Editorial

We Are a Team … With Room for Improvement

By Richard H. Savel, MD, and Cindy L. Munro, RN, PhD, ANP

In some of our previous editorials, we have emphasized the crucial nature of communication in the intensive care unit (ICU).[1-3] We have pointed out the ways in which communication can become a highly complex and somewhat convoluted matrix in the ICU environment. Effective communication is required between nurses and patients, nurses and families, clinicians and patients, and clinicians and families, as well as between clinicians and nurses and clinicians and each other.

Several scholars have attempted to analyze some of these complex communication pathways and to define the very nature of the term *ICU team* in a more formal way. In one article from the University of Toronto, Alexanian et al[4] sought to determine whether what we practice in the ICU qualifies as "teamwork." In another article from the same university, Haas et al[5] performed an analysis on communication between surgeons and intensivists. Is it possible that multidisciplinary, multiprofessional ICU health care workers really do not constitute a team? We hope to convince you that they do.

Defining a Team

In the study by Alexanian,[4] a group of medical anthropologists carefully analyzed and interviewed ICU health care workers at multiple hospitals within a system. They concluded that, although they were able to describe the interactions as "multiprofessional," they could not categorize the members of the ICU as a "team" per se. These authors referred to the work of Reeves et al,[4,6] who defined a team by using incorporated elements discussed in health care literature as "a cohesive group with shared team identity, clarity, interdependence, integration, and shared responsibility."

Alexanian et al[4] stated that the work they analyzed could best be described as "collaboration, coordination, and networking." They concluded that health care providers in the ICU were professionals who happened to share the same workspace, but were not a team. This is where we, the coeditors, both of whom are experienced ICU practitioners, take issue with some of the authors' points. Much of what we do all day (and night) in the ICU involves collaboration, coordination, and networking (communication)—a belief we assert with pride—but our work together goes far beyond those things, and absolutely can be defined as teamwork.

Like other leaders in critical care,[7] we feel strongly that the clinical members of any ICU are, in fact, a team. We think the reason these investigators were unable to describe the work as "teamwork" is that they had not expanded their definition of *team* broadly enough. Of course, if one compares provision of care in the ICU to a relatively simple concept

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of a team—such as, for example, the members of a sports team—the ICU may not look much like a team. But the truth is that an ICU team is much more, not much less, than a sports team. It is a team of teams. And to add further complexity, the types of teams that come together to make up an ICU's overall care team may differ from one another.

In any ICU, there is the most important team: the team of bedside nurses. But not all staff nurses for an ICU will be there every day. There are also teams of physicians, usually intensivists, who help to provide medical leadership for the ICU. Although the physician team typically consists of attending intensivists, at teaching hospitals the teams can include fellows (i.e., those who have completed residency training in a specialty such as internal medicine, surgery, anesthesia, or emergency medicine) who are in the process of becoming intensivists, as well as resident physicians in their initial phase of training following medical school. Other team members include advanced practice providers, respiratory therapists, clinical pharmacists, registered dietitians, physical and occupational therapists, social workers, case managers, patient care technicians, and information specialists. To call this group of health care professionals anything but a team is confusing and borderline illogical.

To assert that we are not in fact a team is to trivialize what we do. Anyone who has worked in a highly functional ICU knows what a good team feels like. Such ICUs include extraordinary nurse leaders who work with talented bedside nurses in a united effort to provide high-quality, cutting-edge, evidence-based care to patients. In these kinds of units—better yet, let's just call them *teams*—a high degree of organization and implementation of protocols exist to empower the bedside nursing teams to make important decisions within the confines of an agreed upon set of guidelines. Rest assured that great effort will have been exerted behind the scenes to create a rational, reasonable approach to important and complex disease entities such as severe sepsis syndrome, respiratory failure, and hyperglycemia. It probably goes without saying that getting buy-in *before* implementation of such protocols from representatives of each part of the ICU team is crucial for successful implementation.

So rather than suggesting that the work we do in the ICU somehow is not teamwork, perhaps we should reframe the issue. In our view, the fundamental question is not *whether* the ICU team exists, but whether it's functioning well. How can the quality of the team be improved, for example? In our view there are 3 obvious areas for improvement: hierarchy, input to decision-making, and communication.

Unfortunately, as the authors point out,[4,7,8] the classic hierarchy of medicine to some degree translates even to the ICU team. It's true that the ICU team often consists of doctors and nurses working closely with each other, with doctors ultimately being responsible (even if purely from a legal standpoint) for the overall medical care plan for each patient. But just because a physician and a nurse are working together in the ICU does not necessarily negate the idea that those 2 people, or other groups of people, constitute a team.

In cases where nurses feel they lack the right kind of input into the patient's care plan, such a circumstance should be rectified swiftly. More meetings and formal feedback ought to occur at the level of local nursing leadership, and that feedback ought to be shared with nursing administration and physician leadership so they will take a hard look at what is actually happening at the bedside and make necessary improvements. The job of the bedside nurse is far too important to permit anything less.

Communication Between Intensivists and Surgeons

The team situation in surgical ICUs is different. In surgical ICUs, the role of the intensivist contrasts a bit with that of a purely medical ICU in which the medical intensivist often makes all medical decisions. For surgical patients, the role of the attending surgeon and attending intensivist is a complex and occasionally contentious one. The study by Haas et al[5] describes a formal analysis of "good" and "bad" communication between the surgeon and the intensivist. A team can easily break down if roles and lines of communication are not well orchestrated.

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What we found appealing about the study by Haas and colleagues[5] was that it accurately reflected our clinical experience, both good and bad. The authors emphasized that the attending surgeon has a special role to play with the patient, and that both intensivists and surgeons in some cases feel their expertise is not being respected or their voices are not being heard. Inflexibility on the part of the intensivist can lead to confusion and conflict.

One example of poor communication between intensivists and surgeons involved performance of procedures (such as dialysis) on surgical patients in the ICU without approval of the attending surgeon. Another crucial example was lack of involvement with the surgeon on end-of-life issues. Unilateral actions by intensivists can lead to poor relationships with surgeons, which in turn can result in suboptimal care for patients and poor overall unit function. By contrast, "good" communication is what one reasonably expects; that is, there should be frequent contact between intensivist and surgeon, with each sharing his or her perspective on the situation so a consensus plan can be built.

Conclusion

For decades now, the editorial leadership of this journal has consisted of critical care practitioners with backgrounds in nursing and medicine who have collaborated closely and proudly with one another as a TEAM! Given such a legacy, we find it distressing that some recent contributions to the medical literature assert that members of our multiprofessional ICU workforce do not qualify as teams.

Our response is to stand up to this. Consider this a clarion call to our readers to stand up for our patients, our teams, and ourselves. If we feel that our voices are not heard, our input is not valued, or our communication is not of the highest caliber, it is our duty to make a change. For the good of our patients, we must reconcile the fact that even though various members of the multiprofessional team have different roles, we are very much a team working together with one common, unwavering goal: to deliver the best care possible.

The statements and opinions contained in this editorial are solely those of the coeditors in chief.

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None reported.

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