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## Creating competent and caring physicians: ensuring patients are our North Star

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*Scenario:* An ICU team, composed of a critical care physician, two residents (one bleary-eyed and disheveled after being on call last night), a nurse practitioner, pharmacist, respiratory therapist and nutritionist, and an experienced charge nurse and bedside nurse, round on an elderly patient. The large and somewhat awkward team stand at the door to the patient's room as they thoroughly review his history, physical exam and laboratory data, summarize relevant literature, and discuss evidence-based therapies. The plan is state of the art. The patient, though intubated, is awake and alert and holding hands with his wife during the team visit. Both attempt to listen attentively to the ICU team's technically excellent discussion but are unable to comprehend. The ICU team walk away, feeling deservedly proud of their technical acumen, and totally unaware of their communication failure.

The patient and his wife had a different experience. They felt alone, frightened and disconnected from the

rounding process, even though the husband was the focus of the team discussion. The couple would have embraced a more attentive team, who introduced themselves, listened to the couples' concerns, and explained the husband's medical condition in language both could understand. The couple appreciated the technical brilliance of the ICU team, though technical competency was assumed, but they found it totally insufficient. At this extremely vulnerable juncture in their lives, the couple wanted a competent and caring physician who recognized them as unique individuals, not a diseased organ or an interesting case.

Scenarios such as this are far too common around the world. Laudably, we have made significant advances in critical care. We know that staffing ICUs with intensivists reduces hospital mortality by 30%. In fact, most ICUs in Europe employ intensivists – far more than in the USA. We have technologies and therapies that provide life-saving benefits to patients, but these alone are not enough. Amidst this highly technical environment where care is what we *provide*, it must also be what we *do*. We must demonstrate a heart to heart connection with patients that conveys our understanding of what it means to be vulnerable, frightened and human. Either care delivery approach alone is insufficient.

For the most part, we have little information regarding the desires of ICU patients and their families. In many industries, great effort is taken to identify “the voice of the customer,” and to meet or exceed the consumer's needs. Delivery of services is organized around the customer. Customer service often suffers in healthcare, where activities are typically organized around the physician's or hospital's efforts to admit and discharge as many patients as possible [1].

It is in the context of this background that Dr. Rothen and colleagues courageously report research that is so illuminating [2]. They had the courage and the compassion to ask patients and their families what they wanted from us, and then incorporated these skills into a competency-based

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training program. The study was conducted as part of an international partnership of training organizations, which developed a competency-based training program in intensive care medicine for eight European countries (CoBaTrICE). The authors conducted a detailed survey of patients who received care in an ICU and their relatives, to identify the knowledge, skills and attitudes they expect from an intensive care medicine (ICM) specialist.

Technical competency was at the top of the patients' and relatives' lists. They want us to be skilled at diagnosing diseases, delivering evidence-based therapies, and monitoring their progress. However, they also want us to listen to their concerns, talk to them, and partner with them to treat their pain. In reality, patients want to be treated as a person, not a diseased organ. Patient perceptions of what they desire from ICM physicians are remarkably consistent with the quality-of-care domains published by the US Institute of Medicine: deliver care that is safe, effective, patient centered, efficient and timely [1].

Rothen's study also illuminated other important points. First, the world is small and we are more alike than different. Seventy ICUs from eight European countries provided results; remarkably, findings varied little among countries. Even if a larger number of countries had been sampled, we suspect the results would be similar – patients and their families want competent *and* caring physicians.

Second, it is unlikely that any single institution can develop such an extensive competency-based training program alone. Staff may lack expertise in all of these areas, and the time and technical resources required would likely outstrip even the most well-funded departmental budgets. It is neither efficient nor effective for individual institutions to develop their own curriculum. The novel CoBaTrICE effort fills the void by drawing on a wide variety of experts and providing the technical support to produce a state-of-the-art curriculum that can be broadly delivered. As we recognize deficiencies in the “see one, do one, teach one” model of training, and move toward competency-based training, the CoBaTrICE effort is leading the way, not just for ICM but for all medicine. We look forward to this becoming a global collaboration.

Yet, we recognize that a curriculum alone will not likely lead to behavior change [3, 4]. In addition, communicating well and slowing down to listen in the face of high workload and technically challenging cases are difficult.

I (P.P.) routinely ask at least one patient a week who is leaving our ICU; “what was it like to be a patient here?” The answers are sometimes humbling, but always illuminating. Our care often falls short in meeting the patient's and the family's communication needs.

If didactics are not enough, what else can we do? We recognize a continuum from knowledge to skills, then to behaviors, and finally to outcomes. We need additional strategies to move clinicians along this continuum. One promising strategy is the use of simulation, perhaps

with standardized patients and ideally with an interdisciplinary team, to normalize language and behavior among disciplines and to practice teamwork. The simulation laboratory provides a safe setting for clinicians to practice these challenging communication skills and criticize their own efforts. Such training will likely require exercises to help clinicians reflect on their own feelings, skills and behaviors with regard to communication and relationships.

A second strategy is setting up some simple rules (habits) in our ICUs. Aristotle said, “we become what we do, excellence therefore is more of a habit than a virtue.” What are some of the potential habits that help ensure we meet patients' and families' needs? We have a couple of suggestions, acknowledging that the evidence is often at the level of opinion:

1. Invite patients and families to participate in rounds and view the daily goals (plan of care) [5]. Besides being efficient (families generally ask less questions outside of rounds), it is very comforting for families to see an entire care team focused on making their loved one well again.
2. Expand visiting hours. Many ICUs have completely eliminated restrictions on visiting hours. Though open visiting hours may pose challenges for the care team and introduce new risks, patients generally do not want to be separated from their loved ones. Our pediatric colleagues have long understood this fact. Whether you are 6 or 60, being with loved ones is comforting.
3. Provide families with an information brochure about what they can expect in the ICU and where they can go for support.
4. Have a weekly conference with patients and families. ICUs are scary and confusing to patients and families who often get conflicting information from the various caregivers. Once a week or more often, the care team should meet to discuss prognosis, then meet with the family to listen and address the patient's and family's concerns, fears and values, discuss prognosis and goals, and offer spiritual and emotional support.
5. Every week, ask at least one patient and their family what it was like to be a patient in your ICU. This approach is a practical way to gain insight into the “voice of the customer,” and gives us valuable information for improving the care we provide. Indeed, we have found such open-ended questions more informative than more formal patient satisfaction surveys.

Implementing these strategies may improve communication and caring, but it will require a culture change in many ICUs. Physicians, nurses and other clinicians will have to develop new knowledge, skills and behaviors together. We will also need to ensure technical competency. This will require a robust quality improvement program in which the quality of care provided is rigorously measured and improved. ICM will need to develop training pro-

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grams, such as a master's in public health, to provide clinicians with the skills to design, implement and evaluate quality improvement programs.

Critical care has made tremendous strides to improve technical care. The courageous CoBaTrICE study demonstrates that patients need more [6]. Many efforts are under way to fill this gap [6]. We must demonstrate to patients and their families that we are both competent and caring; this will be no easy feat in our often understaffed and overworked ICUs. The CoBaTrICE effort will surely help with both. Perhaps the greatest asset of the CoBaTrICE effort is its creation of a learning community that can be used to improve care across Europe. For example, imagine if CoBaTrICE obtains information from an error-reporting system and quarterly or semi-annually

focuses its education on mitigating that specific error [7]. Or, imagine if CoBaTrICE entered upon a collaboration to eliminate central line-associated bloodstream infections (CLABSI). Spain, for example, is exploring the implementation of a country-wide program to eliminate such infections. CoBaTrICE can help disseminate educational content for these programs, which could result in focused improvements in ICU care.

The CoBaTrICE effort will help ensure physicians have the knowledge and the skills needed to be competent and caring ICM clinicians. The potential to combine this curriculum with focused and measurable improvements in the quality of care is breathtaking. Through such programs we can ensure that patients reliably receive high-quality care. After all, excellence is more of a habit than a virtue.

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