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Interview with Jeffrey Lipman

Jeffrey Lipman is Director of the Department of Intensive Care Medicine, Royal Brisbane and Womens' Hospital, Professor and Head of Anaesthesiology and Critical Care, University of Queensland. Sherry Scharff asked this ICU Management Editorial Board Member to share his thoughts on management challenges, the effects of economic downturn in his part of the world and the future of intensive care medicine.

Can you briefly describe your department (number of staff, beds, mortality rate, etc.)?

The current Royal Brisbane and Women's Hospital is a 942 bed general, and is a tertiary referral hospital encompassing a number of specialties including vascular, facio-maxillary, plastics, ENT urology and neurosurgery, and is the only Queensland centre for burns and bone marrow transplantation. The Department of Intensive Care Medicine (DICM) runs a 30-bed ICU. Like all other Australian ICUs we run the Unit as a "Closed" ICU working collaboratively (closely) with the referring specialties. The case-mix is adult surgical/medical excluding cardiothoracic. The unit also provides care for gynaecological and obstetric emergencies from the Women's section of the Hospital, and ICU back up for the major haematology / bone marrow transplantation service on campus.

Training is recognised by the Joint Faculty of Intensive Care. Teaching of undergraduates and postgraduates is an integral component of DICM's programme, with formal teaching sessions for all grades of staff.

Our Unit has a strong academic focus linking into a newly formed University "Burn Trauma and Critical Care Research Centre" (www.som.uq.edu.au/research/burns/default.asp). There is a very active clinical and laboratory research programme with a national and emerging international profile. Current research interests include aspects of head injuries, sepsis with an emphasis on antibiotic pharmacokinetics (including microdialysis) in critical illness and improved prevention and diagnosis of pulmonary infection in ventilated patients.

Senior medical staff consists of eleven full-time Intensivists. There are eleven ICU advanced trainees and nineteen junior registrars who participate in an independent junior medical roster. The registrars are trainees drawn from the Anaesthesia, Physician, Surgical and Emergency Medicine streams and working along side Intensive Care registrar posts.

The nursing staff component is over 200. We have about 2500 admissions/pa with merely 6% mortality. Australia and New Zealand have a central repository that gets de-identified data of all admissions from almost all ICUs within the two countries (ANZICS CORE – Australia and New Zealand Intensive Care Society's Centre for Outcome and Resource Allocation). They produce various reports, one of which is often used as a Key Performance Indicator for ICUs. It presents the individual ICU's "hospital outcome data" comparing it to APACHE II database, APACHE III (J), SAPS 2 etc. It also compares each Unit to its comparators across the two countries (i.e. we compare ourselves to other tertiary referral Units). Our APACHE II SMRs for 2008 were 50.8%.

What would you say is the most challenging part of your job?

Working in ICU reminds me a little of my competitive squash days. The closed, stressful, claustrophobic environment of the squash court during a tense competitive game often brings out the "worst" of one's behaviour, temper tantrums, throwing rackets, swearing etc. The stressful environment of ICU can be the place where all one's personal issues can come to the fore.

I find one of the most challenging parts of my job is to keep the ICU as stress free as possible for all those that work within. The interpersonal relationships of various staff members, both with the "outside" consultant staff and alleviating stressful interactions between ICU staff themselves, is demanding. We work hard at keeping stress levels as low as possible, giving members of the unit a feeling of ownership, of feeling part of the team. We try and distribute workloads evenly or certainly appropriately, not allowing inexperienced staff to be left alone with tasks or workloads they cannot manage.

Can you describe a recent success (department/professionally)?

We have recently started a formal telemedicine consultation service with a small peripheral hospital ICU upstate. Queensland has the tyranny of distance with a large coastline and small scatterings of populations all along that coastline. In keeping with the worldwide move to the big cities, it is difficult to staff small ICUs along the coast. We believe telemedicine can solve some of the problems of small isolated ICUs. It provides "tertiary level intensivist" consultation service, provides some collegiate support for the practitioners in that area and we believe earlier and more appropriate tertiary transfer of patients centrally.

There are obvious and less obvious hurdles in setting up such a service. One of the latter is potential medico-legal problems that need formal

attention. Firstly all patients or surrogates give formal consent before any consultation. We have set up a system that tapes all conversations, we have a secretary that sits in the consultation with the intensivist at our end, at the end of the hour's consultation every day, a summary of the discussion is dictated by the intensivist, transcribed by the secretary and a copy with both parties' signatures is placed in patient's base file and a file created for the patient with us.

What does your department excel at?

We believe our mortality rates are as good if not better than most places. This is in fact best shown by our Burns patients. We have recently published a study on 10 year mortality rates of our Burns patients (Dulhunty J, Boots RJ, Rudd MJ, Muller MJ, Lipman J. Increased fluid resuscitation can lead to adverse outcomes in major- burn injured patients, but low mortality is achievable. Burns 2008;34: 1090-1097).

What poses the greatest threat to patients in ICU's (infections, staff ratios, lack of equipment, medical errors)?

I am convinced that the answer to this question is nursing staff shortages.

There is no doubt in my mind that the best monitor is a good bedside nurse. For theatre work, most places will not allow the anaesthetist to leave the operating suite whilst the patient is still anaesthetised. For this, not only is there peer-recognition but there is also commensurate financial reward. I believe there will never be ideal financial recognition for the good ICU nurse who has to deal with not dissimilar anesthetised patients while the attending physician often is doing other things or seeing other patients.

Are there particular issues you deal with in Australia that are unique (from others around the world)?

Not really. Whilst the medical system is really good here with an excellent public health system, and we treat octogenarians in ICU, there are still resource allocation issues. The only difference is the "bar" is set much higher.

Has the current economic downturn affected healthcare in your country? In your hospital? Do you think there are effects to come?

Absolutely. Nursing staff are returning for a definite, reliable income. Not only their own income was in jeopardy wherever they were working, but often that of their partners' too, hence coming back into a "reliable" income has become one of our unforeseen benefits of the economic downturn. Talking to other senior staff in the hospital, I have found the same thing is happening with other job advertisements, particularly in relation to administrative staff, but also allied health staff advertisements which would normally attract one or two applicants, now attract double or triple that number.

Whilst all sounds good in the government healthcare sector with the above, I suppose it could be a worry when the economy turns the other way. Will there be a reversal and an exodus to the private sector again?

What are the most important skills for a manager of an ICU?

"People" skills! This is not taught well at Medical School or during Specialty Training.

Have you some parting wisdom on the state of the critical care field?

Medical science and technological advances are allowing us to keep more patients alive for longer. Unfortunately sometimes we just delay death. This is distressing for both the family and the ICU staff. The parameters of these two situations are often blurred. It is my hope that somehow without limiting progress, we will develop better methods of delineating the two issues, thus helping both our patients and our hard working, dedicated colleagues.

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