EDITORIAL

Tell me what you need. I hear you

Digame qué necesita. Le escucho

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Available online 6 April 2019

Our Units are working well, very well. We are achieving high survival rates. The scientific-technical quality is very high. The preparation of our professionals is clearly good: advanced skills are acquired to adequately care for extremely ill patients. We face new healthcare challenges beyond the physical walls of the Intensive Care Unit (ICU), seeking to ensure the early detection of critical patients or helping them to recover normal life, with follow-up in the post-ICU syndrome clinics. Furthermore, we try to improve the human aspect of our care, making our Units friendlier for patients with the intention of mitigating the hard experience of having to enter intensive care. We feel satisfied, very satisfied with all this, and are keen to continue advancing.

It is in this context where initiatives have arisen in recent years to determine whether such advances are also accompanied by care of similar quality for the families of our patients. The critical patient must be viewed as a human being in all dimensions including social and familial. This patient-family binomium is crucial even in the ICU, and both parts of it require adequate attention. A number of measures and recommendations have been introduced in recent years referred to “care focused on the patient and family”, precisely with the aim of also addressing the needs of the families of the critically ill.

Among these family needs, a fundamental consideration is communication with the healthcare professionals. Such communication is one of our pending issues, one of our weak points or, seen from the opposite perspective, an important opportunity for improvement. It is known that one of the main factors underlying patient and family dissatisfaction with healthcare is the lack of effective communication with the professionals. We must point out that there are important shortcomings in training in this area in the university health sciences education plans. During grade and post-grade training, we spend a lot of time and effort in gaining a broad range of knowledge and scientific-technical skills. A good part of this knowledge will never be needed in our professional life and is justly forgotten. However, one thing which we will need from the first day to the last, and which constitutes one of the most challenging aspects of our work, does not receive due attention in terms of either education or training. We, of course, talking about effective communication, which can be contextualized within a series of skills that serve as a complement to our scientific-technical capacities. These involve emotional, ethical, relational, spiritual and other elements that afford tools as crucial to our professional activity as a desire to help, active listening, accompaniment, teamwork, empathy and compassion. The good news is that all this can be learned.

If we think carefully about it, we can see that patients and their families judge us daily precisely in relation to these skills. They indeed have criteria for appraising the way they are treated, the time spent on them, and our willingness to understand them or to help them beyond strictly scientific and technical issues. Furthermore, they take for granted...
that the quality of care provided will be high, even if in the
great majority of cases they lack the knowledge or data
needed to assess such quality.”

We know the latest advances in the management of
sepsis, the latest recommendations referred to cardiopulmonary
resuscitation, the developments in the treatment of stress... But do we know something as basic and neces-
sary as the fact that there are clinical practice guides for
adequately assisting patients and their families?

Communication, understood as a shared and bidirec-
tional phenomenon, is the cornerstone of the professional
patient-family relationship. It involves not only fundamen-
tal healthcare reporting in which the professional informs
the patient/family about the disease process, planned inter-
ventions, time course or prognosis, but also another crucial
element that marks the difference: a willingness to listen,
and to do so actively.

Only by listening can we understand the real needs of
the patients and their families, their concerns and fears:
the uncertainties they face. Only by doing so can we help
them and satisfy their needs.

Recent studies indicate that many issues referred to
information and which are important for the family of the
critical patient are not held to be so relevant by the profes-
sionals: intensivists or intensive care nursing staff. This is
a significant point. We must be aware of the fact that much
of the information we provide is not assimilated, and that
much of it does not correspond to what the family wants
or needs to know. Their priorities differ from our own. This
does not mean that we should not offer all the information
we feel to be important. But we must know how and when to
do it, with respect, empathy and sensitivity addressing the
emotional situation of the family and being aware of the dif-
ficult situation they are going through, and the strong impact
it has upon their lives.

The present issue of medicina intensiva publishes an
interesting article on the current need to further and bet-
ter adapt our care activities in the ICU to the needs of
the patients and their families. It again underscores family dis-
satisfaction with the scant attention paid to their needs and
demands: the lack of communication, or deficient commu-
nication, is the most frequent cause of complaints.

The novelty of the study is that it combines two method-
ologies: analysis of the difference between importance and
satisfaction of the family needs based on the Critical Care
Family Needs Inventory (CCFNI) (a widely used tool), and
the prioritization of such needs through importance per-
formance analysis (IPA). This combination can help us to
prioritize actions for improvement. In many cases there are
peculiarities of each Unit and cultural aspects of each coun-
try that do not allow the results to be extrapolated to other
centers. Further studies of a multicenter nature are there-
fore needed to establish whether the problems detected are
common to those found in other Units. Nevertheless, the
present study uses methodology that is perfectly valid and
reproducible in application to future research.

If we wish to continuously improve our Units, ensuring
quality and excellence, we must not forget to pay attention
to the needs of the families. Let us listen to them.

References


