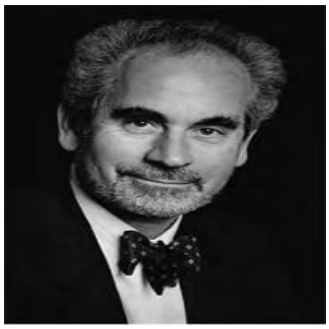
ICU MANAGEMENT & PRACTICE

ICU Volume 10 - Issue 3 - Autumn 2010 - Viewpoints

Critical Care in the United Kingdom



Professor of Intensive Care Medicine at the University of Birmingham, Prof. Julian Bion also has an honorary consultant appointment with the University Hospital in Birmingham. He also has a number of high-profile national and international roles in the field of intensive care, including being an Editorial Board Member of ICU Management and is a former President of the European Society of Intensive Care Medicine (ESICM).

One of the most significant national projects Prof. Bion is currently involved in is setting up a new faculty of Intensive Care Medicine for the United Kingdom. This is seen as a major step forward for the discipline as a whole, and will have some impact on helping to establish Intensive Care Medicine as a recognised discipline at the European level – as a multidisciplinary speciality. In the first of this two-part interview, Prof. Bion shares his views with Managing Editor Sherry Scharff on the evolution of the discipline, the challenge of integrating care, and battling bugs in UK hospitals.

Are there Particular Issues you Deal with in the UK that are Unique from Others Around the World?

There are a number of things, which distinguish the United Kingdom, and while not unique to the UK, when you put them together as a package it makes the healthcare picture in this country a much more interesting one. I think first of all, there have been major social changes in the United Kingdom over the last 30-40 years, which could probably be best summarised as a questioning of authority. This has resulted in a lot of medical care now being negotiated rather than mandated. What I mean by that is that patients and families now expect much more communication, more explanation, which I wholeheartedly endorse. In my opinion, this is much preferred over the scenario of 50 years ago, where the doctor was always right. Of course, the challenge is that you need to spend much more time in providing a thorough explanation, listening, discussing... and while I think that is fundamentally important, and I wouldn't think to surrender it for a moment, time isn't always on our side. Our working hours, for the senior staff and consultants, are very arduous; we certainly do not adhere to European working time directive standards.

The second is that intensive care research in the UK is really starting to take off. It has been a very long time in coming because it has been difficult to access research funding but with the establishment of the National Institute for Health Research (NIHR), critical care now has its own specific support mechanism for research, which makes it a bit easier to engage funders and to provide some sort of infrastructure for clinical research, so that has been very important. We have a professional network of specialty groups for critical care under the umbrella of the NIHR, which is being chaired by Prof. Tim Walsh. The Intensive Care Society has its own critical care research forum and we also have an informal critical care trials group which meets every year, which is just an informal collaboration of researchers. We also have the Intensive Care National Audit & Research Centre (ICNARC), the director of which is Prof. Kathy Rowen and that has provided us with tremendously important case mix data which provides the basis for health research and quality improvement to some extent, although they are not yet developed, the basis for a quality accreditation process.

An exciting recent development has been the establishment of the faculty of Intensive Care Medicine, led by the World College of Anaesthetists with representation from all the royal colleges, and we have just established the board for the faculty. We will be holding our first meeting before the end of the year. We still have to elect a dean of the faculty, but since we have a faculty, we have, for the first time, a formal presence in both undergraduate and post-graduate training to support the professional presence that has been provided through the intensive care society, so it is a very important development for us.

What Poses the Greatest Threat to Patients in ICUs?

I think the lack of integration of care poses a very real threat to patients. The acutely ill patient crosses many professional boundaries and also presents an unstable state over time so you have three challenges to overcome at once. The first is that patients move from one location to another while in the hospital. They may be seen in their community, but often not by their GPs, because their GPs no longer have to do on-call at night, extraordinarily! So patients are picked up by the emergency service, brought to the emergency department and then must be moved

© For personal and private use only. Reproduction must be permitted by the copyright holder. Email to copyright@mindbyte.eu.

through (within four hours) to either acute medicine admission wards or surgical wards. In that transition, they often move into the care of different individuals; often junior staff if it is out of hours. If it is a surgical patient, the patient enters theatre, and then returns to a surgical ward. If their condition deteriorates, then they may be moved to intensive care or even go directly to intensive care from theatre. Medical patients go from the medical admissions unit to the acute medical unit and from there to a medical ward and from there to an intensive care if they deteriorate. After intensive care, the majority will recover (with an overall 20-30% morality rate) and go back to a ward. These are multiple transitions in space and time and at the same time, patients are enduring multiple transitions of doctors and nurses because these people are now, apart from the consultants doing shift work. So the only constant is the specialist, the consultant. The trainees will move- some shifts, in emergency departments for example, start at 6 pm in the evening and 2 am in the morning and then you have a new shift starting again at 2. These are pretty unfriendly rotas, and while they satisfy the European Working Time directives, they don't do anything for patient care or the trainees. So the consultants have the responsibility of integrating care, and it is really quite difficult to do that.

The third element is as I've said, that the patients condition is continuously changing- creating a moving target. These three components make management of the acutely ill patient particularly challenging. So I think we haven't quite learned how to manage this moving target effectively. Birmingham provides a major centre for understanding how best to care for acutely ill patients, because not only do we have the largest patient catchment area anywhere in the UK, we also have more patients than any hospital in the UK, in addition to housing the Royal Centre for Defence Medicine, where all the conflict casualties come. We are engaged with our military colleagues; both physicians and nurses, learning from the military experience and applying that knowledge to the acutely ill patient generically; so I think that is special area of expertise, which we are developing.

As this Issue is Focused on Problem Bugs, Can You Comment on Any Specific Hospital-Acquired Infections with Regards to Your Institution, or the UK in General?

In the UK, we've seen a significant and very satisfying reduction in MRSA infections /MRSA bacteraemia, because that is the benchmark. Some of that has come about through routine measures and adherence to basic standards of hygiene including the ready provision of alcohol-based hand rubs throughout the hospital. There certainly is a great deal more awareness, I mean we are not perfect, but there is a high level of adherence and a greater willingness, for example, of nurses and junior doctors to question the behaviour of more senior staff. Of course, that is just one example; I am not implying that junior nurses are perfect and beyond reproach and senior consultants are useless or need to be carefully observed-I don't mean that at all. There is really an environment now, certainly, of widespread awareness of the dangers of cross-infection, and more willingness to follow the rules.

I do think, however, that self-discipline and teamwork do continue to be areas, which are problematic in all areas of healthcare, as they are here in the UK. So further to simply adherence, implementation of best practice is still an area for improvement.

One aspect that I am closely involved in is the project, being led by the National Patient Safety Agency, called "The Matching Michigan Project". This is a quality improvement study being funded by the department of health for two years, and I am the clinical lead for England. It is focused on reducing blood stream infections from central venous catheters.

Initially it is a project for intensive care units, but we hope to spread it throughout the whole hospital. We are already experiencing a reduction in blood stream infections from central venous catheters as a result of this. One of the interventions is indeed a checklist, but even more central to the success of this initiative is showing people that there is a problem worth addressing, as not everyone thought there was. Providing data is transforming critical care. Using a checklist as a means of promoting best practice is important but we also included a range of other behavioural measures focused on improving patient safety. This database that we are creating pools information from other centres in Spain, Australia, among others, and we are working very closely with Prof. Pronovost in the US, who is one of the advisors on the project.

Published on : Tue, 30 Nov 2010

© For personal and private use only. Reproduction must be permitted by the copyright holder. Email to copyright@mindbyte.eu.