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An Interview with Prof Jacques-Andre Romand

Interviewee

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Jacques-Andre Romand shares his management experiences from a surgical intensive care unit (SICU).

Introduction

Doctor Romand, a practicing intensivist and anaesthesiologist, researches haemodynamics and is responsible for recruitment, education and training in the SICU at Geneva University Hospital. The hospital has over 1000 beds with approximately 8% of the budget dedicated to intensive care. The SICU has 20 beds, 5 attending physicians, 5 registrars and 10 internal residents. The nurse to patient ratio varies but is at least 1:2 during the night. Serving 1600 patients per year, the unit has a mortality rate of 10%.

What are the Main Directives of Your Role?

Delegation has allowed me the chance to experience intensive care management, together with my colleague, Bara Ricou. I spend around 60% of my time in clinical practice, 5% in research, 15% on administration, 10% on pregraduate teaching and 10% on personnel issues. I am a specialist on the unit with clinical duties, and for 50% of the time I'm on call 24 hrs, which means I need to reach the hospital within 30 minutes. Apart from clinical work, my main goal is to educate the physicians in ICU. Together with my colleagues, I'm responsible for the core curriculum, organizing education for residents through lectures in our ICU. We also organize regional lectures and day courses. We include clinical bedside teaching, usually on a one-to-one basis, to help trainees learn how to work independently. A specialised registrar or the attending specialist does the rounds with the junior physician. Support is through tutorials and mentor relationships, which work very well. I also review literature and select relevant papers for registrars to study.

Research is also important. My own research – which I love – is in haemodynamics. I'm also the President of the Medical Faculty Council, a reviewer for my specialty at the university, and I'm involved with a humanitarian mission to support training in intensive care in Mongolia. There is also administrative work.

How Would a Typical Day Proceed?

There are two 121/2 h physician shifts for both week days and week-ends which change at 0700 and 1930 hours. Two specialists and two interns are present for all shifts except the week-day shifts, when two interns and one specialist are present.

During their rounds with the surgeons, the triage team discusses which patients can be moved out of intensive care, to free up beds for new patients. One attendee and one head nurse share the triage responsibility. Elective surgery accounts for one third of our patients. Although we are a closed unit and responsible for the decisions we take, we liaise closely with surgeons on this. Sometimes with "standby" situations, we have to say "no" to surgery, because no bed is available. This rarely happens, but is very frustrating for patients.

What Extremes are There in Your Role?

There are extremes between clinical, training and administrative tasks; for example between applying high level clinical expertise to medically

fine-tune mechanical ventilation, and writing a report for administration to justify why the budget for stationery has been exceeded by 5%. Another example is the contrast between teaching and accompanying a patient to a CT scan because no junior doctor is available.

What Skills are Essential in ICU Management?

Intensive care requires good communication skills. We have open visiting hours from 1100 to 1900 hours, so we can be called on by anyone in the family at any time. Communication is a particularly important aspect with family. You can say almost anything to someone, if you say it correctly. However, an incorrect statement, missed point or unexplained situation can cause major problems. This is true not only for the family, but also within the team. Intensive care is teamwork. Poor communication can damage the nurse–physician relationship. If we experience problems arising from poor communication, we try to teach and encourage the parties to speak together. Otherwise we attempt to arbitrate. Something that takes a few seconds to say may take hours to correct.

We try to encourage teamwork in our department, because with the high turnover, as soon as staff members get to know each other, they are moving on. Incoming and outgoing physicians stay from 3 months to 1 year, anaesthesiologists 6 months and more senior attendees 3 to 5 years. The nursing staff is more stable, with a turnover of 6 to 7 years. We try to get people together outside the unit to help with team building.

What is the Hardest Decision You've had to Make?

The hardest thing is to fire somebody. We usually manage to avoid reaching such an extreme situation, however.

What has been the Most Satisfying Experience?

We receive letters from patients or family members thanking the team for the care. This happens also after patients have died; family members tell us that they feel we have done the best that could be done for their loved ones. These letters are rewarding for the whole team. Sometimes particular thanks for the ICU team are even acknowledged in obituaries published in newspapers.

How Would You Improve Your Department?

The difficulty we currently have is that the continuity of care is unstable because of the working hours regulations imposed by the state. How do we handle a patient who is staying in the unit for three weeks? If you change the team two or three times per week, important information gathered by the first team may not reach the third one.

The vast quantity of information stored on computers doesn't necessarily help, because physicians can't filter out the information they need. We are looking for a new patient management system to alert with warnings. There are so many possibilities to make mistakes with drug interactions, drug allergies, etc. We need a system to collate information and create expertise, to provide physicians with good relevant information.

We are also testing an alternative solution to overcome difficulties with the new working hours. We aim to achieve an acceptable average over several months to avoid interrupted shifts for the medical physicians. Our system may not be compliant with the law, but it is accepted by the people working in intensive care.

What Management Training have You Followed?

I followed a one year management course and a micro- MBA, which helped me to understand the concepts of budgeting. 80% of our budget is used by human resources, which only leaves a margin of 20%. This will be more important soon because our hospital will be reimbursed by the admitting diagnosis. An appendectomy is covered by a certain amount of money, independent of the variations in complications or length of stay. An understanding of these things helps when negotiating with administrators.

What Financial Issues do You Deal with?

Companies demonstrate their latest products to a team which includes me, one nurse and one logistic in the ICU. If interesting, we propose the product to a larger team for review, and if there is agreement, the nurses begin formal testing. If the product fits our needs, we add it to the list of things to be budgeted for. Hospital administration doesn't get involved in the choice of equipment.

We budget in advance each year anticipating what we will need. Salary is covered by the state scale, so budgeting is for equipment and drugs alone. If we select a new and more expensive drug to use, we need to account for this in the budget; otherwise the increase in expenditure will be queried. The agreed budget is awarded at the beginning of year, but not fixed to the objects required, which allows some flexibility.

What General Issues Should ICUs be Addressing?

ICU is only a small part of the overall journey of the patient in the hospital. We see now, for example in the RIVERS study (Rivers et al. 2001) that intense haemodynamic management in the first 6 hours following admission can change the life of the patient. Much happens to the patient before and after intensive care. We need to share intensivist expertise for preventive results. For example, if a patient with head trauma has not been treated appropriately by paramedics, even the best ICU in the world cannot change the outcome for the patient.

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