

# The ideal intensive care unit: open, closed or somewhere between?

Lindsay I G Worthley

Some time ago, a newly appointed surgeon to our hospital towered over the intensive care unit nursing chart and questioned the nurse about a recent order.

"Who ordered this for *my* patient?"

"Dr Worthley did", she replied.

"Well please tell him that I would like to see him", he barked.

"He's in his room just down the hallway if you would like to see him", she replied and moved to direct him.

"No. I want him here now."

The nurse hurried to my room and peeked around the door. "Mr Smith wants to see you about the new patient."

I smiled. "I heard the conversation from here", I said wearily as I stood, stretched and walked slowly to the ICU bed. I held my ire in check, as I knew that this would probably be yet another of the typical exchanges that not infrequently followed the employment of full-time intensivists in our unit.

"G'day. You must be the new appointee to the Hoffman surgical unit. I remember discussing your curriculum vitae with the selection committee before your appointment. I wonder if we could talk in my office."

He looked a little perplexed at my introduction, probably trying to assess my position in the political "pecking order" within the hospital. He then straightened.

"I would prefer to discuss the patient here."

I bared my teeth. "Sure — but perhaps in my office first." I gestured to my door while walking away. He reluctantly followed, but slowly gained pace so as to reach my room first. As I entered I pulled the door shut, offered him a seat and brought my chair from behind the desk to allow me to face him directly.

"Before we discuss the patient's treatment, I think I should make the clinical responsibility for patients in our ICU quite clear. The primary responsibility for treatment is with the intensivist, and we consult with the home team and other specialists when the need arises. We don't have 'his' or 'her' patients, we have 'our' patients, and in the event that the home team feels that there may be aspects of our treatment that require explanation, we are only too happy to discuss this with them — civilly."

"You manage all the surgical problems then?" he sneered.

"If we believe that there is an operative problem, we will notify the home team of our concerns. However, when

cardiac, respiratory, renal or infective problems develop, we will manage these without notifying the home team first, in much the same way that a surgeon may operate on a patient with an acute abdomen referred by a medical team without contacting them first during the operation to say, 'An omental adhesion is obstructing the bowel, do you want me to treat it?'"

While we continued our robust discussion, I would add that, following this episode, "Smithy" and I became firm friends. He now respects the intensivist's opinion and, while he initially threatened to stop sending all his acutely ill patients to the ICU, he now demands that they be admitted to our unit. Indeed, confrontation between a home clinic and the intensivist in relation to patient management is now rare, and more often relates to bed unavailability.

Recently, I was amazed to learn that a new intensive care medicine graduate preferred to work in an ICU that functioned more as an "open" unit compared with ours, which prompted me to reconsider the concept of intensive care medicine as a specialty, and the idea of "open" and "closed" units. Generally, a closed unit is defined as one where all care is directed by the resident intensivist, whereas an open unit is defined as one where the admitting clinician directs all treatment,<sup>1</sup> or where an intensivist will be consulted only at the discretion of the admitting clinician.<sup>2</sup> The terms "open" and "closed" are not ideal descriptors, as they tend to indicate a culture of inclusion for open units and exclusion for closed units. This is incorrect as the terms simply relate to those who direct the patient's care. The terms, "service" units for open ICUs, and "specialist" units for closed ICUs, may represent the operative status more accurately.

While Australasian ICUs generally function with the intensivist taking primary responsibility for the patient's care (ie, they manage critically ill patients in a closed unit), the Joint Faculty of Intensive Care Medicine does not mention the words "open" or "closed" in their documents classifying Level I, II and III ICUs.<sup>3</sup> Nevertheless, with a common certification process, there is a broadly similar approach to patient care by most Australasian intensivists,<sup>4</sup> and it would be a minority who would embrace the concept of managing critically ill patients in an open or service unit.

To work as an intensivist in an open unit would require one to act as medical broker (ie, with a broad smile, a long list of telephone numbers, and no contrary view) consulting

## POINT OF VIEW

widely for cardiac, respiratory, renal, etc, opinions, generating a range of conflicting options that would tend to lead to a compromise in the care of the critically ill patient. Indeed, many studies have recorded a decrease in morbidity and mortality when critically ill patients are managed in a closed unit compared with those who are managed in an open unit,<sup>2,5-12</sup> indicating, at the very least, that an open model is not ideal.

As to the idea of a “more open” unit (eg, some ICU patients managed by the intensivist, and the rest managed by the home team): this is a concept that is not commonly promoted by either open or closed unit advocates. It is like wanting to be half pregnant. However, if the intensivist, in wanting to work in a more open unit, is expressing a wish to have less responsibility, this may indicate that his or her training is incomplete.

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