



**HAL**  
open science

## **Thank you letters from patients in an intensive care unit: From the expression of gratitude to an applied ethic of care**

Alexandre Herbland, Michel Goldberg, Nathalie Garric, Olivier Lesieur

### ► **To cite this version:**

Alexandre Herbland, Michel Goldberg, Nathalie Garric, Olivier Lesieur. Thank you letters from patients in an intensive care unit: From the expression of gratitude to an applied ethic of care. *Intensive and Critical Care Nursing*, 2017, 10.1016/j.iccn.2017.05.007 . hal-01619172

**HAL Id: hal-01619172**

**<https://hal.science/hal-01619172>**

Submitted on 31 Oct 2017

**HAL** is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

## **THANK YOU LETTERS FROM PATIENTS IN AN INTENSIVE CARE UNIT:**

### **FROM THE EXPRESSION OF GRATITUDE TO AN APPLIED ETHICS OF CARE**

Alexandre Herbland<sup>a</sup> \*, Michel Goldberg<sup>b</sup>, Nathalie Garric<sup>c</sup>, Olivier Lesieur<sup>a,d</sup>

\*corresponding author : [alexandre.herbland@orange.fr](mailto:alexandre.herbland@orange.fr); tel : (33) 546456607

<sup>a</sup> Service de réanimation polyvalente, Hôpital Saint Louis, rue du docteur Schweitzer, Groupement Hospitalier La Rochelle Ré Aunis, 17019 La Rochelle Cedex.

<sup>b</sup> Laboratoire Littoral, environnement et sociétés (LIENSs). UMR CNRS 6250 Bâtiment Curie. Université de La Rochelle, 17000 La Rochelle. E-mail adress : [michel.goldberg@univ.fr](mailto:michel.goldberg@univ.fr)

<sup>c</sup> [EA 4643 Construction discursive des représentations linguistiques et culturelles \(CoDiRe\)](#), Université de Nantes, 44000 Nantes. E-mail adress : [nathalie.garric@univ-nantes.fr](mailto:nathalie.garric@univ-nantes.fr)

<sup>d</sup> EA 4569, Laboratoire d’Ethique Médicale et Médecine Légale, université Paris Descartes. E-mail adress : [olivier.lesieur@ch-larochelle.fr](mailto:olivier.lesieur@ch-larochelle.fr)

## **ABSTRACT**

### **Introduction**

Patients’ perception of an intensive care unit (ICU) stay can lead to a better understanding of the expectations and needs of patients hospitalized in intensive care so that care for critically ill patients can be adapted and improved. Thank you letters are sources of original information which come directly and spontaneously from patients.

### **Objective**

The objective of this study was to analyse the thank you letters from patients who required intensive care treatment and to identify messages that could be intended for the ICU team.

### **Design**

We conducted a qualitative study according to a thematic analysis. The body of research consisted of 17 letters from patients hospitalized in ICU.

### **Setting**

The study took place in the medical-surgical ICU of a French general hospital. The ICU is made up of 16 resuscitation beds and 4 beds of continuous monitoring unit.

### **Findings**

Two main themes emerged: (i) expression of gratitude through a description of the caregivers’ behavior (humanity and professionalism) and recognition for surviving (ii) the narrative of the ICU experience.

### **Conclusion**

Thank you letters give a rich insight into how the patients perceived their stay in ICU. Letters from patients give direct feedback on the quality of care provided, contribute to give meaning to work and raise the question of what the core values of care should be for all concerned in the healthcare providers-patients relationship.

**Keywords:** Critical care, Qualitative research, Nurse-Patient Relationship, Patients, Holistic nursing, Intensive Care Unit, Narration, Quality of health care, Survivors

## **IMPLICATIONS FOR CLINICAL PRACTICE**

For various reasons, thank you letters should be easily available for all ICU staff:

- These letters contain information which gives insight about intensive care patients' experiences.
- Healthcare providers can find a sense of professional acknowledgement in the letters which is both gratifying and gives sense to the care and services provided.
- The humanity in care relationship comes through the letters and needs to be taken more into consideration in critical care.
- Letters constitute a highly personalized and non-exclusive means of communication which can feed a endless source of renewable information for an applied ethics of care.

## **INTRODUCTION**

ICU patients sometimes express their thanks towards ICU teams by sending a thank you letter. Thank you letters from patients who survived their stay in ICU provide direct and spontaneous personal accounts. Even if the patient's experience in ICU has already been explored by several methods (semi-directive interviews, questionnaires, testimonials) (Green, 1996; Hofhuis et al., 2008; Stein-Parbury and McKinley, 2000) ICU staff may still have inaccurate perceptions of their patients' experiences (Abuatiq, 2015; Randen et al., 2013; Schindler et al., 2013). These letters embody one facet of the patients' experience and feelings, they nevertheless constitute a unique and relevant source of information on this topic. Hidden behind the expression of gratitude, the patients convey potentially significant messages to the health professionals which could be the basis for future action.

Letters of gratitude have been the subject of one study in palliative care (Centeno et al., 2010) but to the best of our knowledge a study focusing on letters received from patients in ICU has not been carried out. The analysis of such data may allow for a better clarification of the patients' experience and messages delivered to the care providers. This feedback from patients can help us to improve our understanding of their needs and their expectations and thus to make adjustments in our care provision.

## **METHODS**

### **Objectives**

The aim of this descriptive study was to examine an ICU patient's perspective through the bias of thank you letters, and to identify the potential relevant messages addressed to the ICU team.

### **Setting**

The study took place in the medical-surgical ICU of a French general hospital. The ICU is made up of 16 resuscitation beds and 4 beds of continuous monitoring unit.

### **Ethical approval**

Ethical approval for this study was provided by the Institutional Ethical Committee of the Atlantic 17 Hospital Community of Territory. According with French law on medical research, written informed consent from the patient or next-of-kin was not required for this observational study.

### **Data collection**

Before 2012 thank you letters received in ICU were not systematically kept and filed, nevertheless medical secretaries would file thank you letters that arrived in a specific file. The project of letters analysis came about by exploring this particular file. In October 2012 we retrospectively compiled the most recent thank you letters received from ICU patients in chronological order in this file. These patients had spontaneously written and sent letters of gratitude after being discharged. The compilation of letters formed the body of research. Data saturation determined the qualitative sample size.

In 2013 we put in place a specific ICU policy in order to classify, count and archive letters from families and patients. All letters received whoever sent them, are collected by the medical secretaries and kept. During the

period from 2013 to 2016 the unit received 92 thank you letters, a minority (30) of which came from patients. Just for information, during the 2012-2016 period the unit received one letter of complaint.

*Dear Hospital manager,*

*Due to major health problems, I was admitted in (month) to your ICU ward and then the cardiology department. More recently (date) I was admitted to the emergency department and then, after a short stay in ICU at (other location) due to a lack of available beds, I was hospitalized again in your pneumology department.*

*I would like you to pass on the information please, to all the people who work in these different departments to tell them on my behalf how grateful I am and to thank them all.*

*I was able to appreciate, not only the quality of their care but also their heartfelt kindness, in such painful moments, as they were understanding, kind and thoughtful.*

*I know how difficult their task is so I was all the more touched by the fact that they were so present and attentive and I would like to tell them how much this helped me.*

*People always feel a little distraught and worried during a stay in hospital and even more so when you are old like me, it is even worse!*

*Please thank everyone from me.*

*Yours sincerely*

*(Signature)*

**Figure 1:** An example of a thank you letter.

The words in brackets refer to specific locations or dates and were omitted to preserve the author's anonymity.

In 2012, 594 patients were admitted to ICU, with an average age of 65 years, an average length of stay of 9.69 days and the mortality rate was 28 %.

### **Data analysis**

We analysed the letters using thematic textual analysis with an inductive approach (Boyatzis, 1998). Coding processed over six phases: familiarization data, setting up initial codes, searching for themes among codes, reviewing themes, defining and naming themes, and finally producing the report. The letters were made anonymous and analysed by four different researchers (AH, MG, NG, OL). The four researchers came from a range of backgrounds more specifically linguistic (NG), discursive analysis (MG), biomedical ethics (OL), intensive care (AH, OL). This ensured that there was a range of perspectives when coding, interpreting and in discussing the findings. The 3 first steps of the coding process were independently undertaken to improve the trustworthiness of the analysis. To enhance the credibility of the research, differences of opinion about coding and interpretative analysis were regularly discussed until consensus was reached and this happened during several analysis meetings. The use of saturation in the analysis reinforced the truthfulness and transferability of findings. In the findings and discussion sections, all statements in quotation marks have been taken directly from the letters to illustrate our findings.

## **FINDINGS**

### **The patients and their letters**

The people who wrote the letters had undergone life-threatening situations requiring a stay in ICU. The patients and their letters characteristics are shown in Table 1. The median age was 63 years (interquartile

range (IR): 44-76). The median length of stay in ICU was 10 days (IR: 2-18). The median interval between leaving the unit and writing the letter was 49 days (IR: 17.5-117.5). Seven patients were not from the area. A whole letter has been translated into English and attached to article (Fig. 1).

Letters	Patients characteristics				Letters characteristics			
	Stay in ICU (years)	Length of ICU stay (days)	Reason for ICU stay	Time period between ICU stay and writing (days)	File type	Words (count)	Lines (count)	Recipients
1	2012	28	Respiratory failure	49	Printed letter	1303	117	All the ICU team
2	2012	14	Respiratory failure, septic shock	16	Handwritten letter	109	11	The ICU
3	2012	2	Respiratory failure (drowning)	19	Handwritten post card	88	7	The ICU
4	2012	3	Neurologic failure (toxic coma)	2	Handwritten letter	98	9	Ladies
5	2011	14	Attack of malaria	9	Handwritten letter	98	9	The ICU Team
6	2008	45	Respiratory failure, neurologic failure (coma)	362	Printed letter and handwritten card	559	43	The ICU manager
7	2009	2	Respiratory failure	33	Handwritten letter	177	16	The hospital manager
8	2004	11	Septic shock	151	Handwritten card	68	6	The ICU manager and the team
9	2006	2	Angioedema	Unknown	Handwritten post card	47	6	All the ICU team
10	2010	2	Respiratory failure	115	Handwritten letter	97	8	The hospital manager
11	2009	24	Septic shock, respiratory failure	87	Handwritten post card	39	5	All the ICU team
12	2007	8	Cardiac arrest, drowning	129	Handwritten letter	182	14	The hospital manager
13	2007	8	Cardiac failure, neurologic failure, respiratory failure	30	Handwritten post card	29	4	None
14	2007	60	Respiratory failure	2	Handwritten post card	33	3	The ICU team
15	2003	10	Respiratory failure	68	Handwritten letter	186	16	The hospital manager
16	2012	18	Respiratory failure	120	Handwritten letter	189	19	The doctors
17	2012	2	Post partum hemorrhage	Unknown	Handwritten post card	63	7	All the ICU team

**Table 1:** Patients and letters characteristics.

The letters were mainly addressed to “the ICU team” and the head of ICU is added two times out of nine. Four of the texts are addressed to the Hospital manager, one post card is not addressed to anyone in particular, one letter is addressed to the male doctors and one card is dedicated to female staff implying “the ICU team”. Each time the people convey their thanks to the complete ICU team and even to all wards the patient had spent time on. Patients often mention multidisciplinary management in their thanks not wanting to forget anyone.

“To each and everyone... physicians, nurses, caregivers, kitchen staff, dietetician, cleaning service, physiotherapists, paramedics, Emergency medical assistance service”. No 1.

“...both young and old, men and women, at all skill levels”. No 10.

### Themes and subthemes identified in the letters

Data saturation was achieved after examining 17 letters. The analysis of the qualitative data resulted in two major themes: The expressed and justified gratitude, and the account of the experience in the ICU. Table 2 gives a summary of the sub-themes and categories identified under each theme.

#### The expressed and justified gratitude

All patients without any exception express their acknowledgements to the ICU staff. They simply wrote “thank you” or gave more reasons for their thanks. Thus, patients not only expressed their gratitude but also explained why. Two subthemes illustrate the rationale for the patients’ gratefulness: the caring attitude of all

staff concerned i.e. the manner in which the medical and auxiliary staff dealt with the patient and the recognition to be alive.



**Figure 2:** Word cloud characterizing the ICU team humanity in care relationship. The size of each word is proportional to its occurrence in the letters examined.

Themes	Subthemes	Categories
The expressed and justified gratitude	The caring attitude	Humanity in care Professionalism Family-centered care
	The patient's recognition to be alive	The good inter-disciplinary coordination A life saved for themselves A life saved for the relatives
The personal account of the experience in the ICU	ICU: an unpleasant place to be	The physical experience The psychological suffering The perception of time
	The striking and memorable aspect of the ICU experience	Positive: the people, the ICU staff Negative: intensive care experience
	The discovery of the world intensive care medicine	The technical environment The progress of medicine

**Table 2:** Summary of main themes, sub-themes and categories.

### The caring attitude

Patients acknowledged four categories.

- Humane behavior is strongly expressed to characterize the attitude of the ICU team with certain words. Humanity in care is illustrated in a word cloud (Fig. 2).

- Professionalism is also underlined with words like:

*“Skills” (no 1,8,12), “quality of care” (no 15), “performing, great profession” (no 1), “professionalism” (no 10), “outstanding care” (no 7), “thanks for your work” (no 6).*

The mastery of modern medical techniques is also quoted:

*“Impressive device to learn how to breathe again”. No 1.*

- Family-centered care. Making families feel welcome and keeping them informed is a caring attitude which is recognised by patients. This is highly acknowledged in their letters:

*“I particularly thank the nurse... because more than just caring for me she also took care of my husband who was disabled and knew nothing about the area (meals, beds etc) thanks, thanks, thanks....”*. No 3.

*“They told me... the time you took with them, to explain what was happening and to reassure them”*. No 5.

- Good inter-disciplinary coordination is an emerging idea from data through the use of words and expressions with high symbolic significance:

- *By thanking the team to have been: “the first link in the chain”*. No 16.

- *“I had an exceptional resuscitation thanks to a solidarity chain and competent staff”*. No 12.

More precisely the smooth coordination is emphasized at various levels of the healthcare system:

- Between main key players of the care network, hospitals and/or other medical correspondents (for example general practitioners) underlying the importance of transferring medical information from the ICU towards the ongoing providers in the care pathway. (No 7).
- Between the different parts of the same hospital, quoting the several units directly concerned by the patient’s care pathway: “paramedics” (no 1,10,12), “emergency medical assistance service” (no 1,10), “resuscitation” (no 1,5,6,7,10,12,14,15,16), “cardiology” (no 15), “pneumology” (no 7,12,15), “post-acute care, rehabilitation” (no 7,16) highlighting the good continuity of care.
- Between different professional disciplines “physiotherapy” (no 1,11), “cleaning, dietetician” (no 1), “catering services” (no 1,7), “nurses” (no 1,3,8,11), “care providers” (no 1,11), “assistants” (no 2), “doctors” (no 1,7,11) “personnel” (no 6,7,10,12) from the same unit. “From the most technical skills to the most humble tasks...”. No 1.

### **The patient’s recognition to be alive**

- Patients are grateful to have survived, and it could be expressed as: “thanks for saving my life” (no 9,16), or more indirectly : “I rediscovered the meaning of life” (No 1).

- Another key idea which is firmly present in the letters is that having survived means being at one with their loved ones. Beyond the life saved, the unity of the family is preserved: “thanks to all of you a family continues to exist” (no 9), “thanks ... so that I can join my son as quickly as possible...” (no 17).

### **The personal account of the experience in the ICU**

The patients give details about their experience in the ICU and also about the present period by relating their return to normal life. Three subthemes characterize the testimony.

-ICU: an unpleasant place to be

- The feeling that best characterizes the patient’s experience of a stay in ICU is of physical and mental strain. Accounts of time spent in ICU are retold using physical, psychological feelings and are based on a particular perception of time.
- In terms of the physical aspect the experience is evoked through physical pain, loss of weight, nudity. Other aspects are addressed with numerous words: “nude, mute, pain, bled dry, integrity, the flagrant lack of autonomy, to the body which searches to understand too” (no 1), “suffering, dependency” (no 1,6), “coma” (no 1,4), “masks intolerance” (no 5).
- The psychological suffering is revealed by these terms: “high anxiety, fears, nightmares, blinding fears, questions about the future, death loomed near us, leave hell, we leave in an altered state, let go” (no 1), “wearisome” (no 8,15), “distress, difficult step” (no 10), “victim of...” (no 12), “disabled” (no 3,15), “worried” (no 15).
- The perception of time is recalled: “tough moments” (no 8,15), “difficult moment” (no 10,17), “very long” (no 17), “patience, your clock seems to have stopped” (no 1).

-The striking and memorable aspect of the ICU experience

The quote “I will never forget” comes up regularly in the letters. This could be interpreted as either negative or positive when it characterizes “the adventure” experienced: “I will hold great memories of my stay, a former patient who never will forget his stay in your unit” (no 6). However when the expression of memory is specifically related to one or more people in particular, the connotation is always positive:

“I will never forget all the care given...” (no 2), “I particularly thank the nurse..., thanks..., I will never forget” (no 3).

-The discovery of the world of intensive care medicine

Patients report upon their vision of the particular and highly technical world of intensive care. This is based not only through physical sensations as a result of direct confrontation with medical devices such as intubation tubes, gastric tubes, tracheostomy cannulas, but also through visual or acoustic sensations (working of machines, screens, alarms from scopes, air suction, gas flow in masks). The mention of technical environment can be included in the broader theme of the progress of medicine:

*“These techniques and gestures highly used”, “tubes everywhere”, “a highly technical medicine”. No 1.*

## **DISCUSSION**

### **The humane aspect of providing care**

The humanity of the healthcare workers is the main rationale for gratitude in the letters. The few references to named ICU team members in letters also highlight the personal relationship that could inevitably emerge between patients and care professionals depending on their differing levels of sensitivity, their personalities and given moments. References to specifically named people in the text always have a positive value. It reveals a human need to establish links in the hostile ICU environment. Humanity of the care providers, which is well documented in the letters, seems all the more precious given that the ICU environment is described as a very technical one: “devices, catheters, probes”.

The analysis of the letters reveals the patients’ need for humane attitude when delivering care. It sounds like an authentic plebiscite for the humanisation of care. The patients’ perspectives support the psychologists’ point of view advocating for holistic care in ICU, interlinked with somatic care and incorporating psychological and relational dimension in care, (Hazzard et al., 2013; Jackson et al., 2014; Papathanassoglou, 2010; Stanton, 1991). Such letters encourage all ICU staff to develop interpersonal communication skills, empathy, attention, enabling the climate of trust which is essential to ensure the quality and the individuality of care which patients hope for.

### **Looking after the families**

In 1853 Auguste Comte wrote: “the human society is composed of families, not by individuals” (Comte, 1853). In their letters patients express their joy to going back to a familiar setting after a period of separation. This comforting and soothing feeling is even more strongly perceived because relatives had been supported by the team during the stay in ICU.

Patients are also most grateful for having been saved for their relatives (in some cases the meaning of their own lives seem even more precious for their loved ones than for themselves). This message reinforces the idea of the critical importance of family links for vital balance, and supports the notion of individuals needing to be close to relatives. In this way thank you letters perpetually operate for the ICU team like a type of alarm system. Letters periodically force us to not forget to provide care for the relatives, to carefully communicate and support them. This attitude is a source of gratitude for the patients, and undoubtedly improves the families’ experience of ICU.



These implications are underpinned by several studies centered on families of patients in ICU resulting in a better understanding of their needs and expectations (Azoulay et al., 2001; Hinkle and Fitzpatrick, 2011). Risks factors for post ICU syndrome in the families and patients have been identified. To illustrate the interdependences of a patient and his/her family, high levels of psychological distress in patients were found to be correlated with high levels of psychological distress in relatives too (Jones et al., 2004). Recent recommendations emphasized the importance of extending visiting times in ICU for families, improving communication and taking into better consideration the satisfaction of the families concerned (Davidson et al., 2007; Khaleghparast et al., 2016; Whitton and Pittiglio, 2011).

### **ICU, a living place**

In the letters patients spontaneously describe their differing states of physical and psychological suffering in ICU which in turn brings about moments of anxiety and doubt. Difficulties encountered in staying in ICU is also reported by studies focused on how patients account their experience (Nelson et al., 2001; Novaes et al., 1999). Otherwise we noticed the recurrent retelling of everyday moments of life and reappropriation of daily habits, as if returning to normal life. If patients rediscover the fundamental meaning of life after discharge, one can *a posteriori* suppose that life had no meaning for them during their ICU stay. This assumption illustrates the loss of markers and the risk of social isolation during this critical period. This observation reinforces the idea that ICU should not only be just a place to survive but a living place (Woodward, 1978), where relatives have an important role to play. Without occulting patients' difficulties that are inherent in their medical status (accidents, severe illnesses), it should be emphasized that in a place offering extraordinary technologies for supernatural situations, we should be extraordinarily humane, kind and natural in order to give back an existential framework for patients and their relatives. Several measures have been initiated in our ICU following feedback from patients. Wall clocks displaying dates and times have been installed for patients in each ICU room to allow a better perception of time passing. A brief account of the patient's life with details about the patient's character, lifestyle as well as her family and work situations is completed by patients or close relatives on their arrival in ICU. The objective being to create a safe and supportive environment for emotional expression and sharing. Promoting the use of different sources of media (TV, radio, internet if possible) and extending visiting hours maintain the link between the patient and the outside world.

From how patients perceive healthcare to providing an insight for providers: a form of constructive feedback Patients' perceptions of intensive care has already been explored (Arroyo-Nova et al., 2008; Hofhuis et al., 2008; Nelson et al., 2001; Simini, 1999). The more common reported sources of patient discomfort are anxiety, thirst, pain, lack of sleep, endotracheal intubation, dependency, lack of understanding, lack of privacy. The grounds for discomfort spontaneously mentioned by the patients in their letters are the same as those reported by other studies and methods.

Care providers assessment and understanding of patients' needs and hopes seem subjective and variable according to each individual. Authors have shown that care providers have an inaccurate perception of patients' experiences (Abuatiq, 2015; Pang and Suen, 2008; Randen et al., 2013) and that their judgment can be distorted by « hyper-attention » or « hypo-attention » about patients' subjective experience (Schindler et al., 2013).

The thank you letters contain precious sources of information, provided that these can be easily retrieved and that the staff are then able to decrypt them. Easy access to the letters should be organised so that all information contained in the letters is available to all. A specific location in a designated place (for instance a bulletin board in the staff rest room) would allow everyone the possibility to read the letters carefully. In practice, the aim is to foster a virtuous circle so creating a real service-oriented culture focused on communication based upon this bank of thank you letters. The improved perception of patients' experience

(needs, sources of discomfort and sources of satisfaction) by the staff could lead to substantial adaptation of health-care practices and subsequently an improvement in patients' conditions. The patients would benefit consequently not only during their ICU stay but also after discharge. Indeed, ICU discomforts are shown to be risk factors for short and long-term psychological disorders (Rattray et al., 2010), conversely improved ICU conditions could also benefit all patients after ICU (Granja et al., 2005).

ICUs are usually characterized by a large number of employees with a high staff turnover (Cartledge, 2001). The arrival of new employees, trainees, or students is constant. Staff renewal is periodic due to managerial requirements (staff shortages, absenteeism, deployments, replacements) or as a result of professional training courses (nursing students, care assistant students, residents, medical trainees). In this context letters provide an immediate source of information about patients' feelings, experiences and needs to all new and old staff members both old and new alike.

### **Quality of care**

By broadly addressing their letters to the "ICU team" and highlighting the close team work, patients acknowledge and recognize that healthcare organization is based on people working well together cooperating, exchanging and passing on information.

Letters provide feedback about the quality of care not only on a technical aspect in terms of professionalism, continuity of care but also as regards to relationships (listening skills, support and solidarity). Assessment of quality of care is compulsory for health institutions through specific follow-up indicators (Rhodes et al., 2012). However the quality of care is more than just effectiveness, security, accessibility, or efficiency. The relationship aspect represents an essential component which contributes to the patient's overall well-being. The care relationship between patients and healthcare providers is quantifiable via measurements tools like the modified version of the Family Satisfaction-ICU (FS-ICU) questionnaire (Mosleh et al., 2015). However given the subjectivity of each patient and the care providers' own emotional involvement in the care relationship (Burnard, 1987) there are some dimensions of the patients' well-being which are virtually impossible to measure. In ICU, listening, being present, finding the right words, are all the more important as patients are both physically and psychologically vulnerable.

### **Self-esteem, professional satisfaction of health care staff**

Apart from merely thanking, the rationale and arguments formulated by the patients increase the gratitude initiative. The staffs professionalism coupled with humanity in caring represents the most important areas of gratitude. Healthcare providers in ICU are strongly involved in their work, which is perceived and appreciated by patients.

Professionals working in ICU are particularly at risk of developing burnout syndrome (Poncet et al., 2007). Insufficient rewards are part of the organizational factors associated with burnout. Easier access to letters and their messages can help to boost self-esteem, notably for the lower skilled workers who may feel undervalued and in need of support. The ICU team can find in the letters a kind of professional acknowledgement which is both gratifying and gives sense to tasks undertaken this in turn can lead to a sense of accomplishment. The thank you letters play an important role in the staff's well-being, which in itself is a crucial parameter for patients' well-being (Kentish-Barnes and Chaize, 2010). To illustrate this point a recent publication describes how a palliative care team uses thank you letters as a source of motivational empowerment (Martins Pereira and Hernández-Marrero, 2016). In our unit the allocated area for the thank you letters has gradually shifted towards a broader space where all the expressions of thanks (in the form of phone calls, visits, gifts with short messages, letters) from relatives and patients are relayed to the staff.

### **Letters as an advocacy for an ethics of care ?**

Ethics of care can be defined as « ...an ethic grounded in voice and relationships, in the importance of everyone having a voice, being listened to carefully (in their own right and on their own terms) and heard with respect. As an ethics of care which directs our attention to the need for responsiveness in relationships (paying attention, listening, responding) and to the costs of losing connection with oneself or with others. Its logic is inductive, contextual, psychological, rather than deductive or mathematical » (GILLIGAN, 1982).

The thesis of Carol Gilligan (1982) establishes the principle of « ethics of care » as an essential social link in the American society of the seventies-eighties, whose principal concerns were self-fulfilment by autonomy, independency and financial success. Joan Tronto (1993) defined four phases of caring (caring about, taking care of, caregiving, care receiving) and four elements of care (attentiveness, responsibility, competence, responsiveness of the care receiver) requiring certain attitudes and skills from both care providers and care receivers. Thus care is thought as a reciprocal practice involving cognitive, emotional, and action strategies (Tronto, 1993) from both parts. Within this framework thank you letters represent the responsiveness of the care receiver and therefore embody the phase of “care receiving”. Patients tell the healthcare providers through the letters that the care provided met their needs. Some of the most used words to characterize the professionals’ human relationship in the letters (fig 2) perfectly resonate with the first three phases of care: “Attentiveness” with “caring about”, “understanding” and “kindness” with “taking care of”, “devotion” with “care giving”. The first three elements of care are also enhanced by the recognition of the dedication and professionalism of the ICU staff.

The analysis of the letters leads us to believe that the “taking care of” needs to be taken more into consideration, as an advocacy statement to be submitted to all concerned in the healthcare providers-patients relationship.

Thus, thank you letters take on a particular dimension that far exceeds its simple correspondence framework of acknowledgements with polite words. Such letters make up a non-exclusive and constantly renewed medium for an applied ethics of care, which are highly personalized and easily accessible to the staff.

### **Limitations**

From our point of view the letters analysed display a number of common features which give an unquestionable unity to the body of research:

- All patients who had written letters had lived through an impairment of vital prognosis and were in a comparable period following hospitalization so that production conditions were similar. All the letters find their origins in the patient’s spontaneous and personal initiative to address the people with whom they had shared moments of survival.
- The communication support (written speech in the form of letters) is common to all elements constituting the body of research.
- The thank you process as a social practice may be common to whole letters.

The uniformity of data ensures a real coherence which in turn reinforces the reliability of the qualitative analysis.

The patient’s personal judgment about ICU is positive and encouraging and much more relevant because it is well-argued (humane behavior, professionalism, continuity of care). Given the small number of patients who write a letter, the universal scope of these subjective judgments is open to discussion as we do not know the position of patients who chose not to write. Moreover patients who wrote a letter to express their gratitude might have a common personality trait towards noticing and appreciating the positive aspects in life called « grateful disposition » (McCullough et al., 2002). If this assumption is correct concerning the psychology of patients who write a letter, the transferability of our findings could be considered to be limited.

One might wonder whether such an approach is exhaustive and truly representative. However the aim of this study is not to characterize the experience of all ICU patients, but an attempt to decipher the meaning of messages contained in patients' letters. The themes identified and the issues discussed here may not be universally applicable for all ICU patients. In contrast this analysis emphasizes the fact that thank you letters are a concrete and personalised source of information for each ICU.

Other methodological approaches (discourse analysis, linguistic analysis, psychological analysis) could bring about a different viewpoint and another reflection upon the meaning to be given to the letters. Future research exploring thank you letters from relatives in the ICU should broaden and complete our findings, which is planned for our next study. Finally to finish, comparing the results of this study with an analysis of thank you letters of patients from different hospital units and other countries or regions could emphasise cultural variations. Different findings from various ICUs could be recognised and followed up for further work and this on a greater scale.

## **CONCLUSION**

The qualitative analysis of the letters shows for the first time the thematic richness of such data. The two main themes are (i) the gratitude towards healthcare professionals which are justified on differing levels: the healthcare providers' caring attitude (humanism, professionalism, family-centered care), the patients' recognition to be alive for themselves and for their relatives (ii) the unique testimony of the moral and physical strain of a distressing stay in ICU. Letters provide encouraging and informative messages for ICU teams about patients and family support, and also provide direct feedback from the users concerning the quality of care received. The thematic content questions the fundamental care values at stake in the patient-carer relationship in the context of an ICU, which form the very essence of the nursing activity.

## **ACKNOWLEDGEMENTS**

The authors would like to thank Kate Sonsino for her contribution to reviewing and improving this article

## **FUNDING SOURCE**

None

## **CONFLICT OF INTEREST**

None

## **CLINICAL TRIAL REGISTRATION NUMBER**

Not applicable

## **REFERENCES**

- Abuatiq, A., 2015. Patients' and Health Care Providers' Perception of Stressors in the Intensive Care Units: *Dimens. Crit. Care Nurs.* 34, 205–214. doi:10.1097/DCC.000000000000121
- Arroyo-Novoa, C.M., Figueroa-Ramos, M.I., Puntillo, K.A., Stanik-Hutt, J., Thompson, C.L., White, C., Wild, L.R., 2008. Pain related to tracheal suctioning in awake acutely and critically ill adults: A descriptive study. *Intensive Crit. Care Nurs.* 24, 20–27. doi:10.1016/j.iccn.2007.05.002

- Azoulay, E., Pochard, F., Chevret, S., Lemaire, F., Mokhtari, M., Le Gall, J.R., Dhainaut, J.F., Schlemmer, B., French FAMIREA Group, 2001. Meeting the needs of intensive care unit patient families: a multicenter study. *Am. J. Respir. Crit. Care Med.* 163, 135–139. doi:10.1164/ajrccm.163.1.2005117
- Boyatzis, R.E., 1998. *Transforming Qualitative Information: Thematic Analysis and Code Development.* SAGE.
- Burnard, P., 1987. Coping with emotion in intensive care nursing. *Intensive Care Nurs.* 3, 157–159. doi:10.1016/0266-612X(87)90073-3
- Cartledge, S., 2001. Factors influencing the turnover of intensive care nurses. *Intensive Crit. Care Nurs.* 17, 348–355. doi:10.1054/icc.2001.1599
- Centeno, C., Arantzamendi, M., Rodríguez, B., Tavares, M., 2010. Letters from relatives: a source of information providing rich insight into the experience of the family in palliative care. *J. Palliat. Care* 26, 167–175.
- Davidson, J.E., Powers, K., Hedayat, K.M., Tieszen, M., Kon, A.A., Shepard, E., Spuhler, V., Todres, I.D., Levy, M., Barr, J., Ghandi, R., Hirsch, G., Armstrong, D., 2007. Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine Task Force 2004–2005: *Crit. Care Med.* 35, 605–622. doi:10.1097/01.CCM.0000254067.14607.EB
- GILLIGAN, C., 1982. *In a Different Voice.* Harvard University Press.
- Granja, C., Lopes, A., Moreira, S., Dias, C., Costa-Pereira, A., Carneiro, A., JMIP Study Group, 2005. Patients' recollections of experiences in the intensive care unit may affect their quality of life. *Crit. Care Lond. Engl.* 9, R96-109. doi:10.1186/cc3026
- Green, A., 1996. An exploratory study of patients' memory recall of their stay in an adult intensive therapy unit. *Intensive Crit. Care Nurs. Off. J. Br. Assoc. Crit. Care Nurses* 12, 131–137.
- Hazzard, A., Harris, W., Howell, D., 2013. Taking care: Practice and philosophy of communication in a Critical Care follow-up clinic. *Intensive Crit. Care Nurs.* 29, 158–165. doi:10.1016/j.iccn.2013.01.003
- Hinkle, J.L., Fitzpatrick, E., 2011. Needs of American relatives of intensive care patients: Perceptions of relatives, physicians and nurses. *Intensive Crit. Care Nurs.* 27, 218–225. doi:10.1016/j.iccn.2011.04.003
- Hofhuis, J.G.M., Spronk, P.E., van Stel, H.F., Schrijvers, A.J.P., Rommes, J.H., Bakker, J., 2008. Experiences of critically ill patients in the ICU. *Intensive Crit. Care Nurs.* 24, 300–313. doi:10.1016/j.iccn.2008.03.004
- Jackson, J.C., Santoro, M.J., Ely, T.M., Boehm, L., Kiehl, A.L., Anderson, L.S., Ely, E.W., 2014. Improving patient care through the prism of psychology: Application of Maslow's hierarchy to sedation, delirium, and early mobility in the intensive care unit. *J. Crit. Care* 29, 438–444. doi:10.1016/j.jcrc.2014.01.009
- Jones, C., Skirrow, P., Griffiths, R.D., Humphris, G., Ingleby, S., Eddleston, J., Waldmann, C., Gager, M., 2004. Post-traumatic stress disorder-related symptoms in relatives of patients following intensive care. *Intensive Care Med.* 30, 456–460. doi:10.1007/s00134-003-2149-5
- Kentish-Barnes, N., Chaize, M., 2010. Critères de jugement du « mieux vivre » en réanimation. *Réanimation* 19, 204–211. doi:10.1016/j.reaurg.2010.03.009
- Khaleghparast, S., Joolae, S., Ghanbari, B., Maleki, M., Peyrovi, H., Bahrani, N., 2016. A Review of Visiting Policies in Intensive Care Units. *Glob. J. Health Sci.* 8, 267–276. doi:10.5539/gjhs.v8n6p267
- Martins Pereira, S., Hernández-Marrero, P., 2016. “In Memory of Those Who Left”: How “Thank You” Letters Are Perceived and Used as a Team Empowerment Motivational Factor by a Home-Based Palliative Care Team in the Azorean Islands. *J. Palliat. Med.* 19, 1130–1131. doi:10.1089/jpm.2016.0255
- McCullough, M.E., Emmons, R.A., Tsang, J.-A., 2002. The grateful disposition: A conceptual and empirical topography. *J. Pers. Soc. Psychol.* 82, 112–127. doi:10.1037/0022-3514.82.1.112

- Mosleh, S., Alja'afreh, M., Lee, A.J., 2015. Patient and family/friend satisfaction in a sample of Jordanian Critical Care Units. *Intensive Crit. Care Nurs.* 31, 366–374. doi:10.1016/j.iccn.2015.04.004
- Nelson, J.E., Meier, D.E., Oei, E.J., Nierman, D.M., Senzel, R.S., Manfredi, P.L., Davis, S.M., Morrison, R.S., 2001. Self-reported symptom experience of critically ill cancer patients receiving intensive care. *Crit. Care Med.* 29, 277–282.
- Novaes, M.A., Knobel, E., Bork, A.M., Pavão, O.F., Nogueira-Martins, L.A., Ferraz, M.B., 1999. Stressors in ICU: perception of the patient, relatives and health care team. *Intensive Care Med.* 25, 1421–1426.
- Pang, P.S.K., Suen, L.K.P., 2008. Stressors in the ICU: a comparison of patients' and nurses' perceptions. *J. Clin. Nurs.* 17, 2681–2689. doi:10.1111/j.1365-2702.2008.02280.x
- Papathanassoglou, E.D., 2010. Psychological support and outcomes for ICU patients. *Nurs. Crit. Care* 15, 118–128. doi:10.1111/j.1478-5153.2009.00383.x
- Poncet, M.C., Toullic, P., Papazian, L., Kentish-Barnes, N., Timsit, J.-F., Pochard, F., Chevret, S., Schlemmer, B., Azoulay, É., 2007. Burnout Syndrome in Critical Care Nursing Staff. *Am. J. Respir. Crit. Care Med.* 175, 698–704. doi:10.1164/rccm.200606-806OC
- Randen, I., Lerdal, A., Bjørk, I.T., 2013. Nurses' perceptions of unpleasant symptoms and signs in ventilated and sedated patients. *Nurs. Crit. Care* 18, 176–186. doi:10.1111/nicc.12012
- Rattray, J., Crocker, C., Jones, M., Connaghan, J., 2010. Patients' perceptions of and emotional outcome after intensive care: results from a multicentre study. *Nurs. Crit. Care* 15, 86–93. doi:10.1111/j.1478-5153.2010.00387.x
- Rhodes, A., Moreno, R.P., Azoulay, E., Capuzzo, M., Chiche, J.D., Eddleston, J., Endacott, R., Ferdinande, P., Flaatten, H., Guidet, B., Kuhlen, R., León-Gil, C., Martin Delgado, M.C., Metnitz, P.G., Soares, M., Sprung, C.L., Timsit, J.F., Valentin, A., Task Force on Safety and Quality of European Society of Intensive Care Medicine (ESICM), 2012. Prospectively defined indicators to improve the safety and quality of care for critically ill patients: a report from the Task Force on Safety and Quality of the European Society of Intensive Care Medicine (ESICM). *Intensive Care Med.* 38, 598–605. doi:10.1007/s00134-011-2462-3
- Schindler, A.W., Schindler, N., Enz, F., Lueck, A., Olderog, T., Vagts, D.A., 2013. ICU personnel have inaccurate perceptions of their patients' experiences. *Acta Anaesthesiol. Scand.* 57, 1032–1040. doi:10.1111/aas.12148
- Simini, B., 1999. Patients' perceptions of intensive care. *Lancet* 354, 571–572. doi:10.1016/S0140-6736(99)02728-2
- Stanton, D.J., 1991. The psychological impact of intensive therapy: the role of nurses. *Intensive Care Nurs.* 7, 230–235. doi:10.1016/0266-612X(91)90048-V
- Stein-Parbury, J., McKinley, S., 2000. Patients' experiences of being in an intensive care unit: a select literature review. *Am. J. Crit. Care Off. Publ. Am. Assoc. Crit.-Care Nurses* 9, 20–27.
- Tronto, J.C., 1993. *Moral Boundaries: A Political Argument for an Ethic of Care.* Psychology Press.
- Whitton, S., Pittiglio, L.I., 2011. Critical Care Open Visiting Hours. *Crit. Care Nurs. Q.* 34, 361–366. doi:10.1097/CNQ.0b013e31822c9ab1
- Woodward, J.A., 1978. An ICU is place to live--not just survive. *RN* 41, 62.