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The Future of Critical Care in Canada: A Patient-Centred Approach

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The Canadian Healthcare system has reorganised its resources through regionalisation to respond to increasing demands on critical care. The next step should realign critical care services along the patient's trajectory.

Background

The purpose of critical care is to provide a large spectrum of care for patients with critical conditions due to an acute medical illness, exacerbation of a chronic disease, surgical intervention or injury. In Canada, critical care is an ever-evolving medical specialty, provided by physicians with backgrounds in Anaesthesia, Internal Medicine and Surgery. Canada is experiencing the global trends in limited resources and increasing demands for critical care services as a direct result of increasing needs of patients (Shumaker and Hill 2006; Carson et al. 2006; Needham et al. 2004; Needham et al. 2005). Today's patients have more complex diseases requiring highly trained caregivers— an expensive and scarce resource (Roy and Brunet 2005; Jastremski 2006). In addition, there are a greater number of total patients in need of these services because of technological advancements in managing care, leading to prolonged life duration. To improve access, quality and system efficiency, most Canadian provinces have organised services according to a regionalised approach in order to maximize resource utilisation, cost effectiveness and to improve healthcare providers' response to population needs (Bell and Robinson 2005).

A Regionalised Approach of the Healthcare System

To one degree or another, all Canadian provinces have begun to re-engineer their critical care resources to better respond to growing patient needs and demands. Efforts to provide early outreach to improve patient outcomes have been established via critical care outreach teams. These teams deliver critical care expertise within the hospital outside the walls of the intensive care units (Bellomo et al. 2003; Hillman et al. 2005; Scales et al. 2003). To address the shortages in supply, system- level training initiatives and targeted health human resources investments have been made. Quality improvements have been guided through the development of integrated provincial computer tracking systems and establishment of targeted metrics to measure and monitor improvements. Strategically cataloguing resources and concentrating new funding on limited areas, while at the same time, investing in the dialogue around ethical issues of access to critical care services, have approached the limits on capacity. These initiatives are continuing to evolve and the evaluations of the results are still pending. It is certain that these strategies will improve access, quality and system efficiency to a degree (Scales et al. 2004; Bekes et al. 2004; Manns et al. 2003). But can this model alone respond to the vast spectrum of patients and families needs?

The Future: A Patient-Centred Approach with a Realignment of Services

The next steps for critical care services in Canada should incorporate two major principles: A patientcentred approach to better respond to increasing patient expectations, and a realignment of critical care services to harmonize the level of care provided (intensive, intermediate, acute and chronic) with patient needs.

The realignment of critical care resources should create a continuum of care that matches the spectrum of patients needs from prevention to rehabilitation (Vincent et al. 2006). Services must come together around the patient, treating the patient as integral to the care team, instead of viewing the patient as a sum of medical problems requiring the patient to travel through silos of care. The answer will be to combine inter-professional and multidisciplinary expertise into a network of services that can integrate the social, moral and psychological aspects of patient need, in concert with the treatment of their organic medical conditions. This approach requires reconsidering ICU organisation, using appropriate medical technology and developing team spirit through teamwork training (Stone et al. 2006; Craft 2001; Risser et al.1999). Research and education should be integrated to generate, translate and evaluate knowledge at the bedside to continuously improve quality of care.

The patient must also be considered an actor in their own care, using their priorities for outcomes as the main concern. As such, critical care services have to start at home with early education of patients, families and upstream care resources, such as emergency medical services and primary care providers, to create integrated systems of care like the trauma system (MacKenzie et al. 2006; Nathens et al. 2000). Then services can extend to provide early goal therapy through inter action with pre-ICU and post-ICU care across specialties, including emergency departments, acute, chronic, long-term and managed care facilities (Rivers et al. 2001; Spaulding et al. 1997). These services could be provided in unique ways with telemedicine, via videoconference, and medical call centres. Similarly, critical care must grow beyond the focus on “saving life” to allow for complete rehabilitation and social reinsertion into the home and community post-ICU (Herridge 2007; Tansey et al. 2007), in addition to enabling a dignified death for end-of-life care when required (Cook et al. 2006; Heyland et al. 2006).

Conclusion

The regionalisation of critical care in Canada was an essential step in improving access, quality and system efficiency. The next step should be the proactive integration of critical care services into a network and seamless patient navigated system to truly realign the level of care provided with patient needs and expectations.

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