Concern is intermittently raised by some surgeons regarding who has control and responsibility for patients admitted to a hospital under the care of a surgeon and then transferred to an Intensive Care Unit (ICU), most commonly after surgery, but not exclusively.

This is not easily solved by a ‘one size fits all’ approach.

Moreover which clinician ‘owns the patient’ is a notion that is out dated, but rather which clinician has ultimate clinical and legal responsibility for the patient is perhaps more pertinent. More and more the language and the practice is of ‘team involvement’ and ‘team management’, because that is how surgery in particular and much of medicine is practised currently. It is recognised that in very few (if any) situations a single clinician alone can manage a patient during all phases of their illness.

**Post Operative Orders**

The terms ‘orders’, ‘instructions’, or ‘preferences’ for surgeons and the post operative or non operative care of their patients is problematic and what happens in the post operative period is determined by local practices and habits. In some hospitals the surgical staff determine all immediate post operative treatment and observations. In others the anaesthetic staff order the analgesia and fluids whilst the surgical staff manage drains, oral intake, antibiotics and DVT prophylaxis etc. That is reasonably straightforward and works well, as long as local custom is understood and observed. Nursing and junior medical staff must know or are directed as to whom to notify if certain things happen.

**Admission to ICU Post Operatively**

If a patient is managed in ICU post operatively there is a difference. Surgeons usually will articulate their wishes as before, whilst analgesia, fluids and inotropic drugs etc are much more immediate and minute-to-minute considerations, so this is handled by ICU staff - ideally in collaboration with the surgeon, especially if an unexpected course ensues.

Whilst there may be questions concerning who has ultimate responsibility in this situation, local practices may vary and there are often also public and private hospital differences. The solution relies on good communication and appropriate handover within the framework of locally accepted practices and policies. As in all aspects of ‘team work’ this should not default to rule by the strongest personality.

Situations of disagreement or conflict should be handled by collaboration rather than confrontation and argument, and the acceptance that all are trying to aid the patient’s recovery.

Some areas, eg the cardio-thoracic/ICU situation, are slightly different as all cardiac and most thoracic surgical patients will be treated post operatively in an ICU. Management in these special or different circumstances will vary with the facility, local practices and personalities; but will always require communication, collaboration and teamwork, with the patient’s best interests paramount. Input should be available and sought from surgeons of all types, Cardiologists, Anaesthetists, Perfusionists, Intensivists and other clinicians with varying degrees in various facilities. Within the variables experienced it is the College’s view that –

- The overall responsibility for the patient remains with the surgeon under whose care the patient is admitted.
- At various times this responsibility is transferred to others - as the clinical episode progresses, as unexpected circumstances arise, or for a short time during the course of treatment.
- Sometimes this transfer of responsibility is formal and sometimes implicit. However in general terms there should be negotiated an accepted ‘default’ position; and then exceptions can be managed individually.
• Individual facilities/hospitals should have this process articulated in their policies and procedures.
• If deviations are necessary in individual situations, transference of responsibility should be documented in the patient’s hospital records, either handwritten or electronically, however records are usually recorded.
• If there are specific post operative instructions pertinent to an individual patient, then these should all be communicated in writing or electronically, eg
  o medications (frequency, dosage, method of administration);
  o management of drain tubes, invasive monitoring devices, or other devices;
  o action plans in the event of changes, expected or otherwise.
• Handover of care with details of all relevant matters and expectations be discussed clearly and documented; and
• Communication is most important and that it should be mandatory for ICU staff to confer with members of the surgical team if, at any point, they consider it is necessary or appropriate to alter a drug regime determined by the surgical team at handover to ICU, or if there are significant changes in the patient’s condition.

Some situations may require verbal instructions which should be committed to written form or corroborated at the earliest convenience. Individual hospitals should have published protocols and regulations about how this is managed and the local processes and practices should be understood and followed by surgeons and other clinicians.

The medical responsibility will remain with the senior responsible doctor or delegated doctor at the time, remembering primary responsibility may be transferred, even a number of times, during an admission.

The legal responsibility is the same as the medical responsibility.

The key to good overall care relates to clear lines of responsibility and communication being established well in advance and followed routinely. New members of the ‘treating team’ need be made aware of the local arrangements. If changes need to be made from time to time within an institution then these should be made again by collaboration and agreement and widely promulgated.

The College does not hold a view as to the ideal post operative intensive care management system; but within guidelines regarding handover procedures and communication, recommends local practices, collaboration and common sense should prevail.

Approver: Chief Executive Officer
Authoriser: Professional Development and Standards Board