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EDITORIAL

Tell me what you need. I hear you☆

Dígame qué necesita. Le escucho

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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[1] or helping them to recover normal life, with follow-up in the post-ICU syndrome clinics.[2] 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.[3] 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'',[4,5] 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.[6,7] 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.[8] We are, 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

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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.[9]

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 necessary as the fact that there are clinical practice guides for adequately assisting patients and their families?

Communication, understood as a shared and bidirectional phenomenon, is the cornerstone of the professional patient family relationship. It involves not only fundamental healthcare reporting in which the professional informs the patient/family about the disease process, planned interventions, 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[10] 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 professionals: 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 difficult 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 better adapt our care activities in the ICU to the needs of the patients and their families. It again underscores family dissatisfaction with the scant attention paid to their needs and demands: the lack of communication, or deficient communication, is the most frequent cause of complaints.

The novelty of the study is that it combines two methodologies: 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 performance 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 country that do not allow the results to be extrapolated to other centers. Further studies of a multicenter nature are therefore 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.

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