ICU MANAGEMENT & PRACTICE

ICU Volume 5 - Issue 3 - Autumn 2005 - Trends

Interview with Dr. Julian F. Bion, President of ESICM

Interviewee

Julian F. Bion, *FRCP, FRCA, MD,*

Reader in Intensive Care Medicine,

University Department of Anaesthesia & Intensive Care Medicine,

Queen Elizabeth Hospital Birmingham, UK President,

European Society of Intensive Care Medicine (ESICM)

In an interview with Kirstie Edwards, Dr Julian Bion explains the Society's activities towards developing integrated acute care and improving patient safety.

How Can We Establish a Common Definition of Intensive Care?

There is considerable international diversity in the provision of intensive care. Although the majority of countries (and the ESICM) recognise intensive care as a multidisciplinary speciality, in some it is 'owned' by different medical and surgical specialities without common agreement on standards of training and practice. This also means that there is no definition of 'an intensivist' in terms of shared competencies – a common set of knowledge, skills and attitudes expected of a specialist in ICM.

The Society is addressing this lack of a 'product specification' for an intensivist through our innovative project, Competency Based Training in Intensive Care in Europe (CoBaTrICE), part-funded by the EC (www.esicm.org/ PAGE_cobatrice?2cu9). Involving 43 countries worldwide, this is the first such initiative across national borders

for any medical speciality. We are gathering the views of many clinicians and non-clinicians on what competencies a specialist in intensive care should possess, and will link the final core competence set to educational resources and common methods of assessment.

Is Global Harmonization of Standards of Care Feasible and Desirable?

There are very large differences in healthcare systems across the world, in resources, medical practice, ethics and culture. There will always be variations in the 'art' of medicine, but we should ensure that the 'science' is applied equally and appropriately. It is not the purpose of the CoBatrICE project to homogenise the practice of intensive care, but to ensure that we train specialists to a common standard and thereby ensure best practice in terms of outcomes for our patients and their families. The Surviving Sepsis Campaign is another example: with the Society of Critical Care Medicine, the International Sepsis Forum, the Institute for Healthcare Improvement, and many other professional societies we are promoting best practice (sepsis care bundles, www.ihi.org/IHI/Topics/CriticalCare/Sepsis/Tools/ SevereSepsisBundle.htm) in the challenging area of severe sepsis and septic shock, with the aim of reducing the mortality of this syndrome by 25%. This requires a new focus on integrating acute care across hospital disciplines, between different locations and over time.

Why and How is the ESICM Progressing Integrated Acute Care?

Most hospital care is provided in vertically oriented disciplines with relatively little horizontal integration between them. While this may work adequately for patients requiring elective treatment, acutely ill patients present special problems (Bion and Heffner 2004). They often require care from more than one clinical discipline, their condition changes rapidly over time, the clinical course is difficult to predict, and they are more susceptible to healthcare error, including nosocomial infection, prescribing errors, and failures in communication and discontinuities in medical and nursing care.

As an example, in the UK, the professionally-led National Confidential Enquiry into Patient Outcomes & Deaths (a permanent grouping within the National Patient Safety Agency) has recently investigated (www.ncepod.org.uk/ 2005report/NCEPOD_Report_2005.pdf) the care of acutely ill medical patients admitted to intensive care. This demonstrated deficiencies in timely identification and effective treatment by medical and nursing staff before referral to intensive care, and inadequate involvement by senior medical staff at the time of admission to intensive care. These problems are not unique to the UK, but are common to all healthcare systems.

As emergency care now constitutes between 30%-70% of the work of most health services, we need to find a new model for caring for the acutely ill patient based on patient needs rather than the traditional hierarchies of medical disciplines. Healthcare managers, the pharmaceutical industry, hospital architects, medical educators and patient groups amongst many others will need to collaborate with intensive care and emergency and acute medicine, to re-engineer hospital systems to improve the safe care of this 'hidden population' of acutely ill patients. Key components will include better process control (managing the entire patient journey), transdisciplinary collaboration and teamworking, and methods for translating advances in speciality-based research into improvements in education and training in generic aspects of acute patient care.

At local level, healthcare systems need to re-engineer acute care as an integrated service. Following the patient journey is a powerful concept which makes it easier to identify local problems and solutions. Currently, the acutely ill patient moves through different locations and clinical teams with varying expertise and resources. Rapid Response Teams (RRTs) such as medical emergency teams, nurse-led critical care outreach, or hospitalists, are helping to change medical culture and improve outcomes for patients by providing early support and medical intervention where required, and improving communication between teams. These developments require similar integration of planning and funding at national level.

At national & international levels, in addition to funding these new developments, we need to focus on education and competency-based training. Competencies break down barriers, and make it easier to build teams by identifying shared competencies. CoBaTrICE is the tool we are using for this purpose. Our Professional Development division is also providing training in team working in emergency situations; at each Congress, we hold two instructor courses with the Society of Critical Care Medicine (SCCM): Fundamental Critical Care Support and Fundamentals of Disaster Medicine. Our multiprofessional distance-learning programme, Patient- Centred Acute Care Training (PACT), covers all aspects of acute care including team working and communication, integrating knowledge and skills in critical care and supporting continuing professional development for specialists. Some countries such as the UK are also building

competency-based training in acute care at undergraduate and junior doctor level, as essential components in developing acute care clinicians.

To support this complex set of interventions, I am proposing to develop an international multidisciplinary Forum for Integrated Acute Care representing all stakeholders, including managerial and patient organisations. The proposal is being considered by the World Alliance for Patient Safety for potential adoption as a strategic concept. We will also apply for EU funding.

Who are the Members of the ESICM and How does it Function?

The ESICM is a society of over 3000 members, mostly senior intensivists, and a growing number of trainees, nurses and managers. We have recently completed a comprehensive restructuring of the society into three divisions: Administration, Scientific Affairs (Research and Congress), and Professional Development (Education & Training, and Editorial & Publishing). The statutes permit any full member to stand for office including the presidency, whether medical or nursing. The Society's council comprises one member per country and one per scientific section. All officials serve the ESICM voluntarily, without reimbursement, and all are active practicing clinicians. We are supported by an outstanding office team led by Mme Suzanne Smitz Der Smet, by the goodwill of our colleagues, and by our families.

The mission of the ESICM is to promote the highest standards of multidisciplinary care of critically ill patients and their families through education, research and professional development. The ESICM has many achievements of which it can be proud, including two EC grants, one for CoBaTrICE and the second for GenOSept (see the article in this issue by Frank Stueber on pages 22 to 24). The society is also actively funding research, and at this congress will be announcing grants worth over 300,000Û from society funds and industry partnerships. Our professional development programme led by Dr Dermot Phelan includes the internationally recognised European Diploma of Intensive Care. Our journal, Intensive Care Medicine, led by Professor Laurent Brochard as Editor-in-Chief, is one of the highest rated intensive care journals worldwide.

What is the Society's Relationship with Other Organisations, Including Industry?

We have exceptionally good relationships with other international organisations, as exemplified by the Consensus Conference programme, and the Surviving Sepsis Campaign. Relationships with industry are excellent, and I intend to develop these further while ensuring that we maintain the highest standards of ethical practice in terms of identifying and managing potential conflicts of interest.

How do Clinical Practice and the ESICM Presidency Complement Each Other?

I and my ESICM colleagues remain in full-time clinical practice, which ensures that we retain a very good grasp of the practical and emotional difficulties of being a frontline clinician. At the same time I can see how healthcare can be improved from an international perspective. The ideas which we create in the Society must in the end bring improvements in care to our patients and their families. Some can be delivered in a year or two, others require a medical life time. This is the power of an organisation; it outlives us and if set up properly, continues independently of any one person.

Does the ESICM Presidency Meet Your Expectations?

Yes. It's a privilege to work for an organisation when you are voted in by the members, and I'm aware that there are many first class people

around the world who could do this job as well. I hope that I can meet people's expectations. My main ambition is to take intensive care into the arena of the whole of acute medicine and to place it at the centre of the modern hospital, to improve patient safety and acute care.

I also have a smaller ambition, which is to improve the Society's social interactions. To this end I have instituted a wine tasting in the industrial exhibition reception, which this year in Amsterdam will be accompanied by an international buffet for all participants at the opening of our annual Congress on 25th September. Please join us!

Thank you, Dr Bion.

Published on : Thu, 20 Oct 2011