Editorial

Measuring family satisfaction in an Indian Intensive Care Unit

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With reference to the article in this issue of the IJCCM[1] addressing family satisfaction, I would like to congratulate the authors for their conscientious attempt to scientifically address an important, yet overlooked aspect of intensive care treatment. The authors' effort at knowing family satisfaction and experience of intensive care treatment is a great step forward in educating intensivists regarding importance of family satisfaction and experience and may pave way to many similar larger comprehensive studies in the future.

This study has many positive outcomes that correlate closely with common beliefs and expectations of the general population. Families of patients admitted to Intensive Care Unit (ICU) received undivided attention and time from ICU Physicians and members of the ICU team, and there was scope for joint family meeting when appropriate. The ICU team also involved family counselors when there was an overt communication need. This highlights caring attitude among the ICU physicians involved in this study. Consciously looking at ICU visitation policy, granting extra visitation time when needed and making the family presence felt at the bedside of terminally ill and dying patients is really commendable. The ICU team in this study also had the process of sourcing family experience through a feedback system.

In this study, out of total 515 patients, 200 consecutive eligible families of patients were interviewed who stayed in the ICU for more than 3 days. Additional information about: (a) How many patients left hospital against medical advice (LAMA) and whether these families were also interviewed, (b) how many patients admitted to ICU had physical symptoms, (c) how many patients had end of life care needs and whether these needs were met, and (d) stating what were the specific advanced health-related communication issues identified and how these issues were met, would have made this study more robust and relevant. Information regarding a number of ICU patients needing limitation of life-sustaining measures and how these issues were addressed and identifying family satisfaction in these family groups could be useful. Furthermore authors have already mentioned in their paper that the questionnaire used in this study is adaptation of an international questionnaire and is not validated in Indian setting and subgroup analysis of families of ICU survivors, ICU nonsurvivors, and ICU end of life care provided was not done.

The study by Wall *et al*. showed families of patients dying in the ICU were more satisfied with their ICU experience when compared to families of ICU survivors.[2] The reasons attributed were intense family-centered aspects of care in dying patients. Though this study has not done the subgroup analysis

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of ICU survivor versus ICU nonsurvivor, it brings out the role of communication, counseling and family support, and not just outcomes of ICU management. Family satisfaction in the ICU (FS-ICU) survey is a validated method for determining family satisfaction of ICU care, which examines satisfaction of care domain and satisfaction of decision-making domain. Hence, authors can consider doing a larger study using FS-ICU tool[3] and including psychometric properties may further improve the assessment process.[4] The study by Jongerden *et al*. on role of ICU environment on family satisfaction showed that family satisfaction with ICU experience increased by 6% in an ICU environment with reduced noise, privacy of single rooms with daylight, and improved family facilities.[5] In this study, the authors received critical feedback regarding facilities for families in ICU, visitation hours and timing of visitation. Hence, these factors need to be accounted while structuring a qualitative ICU services. US Society for Critical Care Medicine guidelines recommends training in "good communication skills should become a standard component of medical education for all ICU caregivers" and there is evidence to suggest that empathic communication, skillful discussion of prognosis, and effective shared decision-making reflects quality of care provided in ICU.[6] The study by Shaw *et al*. showed training multidisciplinary teams of ICU healthcare providers in communicating with the families of patients admitted to ICU significantly improved family satisfaction and ICU experience.[7] This study has clearly demonstrated the role of staff interaction and role of medical counseling to the attendants. Allowing families during family meeting, family involvement in decision of limitation of life-sustaining treatment, emotional support, assistance to families with regards to coordination of care, are the other factors known to improve family satisfaction of ICU care.[8,9]

Assessment of family satisfaction and interpretation of results by themselves may not serve any purpose unless and until succeeded by measures taken to holistically and comprehensively assess needs of patients and families in ICU and remedial steps are taken toward improvement.

This article, first of its kind in India, surveying family satisfaction in ICU setting may help other intensivists to consider outcomes of this study, implement them in their practice and conduct larger studies on the same line. The further studies on family satisfaction among families of ICU admitted patient can be done more descriptively using validated tools that accesses infrastructure for families in ICU, family care process, family involvement in decision making, family communication, psychosocial assessment of families, and family distress. It will be also useful if these studies compared satisfaction among families of ICU survivors and ICU nonsurvivors and include family satisfaction of LAMA patients and what form of continuity of care these patients/families received on discharge. On a concluding note, this was a well-conceptualized, well-intended, well-done study that can serve as a framework for many future studies on family satisfaction in Indian ICU setting.

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