

## Critical care evolves to become patient-centred rather than clinician-based

Madam, critical care has evolved in the past few decades to become patient-centred rather than clinician-based. In 2007, the American College of Critical Care Medicine task force published forty-three recommendations, endorsing a shared decision-making model which incorporates the family-centred care theory, where the family is a 'social unit that has significant effect on the patient's outcomes.'<sup>1</sup> Part of the Patient-Centred approach or Patient and Family-Centred Care (PFCC) is to shift from a patriarchal or disease-oriented philosophy to a more holistic, multi-disciplinary one, in which the family of the patient, including non-blood related 'kin', are actively involved in medical decision-making and management.<sup>2,3</sup>

Currently, in our intensive care unit (ICU), the transition to patient-centred care has been made at the nursing and administrative level. We have an open, multi-disciplinary adult ICU, where pulmonary critical care, as well as intensive care and non-intensive care trained anaesthesia faculty rotate on a weekly basis. The care administered is at the discretion of the attending physician and is often of the clinician-based, paternalistic model.<sup>4,5</sup> Cultural attitudes also play into this as traditionally physicians make all decisions for their patients in Pakistan .

The multi-disciplinary team includes daily coverage by an intensive care trained anaesthesiologist, a primary surgeon, a microbiologist, a nutritionist, a pharmacy representative, an ICU nurse and a charge nurse, as well as residents from Medicine and Anaesthesia department. In addition consults are obtained from pulmonology and infectious disease specialists. Families play a crucial role in the care of the critically ill patient. The ICU environment has traditionally been unwelcoming and unfriendly. Providing a 'de-mystification' of the care and allowing families to be a part of the decision-making has proven

to be a useful tool. This has shown to improve not just satisfaction amongst the 'consumers' or families but also in the actual outcome of the patient. This paradigm shift proves very vital in the patients' outcomes. The attending intensivist also follows the patient in the Bipap unit. This continuity of care helped in the transition of the family as well as the patient. Having two weeks of continuous intensivist on call during a patient's admission smooths the ups and downs in tumultuous course for the family. A successful management of his/her critical condition requires the full support of all consulting physicians and having the family on board means their approval and input.

Including the family as an integral part of the multiple professional ICU team is essential for the better outcome of a critically ill patient and may reduce the gap in communication and the misunderstanding that often occurs leading to frustrations and hurt feelings of the families involved.

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### References

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