

## Making a difference

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I am honored to be your incoming president for 2009. I have been a member of the Society of Critical Care Medicine since 1991, and I deeply believe in the vision and mission of the Society of Critical Care Medicine.

We are a multidisciplinary critical care organization that is committed to fostering collaboration as the essential ingredient in providing the highest quality critical care to patients suffering catastrophic illness. Although the number of hospital beds is shrinking, the percentage of critical care beds is growing, and the need for critical care physicians, nurses, respiratory therapists, social workers, pharmacists—in essence the need for the entire critical care team—is becoming dire. At the same time, our healthcare system, at least in the United States, is in crisis, and the worldwide economy is faltering badly. In the United States, nearly 46 million Americans, or 18% of the population below the age of 65, were without health insurance in 2007 (1). The dizzying spiral of layoffs and business failures is rapidly swelling the ranks of the uninsured because people can no longer afford prohibitively expensive health insurance.

We know that the uninsured wait longer when seeking medical help than those who are insured, often use emergency rooms as their primary point of contact for medical care, come into the system with more severe illnesses, and have worse outcomes than those with insurance. Around the globe, as countries across all continents face deepening economic gloom, the ability to provide an adequate healthcare safety net is challenged. The desire and intention to provide every citizen with access to high-

quality healthcare—an approach aspired to in most areas of the world—may not be enough as we move into an uncertain economic future.

So, it is appropriate, at a time like this, when we are balanced on the razor's edge of uncertainty, that we ask ourselves, as caregivers in general and critical care clinicians in particular: can we make a difference? I would like to offer some questions for us to contemplate and consider together during this year that we work together.

I believe, and I know that most of you share this belief, that we *can* make a difference. We can make a difference in our patients' lives and, just as importantly, in our patients' deaths. Furthermore, I think we can make a difference in helping our culture move forward during this uncertain time. How we handle ourselves in this environment will likely have a huge impact on future generations of caregivers.

### What Brought Us to Critical Care?

How did we get here? Why did we come to critical care? Why do we do what we do? For many of us – and I will share with you my personal answers – critical care brings a unique opportunity. Our vulnerable patients require a high degree of moment-to-moment attention. The complexity, severity, and rapidly evolving nature of critical illness demand that intensive care unit (ICU) caregivers possess the skill and ability to bring our knowledge, as well as our interpretation of the current literature, to the bedside of critically ill patients. We must integrate that knowledge rapidly into our observation and assessment of a patient, and then quickly develop a cohesive therapeutic plan based on collaborative decision making.

All of this is conducted in a brightly lighted environment filled with bells, alarms, buzzers, screams, moans, and blaring television sets, and populated by the presence of more caregivers and fam-

ilies per square inch than in any other hospital setting. Just as powerful as these intellectual and diagnostic elements is the equally challenging demand, at any given moment, to stop what we are doing, shut out the noise, open our hearts, and sit with a patient's family to help them understand that they might be losing this person they love so dearly.

This balance between intellectual demands of complex illness and emotional and spiritual demands of death and grief is what defines us as ICU caregivers. This challenge to balance intellect and compassion in an intense environment is, for many of us, the force that drove us into critical care. It is the fuel that allows us to care so deeply for our patients and makes us fierce patient advocates. So, when we ask ourselves, "how did we get here?" we can reflect on our commitment to do the best for our critically ill patients through a balance of intellect and compassion.

### What Are the Obstacles?

In our desire to make a difference, what stops us? What gets in the way? Why do we sometimes find ourselves burned out, exhausted, and occasionally disheartened?

As critical caregivers, we face formidable obstacles in the ICU: a technological imperative that drives us to use the new "toys" and new interventions that appear every day and increase the pressure we feel to cure, rather than comfort and care for, our critically ill patients. The environment is often chaotic and frenetic. Communication struggles sometimes arise with patients and their loved ones. Competing agendas may arise among caregivers. Role conflicts may exist. We are exposed to family distress and patient suffering. We need to deliver bad news to our patients and family members on a regular basis, and more frustrating for many of us is the expectation that we should take better care of our patients with almost no help and definitely no funding. Unfortunately, it is easier to de-

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scribe and list these obstacles than to remember to care.

For many of us, our intuitive appreciation of the importance of caring for our patients is where we started. In today's environment, though, we may find it easier to talk about growing numbers of patients, shrinking numbers of nurses, physician shortages, longer hours, fewer resources from administration, and increasingly unrealistic expectations from patients' families. We are more likely to remember these obstacles and be distracted by them than to remember to just, simply, care.

### **Has Caregiving Become a Luxury?**

Remembering to care seems to have become an everyday challenge in our work environment. In many ways, I think, genuine caregiving has become a luxury. In a fast-paced, task- and technology-driven environment, can we find a way to remember to just, simply, care? Certainly, the answer must be "yes."

Every day in the ICU, we see examples of this kind of caring: taking the extra time to meet with families; spending the extra moment reassuring an anxious patient; or refusing to settle for an easy diagnosis and, instead, reviewing and re-reviewing a set of labs and diagnostic tests one more time. These are behaviors we see every day in our colleagues in the ICU.

Fortunately, when we forget to care, we are quickly reminded of our lapse by another member of the ICU team. The collaborative environment inherent to the ICU can be a potent tool in patient care. Multiple clinicians and caregivers, all identifying themselves as dedicated patient advocates, are contained within the ICU team. This aspect of our world—the collaborative team—might provide the best weapon to combat the distractions common in the ICU and serve to help us remember to, just, care.

We are truly fortunate to share our professional world with colleagues from many disciplines who advocate for the same end: providing the best possible care for our critically ill patients. In fact, for generations, remembering to care and keeping a patient's best interests at heart have been the foundations of being good caregivers. For a long time, this is how we made a difference in our patients' lives: by caring deeply for them and for their loved ones, and by wanting to do

what is right for them. For generations—really until only within the last 70 years or so—providing support and comfort was all we could do for our patients. That *was* enough for so many years.

### **What Does it Mean to Be a Good Caregiver?**

It may no longer be simply enough to have the patient's best interests at heart. Of course, this remains at the core of who we are as caregivers, and remembering to care should always be our starting point. We cannot be good patient advocates without this as our foundation. However, medicine has become very complex.

More than ever, the number of details, pieces of physiologic data, and number of diagnostic tests are becoming overwhelming for clinicians to process at the bedside of our critically ill patients. Just remembering to care can drown in this sea of data that streams toward us from all sides. Unfortunately, a belief that having good intentions alone and keeping our patients' best interests at heart will ensure our patients of the best possible care must be regarded as somewhat suspicious. We know what road you can pave with good intentions. Perhaps, 70 years ago just remembering to care and keeping our patients' best interests at heart was enough. Now, the published data say otherwise. Although we would like to believe that as we get older, we get wiser and that our collected clinical experience alone will make us better clinicians, this might not necessarily be the case. The complexities of our medical world, with its technological and scientific advances, make it difficult for even the most dedicated lifelong learner to stay abreast.

Choudhry et al (2) published a study in 2005 on the relationship between clinical experience and quality of health care, the results of which could be considered distressing to many of us. In a very straightforward, systematic review relating medical knowledge in healthcare quality to years in practice and physician age, the authors reported decreasing outcomes with increasing years in practice across all measures of outcomes. In 59 studies with 62 outcomes, the length of time in practice or age was associated with lower performance for all types of quality assessed: knowledge, diagnosis and screening, therapy, and overall outcome.

### **How Can We Do the Right Thing for Our Patients?**

We have come to appreciate from many studies in critical care that the strength and quality of caregiving depends, at least in part, on paying attention to the small details of care. These details are at the heart of remembering to care. Critical care nurses have known and intuitively used these important small details in patient care for generations—rubbing patients' feet with lotion, combing patients' hair, washing patients, remembering to take time to speak with families. Now bedside details have taken on new importance, new urgency. To that list we can now add details, such as remembering to wash our hands, how we sedate our patients and how we wake them up, remembering to turn patients, and the proper angle of a patient's bed, to name just a few.

But *do* we remember to do these things? Do we remember to pay attention to the fine details of everyday care? Unfortunately, the literature suggests that we do not (3). In a major study of reliability in American health care, McGlynn et al reported a study of 6712 outpatient medical records and indicated that the best we could do to be in compliance was 55%, which is a defect rating of 45%. If these data are true, that means our patients have a one in two chance of getting the right thing when they come to see us.

In a 2005 study in *JAMA* of quality indicators of preventive services that are certainly not controversial—no one would argue about mammography or influenza vaccines—the same was true. Once again, the ability of clinicians to deliver care consistent with known quality indicators was, at best, about 50% (4).

Is it just a matter of forgetting to pay attention to details? I think it is more than that. Some of this may be the result of the gap between what we think is happening and what is actually happening in practice. As part of the Surviving Sepsis Campaign, Bauer et al (5) conducted a survey of ICU physicians in 40 ICUs across Germany and asked, using a Likert scale, "How frequently do you do specific things at the bedside?" As an example, 92% of the responding physicians said they used lung-protective strategies in ventilating patients with acute lung injury. An audit of those patients' charts

indicated that, in reality, patients received such care 4% of the time.

Now the challenge we face as caregivers in the ICU, when we ask ourselves how we can make a difference, is to do more than just remember to care. It is also to remember to pay attention to details and ask ourselves, every day, "what details do I need to remember in order for me to do the right thing for my patients?" You could say that when we ask "how can I be a good caregiver?" the answer should be "through a commitment to caring and keeping track of remembering the small things we do at the bedsides of our patients." This recognition or realization of the importance of keeping track represents the evolution of accountability and the benefit of performance measures.

A remarkable truth of health care is that most healthcare performance actually remains unknown or simply not reported. Even though many published reports identify poor compliance with common standards—standards that are widely accepted—there still remains wide variation in clinical practice. In health care, we not only reluctantly self-monitor, we are uncomfortable accepting the idea of self-monitoring, so the results should not come as a surprise to us.

Many of you may have seen the study by Soumerai et al (6) in *JAMA* in 1997, which looked at the incidence of eligible subjects receiving prescriptions for beta-blockers in the 90 days following discharge for an acute myocardial infarction admission. Only 21% were given a prescription. In fact, beta-blocker use was essentially unchanged from the rate before the acute myocardial infarction, and yet, the impact of underuse is clear: there is a 43% excess rate of 2-year mortality, a 20% increase in rehospitalization, and a lower relative risk of death in those patients on beta-blockers. It should not be a surprise that when large randomized clinical trials test interventions and find that they work, when we use them, patients get better. And when we do not use them, they do not.

### Can We Embrace Accountability?

There are many reasons why we often fail to comply with performance measures, and, thus, only slowly translate knowledge to the bedside. Certainly, at the top of the list has to be clinician

autonomy. I am not just talking about physicians' reluctance to give up autonomy. We all cherish our autonomy and closely guard it. Surely, we recognize the need to give up some measure of our autonomy in this complex age. Surely, we must be willing to yield some decision-making power in the interest of improving patient outcomes. Surely, it must be obvious that individual caregivers are no longer the sole decision makers. The data certainly suggest that when we surrender this autonomy and standardize care, patients do better.

Standardization of care, through the application of performance measures that are evidence based, properly tested and validated, easy to measure, free from conflicts of interest, and, most importantly, developed and refined by ICU practitioners, reduces practice variations and improves patient outcomes. Examples abound in the literature (6–8). But we must have no illusions about this: not all studies evaluating the impact of performance measures have been positive and not all performance measures are valid and reliable (9–11).

This is exactly why it is so important that we, as practicing clinicians, step forward to embrace the concepts that doing the right thing for our patients consists of: first, remembering to care; second, that being held accountable for the care we provide to our patients is very likely to make that care better and improve outcomes; and third, that being consistent at the bedside is a good thing.

Only then will we be able to have an impact on the evolution of accountability and take part in the next steps, which include refining the process of evidence-based medicine and ranking the evidence, identifying clinical practices that lead to better outcomes, and developing our understanding of tools that facilitate a change in clinical practice behavior.

As a society, working in partnership with the other North American societies involved in critical care, we have already begun to interact with the government and other third-party payers to take steps in that direction. To maintain our credibility in this process and be full partners at the table of shaping the future of critical care, we must be willing to embrace some measure of accountability and sacrifice some of our autonomy. Being accountable to our

patients for their outcomes is the right message for patients and for all of us: *We will remember to care and remember to pay attention to what we do at the bedside in the ICU. This is doing the right thing. This is being a good caregiver. We can advocate for accountability. If not us, then who?*

### CONCLUSION

In summary, I would like to leave you with these questions to consider and contemplate: Why did we come to critical care? How did we start? What is our motivation? What drives us to this crazy world of critical care?

Can we overcome the distractions of our environment and ICU world and just remember to care? Has caregiving become a luxury?

What does it mean to be a good caregiver? Is it enough to care? How can we do the right thing for our patients? Will we remember the small details?

Can we surrender some autonomy? Can we embrace accountability? Can wide practice variation be good for patient care? Do not our patients deserve to know the results of our care for them? And finally, can we help shape good performance measures?

I look forward to working with you this year and welcome your suggestions. I invite all of you to join me and join Society of the Critical Care Medicine in finding a way to make a difference.

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