

Communication with the Critically Ill Patient in Emergency Operating Room Settings: Clinical Insights from the Anesthesia and Intensive Care Unit of CHU Hassan II, Fez, Morocco

Dr Ahmed Azzabi Zourag, Dr Yasser Kaddouri, Prof Ali Derkaoui

Department of Anesthesiology and Critical Care
Anesthesia and Intensive Care Unit, CHU Hassan II, Fez, Morocco

Abstract: *Background: In emergency anesthesia and critical care, communication is often perceived as secondary to technical stabilization. However, critically ill patients entering the operating room or intensive care unit experience profound vulnerability and heightened emotional distress. Objective: To analyze how anesthesiologists in a tertiary university hospital integrate communication into emergency care while maintaining technical excellence. Methods: This article is based on structured clinical reflection, qualitative experiential analysis, and integration of established communication and human factors frameworks. Results: Communication in emergency contexts becomes concise, directive, yet deeply relational. Non-verbal signals, emotional validation, and congruence significantly influence patient perception and trust. Conclusion: In critical situations, communication transforms rather than disappears. Structured training in relational and non-technical skills is essential for modern anesthesiology practice.*

Introduction

At CHU Hassan II in Fez, Morocco, our Anesthesia and Intensive Care Unit manages a high volume of emergency surgical cases and critically ill patients. Many of these patients arrive unstable, with severe trauma, septic shock, hemorrhage, or acute respiratory failure. In such contexts, the immediate focus is airway protection, hemodynamic stabilization, and rapid therapeutic decision-making. Yet, behind every unstable physiology stands a conscious human being confronting uncertainty.

The seconds preceding induction of anesthesia in emergency surgery represent a pivotal moment. The patient, aware of imminent unconsciousness, may experience intense fear of death or loss of control. This raises an essential clinical and ethical question: how should we communicate when prognosis is uncertain?

Methods

This article draws from daily clinical practice in emergency operating rooms and intensive care settings at CHU Hassan II. The analysis integrates experiential observations with established theoretical frameworks including communication theory, empathy and congruence models, non-technical skills (ANTS), and crisis resource management principles.

Results

1. Communication Under Physiological Instability

Critically ill patients often present with hypoxia, hypotension, severe pain, or altered mental status. These physiological stressors amplify emotional perception. Communication must therefore be simplified, clear, and adapted to cognitive capacity. Short, direct sentences enhance comprehension under stress. Statements such as 'We are acting quickly and staying with you' maintain reassurance without false certainty.

2. The Primacy of Non-Verbal Communication

In the sterile environment of the operating room, masks and protective attire limit facial expression. Eye contact, vocal tone, posture, and controlled gestures become central communicative tools. Patients often interpret calm physical behavior as a sign of competence and safety.

3. Emotional Validation and Cultural Context

In Moroccan clinical settings, family presence, spiritual beliefs, and cultural perceptions of illness influence patient experience. Acknowledging fear explicitly - 'It is normal to feel afraid' - creates alignment and reinforces trust. Respecting spiritual expressions without dismissing them enhances relational depth.

4. Dual Responsibility: Technical Precision and Human Presence

Emergency anesthesiology requires simultaneous algorithmic execution and relational awareness. While performing rapid sequence induction or invasive monitoring, the anesthesiologist must maintain situational awareness not only of physiology but also of patient emotional state.

5. Team Communication and Patient Perception

Calm and structured team communication indirectly reassures the patient. Clear role distribution, concise instructions, and visible coordination reduce ambient chaos. The critically ill patient perceives team coherence as safety.

Discussion

Our experience in CHU Hassan II demonstrates that communication remains indispensable even during extreme urgency. It becomes more focused, more deliberate, and more embodied. Experience refines the ability to balance honesty and reassurance. Emotional regulation of the physician plays a decisive role in transmitting calm.

Training curricula in anesthesiology should formally integrate modules on therapeutic communication, emotional intelligence, and simulation-based crisis management. Such training strengthens both patient safety and professional resilience.

Ethical Considerations

Truth-telling in emergency medicine requires nuance. Providing unrealistic guarantees may offer momentary comfort but risks ethical dissonance. Transparent yet compassionate communication preserves patient dignity while maintaining trust.

Conclusion

In the emergency operating room and intensive care unit of CHU Hassan II Fez, communication does not oppose technical expertise - it complements it. The anesthesiologist must embody both scientific rigor and human accompaniment. Integrating relational competence into critical care practice is essential for modern anesthesiology.

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