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EDITORIAL

# Can patient and family satisfaction influence the management of department of intensive care medicine?☆

## ¿Puede la satisfacción de los pacientes y familiares influir en la gestión de los servicios de medicina intensiva?

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Considering the patient as the center of medical care constitutes a cultural and organizational change included within a quality management model that regards the users and their satisfaction as a criterion of increased specific importance on evaluating excellence. Although this concept emerged in the business world, it has undeniable ethical and human dimensions. We must avoid a radical interpretation of the healthcare institution as only a company or organization centered on technology and clients. Instead, interpretation should be focused on the person, and this requires the health professional to know the patient point of view. This is no simple task, since satisfaction[1] has subjective, emotional and cognitive components, and is based on previous experience, the scientific-technical quality provided, communication skills, complex social factors, and also very particularly on personal expectations. Dissatisfaction is very strong when the expectations are not consistent with the perceptions of the patients or their families–this being the basis of *perceived quality*, which in most (albeit not all) cases corresponds to *care quality*. Such dissatisfaction in turn influences their future expectations. As a result, this process of improvement requires constant revision.

The view we wish to highlight goes beyond meeting the requirements of a quality management model and centers on the more human side of things, related to the vocation of the physician and of the health professional in general. We know the trend[2] that seeks to improve comfort and humaneness in medical care[3,4]–the latter being so very technified in the Department of Intensive Care Medicine (DICM). Listening to our patients, focusing medicine on the person from a position of respect, independently of patient frailty or function, gives sense to our profession, with curative or palliative intent, and despite the technified surroundings. It is moreover a good sign that we have groups and units concerned about the outcomes: not only from the technical and care perspectives but also beyond, seeking improvement in the physician-patient and physician-family relationships, as well as the possibility of pleasing and meeting the expectations of the patients who place their confidence in us.

There has been increased attention to satisfaction surveys, particularly in the last few decades,[5] regarding them as an important quality item.[6–8] The Spanish Society of Intensive and Critical Care Medicine and Coronary Units (*Sociedad Española de Medicina Intensiva, Crítica y Unidades Coronarias*, SEMICYUC) has included these surveys among its relevant quality indicators[9] in both the first version of 2005 and in the update corresponding to 2011.[10] These surveys have also been adopted by the National

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Quality Measures Clearinghouse (NQMC) of the Agency for Healthcare Research and Quality (AHRQ) in the United States,[11] which gives an idea of their international repercussion.

Although care is centered on the patient as the protagonist and final receptor, the characteristics inherent to the critically ill often cause us to have to resort to the family as the representing party in the decision-making scenario, and quality perception is frequently deposited in these representatives—at least in certain phases of the disease process.

A number of questionnaires have been used, and some studies have employed the Critical Care Family Needs Inventory (CCFNI),[12] but knowing the needs and even addressing them is not always directly proportional to the level of satisfaction.

Other satisfaction rating instruments have been developed, validated and extended within the DICM setting in different studies.[13] The best known is the 24-item Family Satisfaction in the Intensive Care Unit questionnaire (FS-ICU 24). This tool has been widely used, as in the study published by Hwang et al.,[14] which shows that important prognostic information has a negative impact upon the family, and that the information routinely supplied by the intensivist within a closed DICM model is better valued by the family.[15]

We have analyzed the interesting study of Holanda Peña et al.[16] who used the FS-ICU 34 questionnaire, which is more complete than the previous version. This questionnaire was administered at least 24 hours after discharge from the DICM, and as a novelty included staff from Extended Intensive Care (EIC). This group with experience in analyses of this kind[17] found the questionnaire scores to increase with an increasing relationship with the individuals under our care. Some items related to nursing care were better scored by the patients than by the families, while the explanations given by the physicians were less valued by the patients and were better rated by the families. This is probably because we spend more time informing the families than the patients, who struggle to maintain competence and autonomy threatened by their strong dependency and serious illness. As pointed out by the authors, this probably also explains why patients assign lower scores to the attention and professionalism of the assistant staff and attendants. In effect, the activities of these professionals are often a reflection of the personal limitations and lack of self-sufficiency suffered by the patients, conditioned among other things by the schedules and routines of the care provided. An important observation is that the agreement observed by the authors between the scores of the patients and their families is not as high as expected. In this regard, and based on the results obtained, the authors recommend that competent patients should be taken more into account in relation to decision making. The agreement between different subjects was also explored by Stricker et al.,[18] who found agreement to be greater between patients and their spouses. In the study published by Hwang et al., satisfaction was found to be greater between parents of patients when compared with other more distant kinships. All these results indicate that greater communication and cohabitation with the patient affords knowledge of the patient perspective, and therefore improves satisfaction and representativeness.

The analyses of most of the commented studies excluded the relatives of patients who died or in which limitation of therapeutic effort was decided. However, it is known that the fact that a patient has died does not necessarily result in a negative opinion on the part of the family or representatives of the patient. Indeed, the opposite has even been described,[19] as a result of increased participation of the families of non-survivors in the DICM in the decision-making process, and greater compassion and communication with the families of patients that have died. Several factors exert a positive or negative influence upon family satisfaction (Table 1), independently of the outcome, as evidenced by a recent review[20] analyzing studies made over the last decade and that have used the FS-ICU.

Based on the analyzed studies, it can be affirmed that the search for satisfaction is a constant element in the medical and nursing professions, particularly among those working in the DICM. This seeking of interlocutor opinion (patient of family) affords feedback for the continuous quality improvement process, and makes us more humane in seeking the wellbeing of others. The personal opinion of the patients

**Table 1** Factors influencing patient and family satisfaction.

| Positive influence | Negative influence |
|---|---|
| Showing courtesy, compassion and respect | Information that is incomplete and hard to understand |
| Good communication, empathy and active listening | Lack of emotional and spiritual support |
| Respect for patient wishes | Conflicts and brief family meets |
| Shared decision making | Resuscitation in end of life moments |
| Family support during discussion and decision making referred to limitation of life support measures | Mechanical ventilation on day of death |
| Gradual (stepwise) limitation of life support | Restrictive visiting policies |
| Pain management | Denial of access to visit loved ones that die |
| Attention focused on the patient and family | Death in the DICM with increased and prolonged use of life support measures involving unknown technology |
| Guarantees of not being abandoned | |
| Honesty in informing | |
| More open visiting regimens | |
| Presence of relatives at resuscitation | |
| Clear and coherent information on prognosis and treatment | |
| Information supplied by high level physicians | |

DICM: Department of Intensive Care Medicine.
*Source*: Salins et al.[20]

should hold a predominant position in the decision-making process, giving importance to their autonomy, without forgetting those factors that weaken autonomy and which are inherent to critical disease. Attention also must focus on the ethical dilemmas due to tension with other principles and values in the complex situations we often have to face. For this reason, training in bioethics and communication skills are key aspects for specialists in intensive care. Attention and communication with the patients and their families are crucial elements for generating confidence and satisfaction. Efforts to communicate with our patients should be a priority concern for improving their wellbeing.

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