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Increased use of protocols in ICU settings

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Dear Editor,

The use of protocols is becoming more and more common place in American intensive care units (ICUs). The concept of a protocol has its appeal; most physicians feel that certain drugs work best—or at least better than others—in specific situations. Therefore, it seems to make sense to devise a plan of action for those situations in which drugs are utilized in doses based on the patient's response to them. In this way, almost anyone can simply follow an algorithm to care for the patient, including physicians themselves who, for example, may not be completely familiar with the use of sedatives and/or pain medications in ventilated patients. However, it is our opinion that protocols are currently being overused in ICU settings to the detriment of the patient.

Protocols are often necessitated by the fact that in the USA ICU physicians are not always available and are not in-house 24 h a day; therefore, critical care nurses use these guidelines for decision-making. Unfortunately, this results in the simplification of patient care on a very large scale. Each patient will respond differently to each situation, and even drugs routinely used may not have a place in the care of certain patients on specific occasions. Patients may respond better or worse than expected to a specific pharmacological intervention, be it an inotrope, pressor, or sedative. This response needs to be either viewed first-hand by the physician or communicated rapidly to him or her. The appropriate measure may not be to increase the dose of one drug or add the next drug on the list; rather, it may be to change the entire regimen or add a drug not routinely utilized. The blind use of protocols does not allow for this type of intervention and can lead to increased patient morbidity. Even if certain exceptions are built into a protocol, if the protocol is routine enough these exceptions may be ignored.

The increased use of protocols also has an impact on the traditional practice of the doctor–patient relationship. The need for hands-on physician interaction with critically ill patients cannot be overstated, as this is the only true means of assessing a patient's response to an intervention and making appropriate decisions as to whether to increase the dose of a drug, add or delete a drug, or change the entire care plan. While the use of certain medications in a protocol may be a reasonable place to start in the care of a patient, one must have the ability, knowledge, and clinical skills to stray from these guidelines when necessary in order to optimize patient care.

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