality of overall decision making and responsiveness of the health care system (Dillon *et al.*, 2024).

Ethical Dimensions of ICU Communication

Three ethical principles can help guide nurses in providing ethical care to patients in an ICU setting: respect for autonomy, beneficence, and justice. In circumstances where the patient is unable to communicate and make decisions about their medical treatment, the nurse must use communication that is culturally relevant to connect with the family of the patient to ensure the family's ability to provide the necessary support and emotionally safe environment for the patient to receive the best ethical nursing care possible (Beauchamp & Childress, 2019; Yulianto & Awaludin, 2024). Research recently carried out in Africa demonstrated an abundance of ways in which barriers to communication contribute to the ethical tension that exists between the patient/family and the healthcare provider (Miranda *et al.*, 2024). ICU nurses report a greater level of moral distress when they are excluded from this process and/or when family caregivers do not have access to high-quality information to assist them in making informed decisions about

the best possible outcomes for their loved one, thus compromising both the ethical care of the nurse and the nurse's accountability (Donkers *et al.*, 2021). The importance of high-quality, effective communication in nursing practice and throughout the healthcare delivery system cannot be overemphasized.

Communication and Quality of Nursing Practice

The effectiveness of nurses' communication significantly impacts how well they perform their duties in the ICU. In addition to being instrumental in providing support to families of critically ill patients and ensuring continuity of care between providers, nurses are responsible for the interpretation of clinical data, especially in low-resource environments such as Cameroon (de León Oliva *et al.*, 2025b). In this environment, nurses' original role as primary contacts for family caregivers is furthered by their continual physical presence at the bedside (Coats *et al.*, 2018; Korsah *et al.*, 2025).

However, due to a variety of factors that affect communication effectiveness (i.e., heavy caseloads, hierarchical organizational cultures, and inadequate education and training on ethical standards and communication) (Alharazi *et al.*, 2025), nurses do not make the most of their potential to fulfil this role. The impact of these factors on a nurse's ability to communicate effectively affects not only nursing practice autonomy and the quality of care delivered by nurses but also overall quality of care and family-patient support outcomes in the nursing environment (Alshalawi *et al.*, 2025; Mohammed A *et al.*, 2024).

Theoretical Framework

This research is based on the theory of family-centered care (FCC) and shared decision-making (SDM) models, which promote the sense of partnership, respect, and mutual understanding between families and healthcare providers(Schwartz *et al.*, 2022) . The dynamics between communication in the context of the Cameroonian ICU are considered one of the most important factors that affect clinical decisions in ICUs, the delivery of ethical care, and the quality of nursing (de León Oliva *et al.*, 2025c).

MATERIALS AND METHODS

Study Area and Justification

This research took place in an ICU at the Yaoundé Central Hospital, Cameroon's capital city, and a tertiary referral center for the northern region of Cameroon. The Yaoundé Central Hospital serves a large and diverse population, offering many types of specialized services (emergency medicine, intensive care unit, surgical services and internal medicine). The ICU is populated with many different professionals: nurses, physicians, and other health-related professionals all working together, caring for seriously ill patients who have complex problems. With over 200 beds, the hospital has significant resources available to care for many different types of patients and has many healthcare providers in its Critical Care Unit, and thus provided a unique opportunity to investigate the process of communication among healthcare providers and family caregivers in a critical care environment. The ICU, with its technologically sophisticated equipment, rapid pace of clinical decision-making, and significant level of emotional demand from families of patients, represents an essential site to study the ethical, relational, and professional aspects of communication.

Study Design

Utilizing a qualitative descriptive exploratory design, this study benefited from the exploratory design's ability to obtain in-depth data regarding interpersonal and ethical dynamics existing between family caregivers and healthcare providers in the ICU. Whereas quantitative analyses can fail to provide sufficient insight into complex relational dynamics, qualitative analysis affords a deeper understanding of how care ethics, clinical decision-making, and nursing practice are affected by both the experience of family caregivers as well as the contextual elements unique to the ICU.

Sampling and Sample Size Estimation

Sampling Technique

Participants who had basic knowledge of the Yaoundé Central Hospital Intensive Care Unit (ICU) were recruited through the purposive sampling method. This method was selected because it provides an opportunity to specifically recruit individuals who would be able to provide detailed, pertinent, and diverse input about communicating with caregivers compared to healthcare professionals (Palinkas *et al.*, 2013) .

Sample Size

Twenty (20) participants took part in the study (i.e., 10 family members who cared for patients admitted in the ICU, 6 ICU nurses, 2 nurse aides, and 2 medical doctors. This was an adequate sample size for a qualitative exploratory study and thus permitted the researchers to collect more extensive detailed information from more than one view. Therefore, the researcher got insight from both perspectives on what types of verbal, non-verbal, and written communication occur in the ICU, as well as on the moral aspects of the communication involved; and finally, how all this impacts nursing practice. Data was collected until they reached saturation.

Data Collection Instrument

Two tools were used for data collection: interview guides and observation grids. Interviews were semi-structured with separate guides for each group of participants containing open-ended questions to allow participants to share their experiences fully and for the interviewer to ask additional questions to clarify or expand on the interviewee's answers. Interviews were recorded with

the participant's permission and supplemented with field notes to capture both rich and accurate data.

An observation grid was developed to enable systematic documentation of interactions between healthcare providers and family caregivers during regular visits in the ICU.

The grid allowed for documenting the following four areas of interaction: *type of communication, clarity/completeness of information shared, demonstration of empathetic/emotional support for the family, and whether the family was involved in decision-making discussions, as well as the effects of the environmental and contextual factors on their ability to participate.*

The observation grid provided an opportunity for the researcher to compare the interview findings with the actual behavior and environmental or contextual factors that were reported by participants but were not able to be observed in the interviews.

Data Analysis

To examine the data obtained from both semi-structured interviews and observation, the researcher used thematic analysis done through a 6-step approach:

1. Familiarization with the data

All audio-recorded interviews are transcribed verbatim. The researcher read through all the transcripts multiple times and reviewed all written observation notes and gained familiarity with the content.

2. Generating initial codes

Each meaningful unit of data was highlighted (marked with a code) and labelled as a 'code.' Both Inductive Coding (derived from data) and Deductive Coding (limitations of prior research) approaches were employed.

3. Searching for Themes

Categories were formed from Codes; related Codes were grouped together to create preliminary themes that represented the Dynamism of Communication, Ethical Challenges, Family Involvement, and Perception of the Quality of Nursing Practice.

4. Reviewing Themes

Themes were reviewed and revised to ensure that they represented the data and that similar themes appeared consistently across all participants.

5. Defining and Naming Themes

Each theme was defined clearly with a name that expressed the essential attributes of the theme and the relationship it has to the Objectives of the Study.The report describes how the final theme is understood concerning the research aims, existing literature, and current theoretical background, where it interprets the dynamics of ICU communication as well as the effects on clinical decision-making, ethical caring, and quality of nursing practice.

Ethical Considerations

Before data was collected, ethical clearance was obtained from the Regional Ethics Committee and an authorization was obtained from the Director of the hospital. The following ethical principles were considered:

1. The participants received clear communication regarding the purpose of the research study, including objectives, methodologies, potential risks, and benefits involved, due to the nature of the study.

2. They were also informed that participation was voluntary and that they had the right to terminate their participation at any time without fear of reprisal or financial loss.

3. All participant identities were anonymously tracked throughout the research process, and the collection of the audio recorded, transcribed data, and notes from observations was kept secure from unauthorized individuals with the use of passwords. Access to audio recordings, transcriptions, and notes collected from observation is only available to the research team.

Research teams made every attempt to avoid any psychological distress as a result of participating in this research project, and they upheld the cultural values of the region where the research was conducted, as well as the ethical and professional standards by which research is conducted in the ICU. Thus, all ethical concerns associated with this research were addressed in a manner that maintained the integrity of the research, while at the same time providing protection for the rights of the individuals who participated in the research

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RESULTS AND DISCUSSION

Participants' Demographic Characteristics

20 participants were included in the study comprising 10 family caregivers, 6 nurses, 2 nurse assistants, and 2 medical doctors. The personal profile of the participants is presented in Tables 1 and 2 below.

Table 1: Demographic Characteristics of Family Caregivers (n = 10)

Variable	Frequency (n)	Percentage (%)
Gender		
Male	4	40%
Female	6	60%
Age (years)		
20–29	2	20%
30–39	4	40%

40–49	3	30%
50+	1	10%
Relationship to Patient		
Spouse	4	40%
Parent (father/mother)	3	30%
Sibling	2	20%
Other	1	10%
Education Level		
Primary	2	20%
Secondary	5	50%
University	3	30%

Regarding the socio-demographic characteristics of the family caregivers, most of them were males (60%) compared to 40% for females. The highest age group was 30-39 (40%) and the least was 50 and above (10%). Spousal relationships were the most represented with a percentage of 40%. The educational level ranged from primary to university, with secondary having the highest frequency (50%).

Table 2: Demographic Characteristics of Healthcare Providers (n = 10)

Variable	**Frequency (n)**	**Percentage (%)**
Profession		
State Registered Nurse	6	60%
Nurse Assistant	2	20%
Physician	2	20%
Gender		
Male	5	50%
Female	5	50%
Years of Experience		
1–5 years	3	30%
6–10 years	4	40%
11+ years	3	30%
Qualification		
Certificate or Diploma	4	40%
Bachelor's Degree	5	50%
Master's Degree	1	10%

The table summarizes the demographic profile of participants, showing a balance in gender (50%) representation among healthcare providers (50%), a diversity of professional experience and qualification levels.

Thematic Analysis of Communication Dynamics in the ICU.

Through thematic analysis, the following three were identified: how people experience communication; what factors influence these experiences; and decisions made

Table 3: Themes, Subthemes, and the Quotes of participants

Theme	Subtitle	Quotes	Participant Type
Experiences of Communication	Inconsistent Communication	"Most of the time we don't have time to explain everything to the family because we have many patients to attend to."	Nurse 3
	Emotional Stress	"I felt scared and upset when the nurse explained my mother's condition."	Family Caregiver 2

Factors Influencing Communication	Workload and Time Constraints	"There are times I just cannot spend enough time explaining because there are three other patients waiting."	Nurse 1
	Lack of Structured Guidelines	"We have no standardized way to communicate with families; that's just all."	Nurse Assistant 2
	Professional and Cultural Barriers	"Some families expect the doctor to explain everything, but we try to involve nurses too."	Nurse 5
Implications on Decision-Making and Nursing	Family Involvement	"I wish they involved me more when they decided to change my father's treatment."	Family Caregiver 4
	Ethical Considerations	"Sometimes I feel morally conflicted when I cannot explain everything due to time pressure."	Nurse 4
	Quality of Nursing Practice	"When I can clearly explain things to the family, they trust us more, and I feel I'm doing a better job."	Nurse 6

based on how someone felt about communicating or not communicating, as well as how that affected how they did their jobs (nursing) daily. The quotes provided by participants were used to validate each created theme.

Experiences of Communication in the ICU

Unpredictable Interaction with Family Caregivers

Participants outlined that depending upon the busy nature of the care environment and the presence of other staff members, the interaction they received from family caregivers varied widely as outlined below:

"*Since we have to care for many patients simultaneously, sometimes we don't have enough time to give adequate explanations to a family." (Nurse 3)*

A family caregiver stated: *"I had to ask multiple nurses about the situation with my father before I really understood what was going on." (Family Caregiver 6)*

Emotional Stress during the process of Communication

When discussing their experiences with family caregiving, many healthcare providers and family caregivers mentioned that they found their communications to be emotionally charged by the seriousness of the patient's condition. Examples include:

"My family members are really worried. That makes it hard for me to talk to them without making them even more scared". (Doctor 1)

"My first discussion with the nurse made me scared and confused about my mother's situation." (Family Caregiver 2)

Factors affecting Communication

In terms of factors affecting communication in the ICU, there were 3 subthemes:

Workload and Time Constraints

High patient acuity and shortage of staff affected the quality and degree of communication as outlined by one participant below.

"There are occasions when I feel that I just cannot spend enough time explaining because there are other patients waiting." (Nurse 1)

Lack of Structured Guidelines

Some participants identified lack of communication protocols as an element that hinders effective communication in the ICU, as one of the nurse assistants responded:

"We have no standardized way of communicating with families; we improvise everything."(Nurse Assistant 2)

Professional Barriers and Cultural Factors

Regarding professional and cultural barriers, the nurses reported cultural values and nursing hierarchy as a hinderance to open communications. For instance:

"Families may want everything to come from the doctor, but we

make sure that nurses are also included." (Nurse 5)
"It is difficult to question doctor decisions even when the questions arise from the families." (Nurse2)

Implications of Communication on Decision-Making and Nursing Practice

Three subthemes were generated:

Family Participation within Clinical Decisions

There was limited communication; hence, limited family participation in decision-making, as shown in the quotes below:

"I wish they had included me more in their decision to alter my dad's treatment."(Family Caregiver 4)

Ethical Perspectives

Healthcare personnel struggled with moral issues, considering that families were not fully advised and involved.

"Sometimes I feel morally conflicted when I cannot explain everything due to time pressure." (Nurse 4)

Effect on Quality of Nursing Practice

Although nurses perceived communication as positively correlated with improved quality of care, communication failure was seen as a triggering factor of stress and moral distress among nurses.

"When I can clearly explain things to the family, they trust us more, and I feel I'm doing a better job." (Nurse 6)

Discussions

The aim of this research was to investigate communication dynamics in the ICU of Yaoundé Central Hospital between health practitioners and family caregivers and their implications for decision-making, ethics of care, and nursing practice quality. The themes that emerged in this research include experiences in communication, influencing factors in communication, and implications of communication in decision-making and nursing practice.

Experiences of Communication in the ICU

The research revealed that communication within the ICU was sometimes erratic and emotionally charged, supporting existing literature about the topic that confirms communication within critical care environments is often disrupted and affected by work-related and emotionally charged elements(De Jong *et al.*, 2020). The worry and misunderstanding from unclear communication experienced by family caregivers was supported by a research study carried out by (Asadi & Salmani, 2024), which found that families with critically ill patients experience emotional distress due to unequal or delayed information provision.

From the theories, these results support the Family-Centered Care theory. According to Family-Centered Care theory, open, timely, and empathetic communication is an essential part of engaging families in care, as postulated by(Seniwati *et al.*, 2023). Unorganized communication hinders the building of trust and satisfaction in the ICU setting.

Factors Influencing Communication

Workload, lack of structured guidelines, and professional and cultural barriers were found to have an importance on communication outcomes. High numbers of patients per member of staff and limited time available restricted the discussion on detailed information, as supported in another resource-limited study (McAndrew *et al.*, 2018). Lack of professional communication guidelines increased the chance of communication being ad hoc, leading to miscommunication.

Furthermore, cultural and professional hierarchies contributed to communication patterns, as Saifan *et al.*, (2025b)found that family expectations and physician authority were related to communication styles. These results are congruent with theory from Ethics of Care, where relationships, context, and attending to others' needs define ethical practice (Hammer, 2006). Nurses' role as a communication mediator between physicians and families can present an ethical predicament when particular hierarchies limit their effective communication (Woldring *et al.*, 2023).

Implications of Communication on Clinical Decision-Making and Nursing Practice

Practices related to communication directly affected levels of involvement in decision-making, ethical issues, and perceived nursing care quality by families. Poor communication was reflective of low levels of involvement by families, as suggested by (Kydonaki *et al.*, 2020) work and consistent with the FCC principle that greater involvement by families is beneficial for patient care and satisfaction levels.

Care providers felt morally distressed when they were not in a position to offer complete answers, thus illustrating the conflict between time/resource limitations and professional duty (McAndrew *et al.*, 2018). On the opposite end of the continuum, effective communication improved levels of trust, satisfaction, and professionals' feelings of competency. Owing to its consistency with previous data, the current study confirms that effective communication is vital to ethical care delivery as well as to professional nursing practice (Popovičová & Belovičová, 2021).

CONCLUSION

In general, the results stress the importance of improving communication structures within ICUs, especially within under-resourced settings such as Cameroon. There is potential for improving communication structures within ICUs by combining Family-Centered Care Theory and Ethics of Care through organized communication channels (structured communication protocols – e.g., regular family meetings), staff training on empathetic and culturally sensitive communication and policies and measures for managing workload and personnel

concerns impacting communication. Such interventions may mitigate moral distress, support ethical nursing practice, and increase family satisfaction and involvement in decision-making. Although the research offers many insights, the small study size and single hospital may not give generalized results.

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