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Understanding the Need for ICU Collaboration

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Introduction

Surgical patients who require post-operative ICU care are categorized as high risk cases based on significant pre-operative morbidity and/or complex operative procedures. Elective surgical patients often undergo extensive preoperative evaluations for risk stratification to determine procedural benefits. Mature deliberation and experience are necessary for risk reduction by selecting appropriate candidates matched to the appropriate procedure. For these patients, research has focused on preoperative investigative tools for risk management; the tacit assumption of postoperative ICU care is that it is essential but without perceived variation as to its impact on patient outcomes. However, recent research suggests that interprofessional ICU collaboration may impact patient care; this article seeks to explore this possibility with a physician's perspective.

Conventional ICU care is procedurally oriented, relatively standardized, and driven by quantitative values which are used to track the progress of patients. However, even with the best ICU equipment and personnel, qualitative factors such as physician-nurse collaborations will impact both patient outcomes [1-3] and workforce satisfaction [4]. Interprofessional relationships between nurses and physicians can be broadly described as a spectrum of interactions with 3 types of interactions defining points on this spectrum. The first, and least desired, is a competitive relationship which negatively impacts patient care due to reduced interprofessional interactions. In this situation collaboration occurs only in critical situations, due to the forced necessity of patient safety, which demands collaborative action. The second is best described as a neutral relationship with interactions and communications occurring earlier, but only sporadically, to avert potential crises. In this scenario collaboration occurs with near crises which then triggers the realization of a collective emotional togetherness [5] reinforcing the need for earlier interactions. The third and most effective interaction is a dyadic type of relationship where patient care is positively enhanced with an established collaborative interprofessional relationship with mutual respect for the roles and responsibilities of each of the parties [6].

Nurses have in the past served in a subservient role to physicians with primary goals of implementing orders, dispensing medication, and providing hands-on care to patients as needed for recovery. Physicians have previously assumed an executive role with respect to ICU patient care with reduced hands-on care unless invasive interventions are required. However, recent changes in ICU care towards a multidisciplinary approach mandate a more collaborative relationship between nurses and physicians. Traditional professional boundaries are becoming redefined due to increased patient numbers combined with decreased workforce personnel [7]. Attempts to deal with these projected workforce shortages include implementation of new technologies [8] and the introduction of nurse practitioners and physican assistants as ICU providers [9]. It is possible that further boundary expansion can occur as part of a collaborative effort with ICU nurses assuming increased activities and responsibilities to alleviate shortfalls and prevent workforce gaps in care [10].

However, there are several important considerations between nurses and physicians in this changing ICU milieu. These include the following concepts: professional focus, affective perceptions with respect to patient care, time management concerns, patient ratios, and structural hierarchy. These differences once identified, help us to understand interprofessional gaps where misconceptions or conflict can occur. Furthermore, by understanding these professional boundaries it is possible to bridge these gaps with dyadic relationships thereby improving patient care.

The focus of nursing has always been a holistic approach, emphasizing a qualitative orientation of improved patient care coordinated in the context of family and home. It is also policy derived and hierarchial and as such tends to be structured and confined. Physicians however, focus more on quantitative data to determine treatment plans with fewer considerations concerning family expectations. Furthermore, physicians feel that as final arbiters for patient care, they are relatively enabled with respect to boundaries for investigations and treatment. In essence, physicians are oriented to consider all life-sustaining efforts as part of the goal of ICU care, as long as they are in line with the patient's previously stated goals of care. Thus their boundaries may be less limited than that of nurses.

Affective perceptions also appear to differ between nurses and physicians with respect to patient care. Nurses experience an overarching concern of improving patient progress; physicians may experience personal feelings of inadequacy and insecurity with respect to patient care [5]. These feelings are dependent on the maturity of the physician, and they become aggravated in times of crises with forced collaboration, heightening feelings of vulnerability, particularly if there has been no previous interaction between the involved individuals.

ICU nurses generally work in a defined ratio of either a 1-1 patient to nurse ratio or a 2-1 ratio. This allows nurses to focus in-depth attention with the provision of individualized patient care while at work. Physicians on the other hand are in charge of multiple patients and may find it difficult to always provide focused individual patient care if there are other high priority patient issues. This can lead to time management issues with competition for attention between nurses advocating during their shifts on behalf of individual patients and physicians who may be managing multiple patients to resolution with an indefinite timeline. Finally the ICU administrative leadership may impact interprofessional relationships with a preference of maintaining silos of professional care instead of a dyadic type of collaborative work which has been shown to improve patient outcomes [6].

Interprofessional collaboration can be a learned multifactorial experience encompassing personalities, professional focuses, and

professional concerns leading towards a goal of collaborative competence [11]. System manipulations, such as the development of new boundaries, can be shared between professions; traditional concepts of professional silos can be improved with interprofessional resources such as shared educational opportunities, particularly during training years [10]. Interprofessional educational process have been shown to impact collaborative team behavior and patient outcomes as assessed by a literature review through the Cochran database [12]. These changes need to be carefully evaluated and supported to avoid token participation without incorporating sustained change [13].

Finally, in this era of safety-driven patient care, the emphasis has been to empower all providers to halt any part of the delivery of care to patients. However, it should be remembered that even before the patient reaches the hospital there may have been significant patient focused deliberations such that the analogy of temporally halting the system to evaluate patient related issues may be more detrimental than beneficial. This could be comparable to asking a pilot to stop the system for a process evaluation when the plane is in the air. An established dyadic relationship would allow an open collaborative discussion thereby improving patient care rather than halting it.

Collaborative decisions with respect to priorities of individual patient care, time management, accountability and resolution of patient problems can be collectively defined and integrated into daily patient care by both professions. A truly involved system would involve earlier partnerships in preoperative patient assessments by combining nurses and physicians in treatment determinations which could potentially facilitate the progress and care of patients through their ICU and hospital stay.

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