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Project documentation
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What are the differences in the working atmosphere at British and German Intensive Care Units?

Written for CertiLingua

[redacted]

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1. Introduction

My project on the differences and similarities of German and English Intensive Care Units (ICU) regarding the working atmosphere and implications took place in London, St George's Hospital, and in Essen, the Hyssenstift hospital.
Since my parents are both doctors I had the opportunity to profit from their and their colleagues' experience. My mother's partner in their community practice used to work in the previously mentioned hospital in London and introduced me to Dr Tony Patel (name has been changed), who helped me through application for the work experience. I went there from June 25 to July 13, 2012 and had a work placement at the General Intensive Care Unit (GICU).
To complete the confrontation I had to do a comparable work placement in a German ICU. I did so from October 18 to 20, 2012.

1.1 Description

Within the framework of the project I am going to point out the differences and similarities of English and German ICUs, regarding their structure and which significance it has on working atmosphere and conditions.
Since I am neither a doctor nor do I have any experience in medicine, my final judgement will be very personal and not be founded on empiric evidence, but on my point of view and my own experiences.
It is not my intention to compare the quality of treatment or education of the staff, but to describe which aspects and issues I found striking and to compare the different situations.
Although there is no direct connection to the curriculum the study and comparison of work places and work atmospheres is a great part of social sciences.

1.2 Personal interest on the project

My personal motivation is my wish to study medicine and to become a doctor myself. This wish made me apply in London in the first place, to gain experience in "the real world". There are so many stereotypes about doctors circulating through society, from the "gods in white" that perform miracles and are given extraordinary presents by thankful families, to the more than realistic approach according to which the working hours and hospital or practice everyday life is the worst you can possibly choose. But stereotypes only feed from ignorance.
My expectation was to answer to me personally what it means to be a doctor today and, then knowing about the circumstances, whether my wish to study medicine is realistic or not suitable for me at all.
On top of that I was interested in the difference between the German and the English ICU, but that there actually was a difference just occurred to me when I already was in London. I had a very altering impression from other hospital work placements in Germany before, and in the following I will explain which issues were important to me.

2. The Project

First of all I should explain the significance of an Intensive Care Unit.
The ICU treats patients with very severe and even life-threatening illnesses. In both, London and Essen, I visited a general or interdisciplinary ICU that offers care to all kinds of patients. In the Hyssenstift that was the only ICU they had, in London they had special ones for cardiology, post-operative treatment etc.
It differs from a normal ward by the usage of medical equipment because many patients need a continuous monitoring or for example mechanical ventilation, and the number of doctors and nurses attending is usually higher than on an average ward to provide extra supervision. There are several extra specialisations to pursue in order to work in an ICU.
Patients usually stay no longer than a week because the major difference is the aim of the intensive treatment: The important question is "who can we let go today?" The first priority is to stabilise the patients in order to transfer them to a normal ward, not essentially to cure them. Because of that it is very important to find the diagnosis, if unknown, as fast as possible in order to secure the patient's survival. On top of that free beds always have to exist for emergencies so these do not have to wait. However there were patients in London that stayed for even 40 days, who were too weak to be transferred to a palliative care unit and stayed at the ICU, waiting to die.
The GICU was in so far the most interesting care unit as there were so many different cases, ranging from a young pregnant woman suffering from pre-eclampsia, a condition of high blood pressure which, if left untreated, can develop into seizures life-threatening for both mother and child, over post-operation wound treatment to a middle-aged life-long smoker suffering from respiratory failure.

2.1 Observations

The day at St George's Hospital in London started for me at 10 a.m. First of all, I made sure to have the latest patients plan, a list of all patients with their temporary or final diagnoses. That way, I quickly was able to get an idea of what was awaiting me that day.

The ICU was divided into two large rooms with each six to eight beds and two separate single rooms for contagious patients. In the centre of each of the two large rooms was an area with computers, phones, medical literature and the shift plans. There, usually the doctors were working on their patients' history while being able to supervise the entire area from that spot. Aligned to that, there was a room for medicaments and medical supplies.
Despite the openness of the facilities it was rather quiet even though the central area was usually crowded and busy. A simple curtain drawn around the bed was used to secure the patients' privacy during examinations or family visits.

There was one Consultant present, the central contact person to ask for advice. The Consultants were originally doctors from another speciality – Dr Patel for example was a gastroenterologist – who rotated every two weeks. During his rotation Dr Patel was responsible for two wards. Then, there were several Specialty Registrars (SR) of surgery, anaesthesia and internal medicine in training, one of whom was again in

charge of the others for the day. Finally, there were two Foundation Year (FY) doctors, meaning they were in a postgraduate training programme.
For easier understanding the doctors wore green scrubs, the nurses blue ones. I got to wear green ones too, and that way I often was confused to be a doctor as well, which of course flattered me.

Furthermore the ICU had a big recreation and dining room for the staff as well as a room for family visits and counsels and a conference room. There, in the conference room, all doctors, the head nurse for the day and further specialists met every day at 10.30 a.m. for a meeting to discuss the patients and their treatment. According to how many patients there were and which Consultant was in charge, those meetings could take up to three hours.
Every patient rotated so that every day there was another doctor treating him, and every day the patient was introduced to the assembly, even though during my stay there were some to stay for more than 40 days. After that, the patient's history was explained up to the latest test results and further treatment options were discussed. Often many specialists were present, like a pharmacologist and several surgeons. The final treatment decisions were written as general to do-list into a book and after the meeting the SR and FY treated their patients according to what was decided in the morning and then did whatever was not crossed out yet on the list. First the minor actions like changing medicaments or ordering an X-ray test were taken care of and every doctor made sure to compare the current data of the patient with the recent one to make note of the development. That way, the doctors worked together and finished rather early.
At about 5 p.m., there were ward rounds and the Consultant checked on the condition of each patient by walking from bed to bed. At that time I usually left and at home I researched on the diseases to be prepared for the next day.

2.2 First Impressions

Most of all, I was immediately impressed by the ICU's working atmosphere and especially the team spirit. For me, that team spirit came into appearance during the daily morning meeting, when taking care of patients and even during lunch. I was astonished because I have never felt a similar mood on a German ward or even in a more personal doctor's practice. Everyone was very friendly to me and very eager to help me, whether I needed scrubs or did not understand a word or even had no change for a sandwich. This was not because they pitied me because I was the new girl from Germany, but because they were used to behave that way in order to establish a healthy and prosperous working atmosphere.

Since I never have been on an ICU before, I was curious about how the stress of, for example, a failing heart would be handled. I only knew about the stereotypic images from TV series, when every patient's life is in danger because of a tropical disease with hardly any symptoms.
Although I knew about those false dreams of curing a medical mystery and prepared to be disappointed, I was surprised of the really calm and often cheerful atmosphere. I often enough had to hear that a patient had little chance to ever leave his bed again, let alone to recover, but still I had some trouble catching all the jokes that were made

during the morning meeting. I suppose this is the only right way to deal with disease and misery. The staff knew that the patients and their relatives counted on the confidence of their doctors and nurses, and it did not surprise me to find out later that people in a happy environment heal quicker and better than ones in an unhappy one.

That brings me to one of the most interesting things I noticed in London. Usually, the doctors and nurses work separately, since their work is on different levels. Yet there is one question the doctors always make sure to ask the nurses, when they for example just examined the patient or changed the medicaments' dosage: They ask them "Are you happy?"
At first, I did not understand what that meant. Are you happy with what? One doctor noticed my confusion and explained that, because the doctors usually had more than one patient and might get confused between them because they would not spend as much time with them as the nurses, they ask "Are you happy?" to make sure they did not miss a little change the nurses might have seen. Especially if the nurse is older and more experienced than the doctor, it is important not to be proud but to rely on experience.
I was very impressed by that approach to patient care, reaching beyond hierarchy. Often the nurses would have noticed something but were not sure when and how to address the attending physician about it. This question prevents that anything is missed. It acknowledges the contribution every part of the system adds to the final result. Listening, I felt like that is one of the most important aspects to build a community. For me, that question symbolises what I understood as team spirit: Working together for the patient's health.

3. Comparison and Reflection

Up until this point I only focused on the English ICU, now I will search for the equivalents in the German ICU system and finally decide which work atmosphere is the more attractive one for me.

Essentially, the structure of German and English ICUs is similar. The Hyssenstift, the German hospital in Essen I visited for two days, is rather small in comparison to the St George's, so it is not surprising that at times the smaller hospital in Essen cannot bear comparison with the larger one. For example, in terms of technological equipment such as impressive simulation seminars to improve teamwork when admitting a patient, the Hyssenstift cannot compete.
However, the ICU in Hyssenstift provides an equal medical care: It also is a general ICU, with a certain amount of beds reserved for surgical and medical cases. In addition to that there are doctors ("Assistenzärzte", from here translated as registrars) from those specialities.
All patients either have their own or a shared room. The facilities are arranged similarly: There is an area in the centre of the ward with all medias of communication, aligned to that a room with medicaments and medical instruments. There also is a kitchen for the staff for recreation, although the hospital's canteen is the preferred spot to eat at, and a special room for doctors to catch up with their paperwork and updating patients' charts.

As mentioned previously, the most important aspect for me was the team spirit uniting the staff in London and creating a very different work atmosphere than I had experienced before. This image was proven to be true – teamwork is neglected, working by oneself is preferred in Germany.
One approach to explain the differences would be a cultural one, starting with how the staff addresses each other. The form of addressing someone as "you" creates a certain proximity, meanwhile the German formal address "Sie" immediately generates distance. This thought probably would never occur to an Anglophone, but, being used to German culture and courtesy, it first made me feel uncomfortable, addressing Dr Patel with "you", so that I always made sure to add a "Sir" somewhere in the sentence.
A further important aspect was the "together time" when the staff had lunch. They assembled, sat down, watched TV and talked about something different than work. Spending time together connects on another level; work alone cannot form a group of people who are close to each other.
Contributing to that was a characteristic of the British health system, the National Health Service (NHS): There was more staff than in Germany. That way it was possible in the first place to sit down for ten minutes and have lunch. In London the proportion of nurses to patients is 1:1, in Germany one nurse covering two patients is the optimum, covering up to four is not an exception but often enough the rule and causing the nurses distress and in the worst case even a distraction.
In London, there are more doctors too, since they work in a shift system so they are never alone. In the Hyssenstift, there was one medical registrar covering five of 14 beds, and a couple of anaesthetic and surgical registrars covering nine. This arrangement was only valid for the medical attending doctors; the surgical staff had another one. Therefore there was a gap between the surgical and the medical staff they had hardly any chance to bridge, again working against the establishment of a team spirit.
The significance of that is obvious. Especially the medical registrar is not able to take a break and be sure someone else will look after his patients. For the surgical registrars it is easier to split up their patients, but still they are rather few in comparison with the St George's staff.

Another aspect regarding patient care is the dilemma of rotation in London versus continuity in Essen.
Both principles have their good features. Patient rotation implies that the attending doctors get to know more patients with different clinical pictures, learning how to deal with them over and over again. On the other hand it might be confusing for the patient to see a new face every day or every second day, since he might not know who to address if something is wrong. That counts double for the relatives and friends, because it is essential for them, too, to have an attachment figure to ask for help and assistance. Finally, there is an idiom in German, "Viele Köche verderben den Brei", which means, "Too many cooks spoil the broth". Transferred to this situation there is the problem of treating the patient correctly if the doctors cannot agree on a diagnosis or a treatment option. Someone might decide on one therapy, the next day that order may be reversed. Although the rotation principle is beneficial and instructive for the physicians, the patients might suffer from the too frequent changes.
This problem would not occur when following the principle of continuity: that the doctor treats the patient he admitted all through his or her stay. It is less stressful for the doctor not to learn a new patient's biography every evening and might increase the chances the doctors memorise the patient's medical condition without the

corresponding chart – a stereotype I, by the way, would like to remove from the people's heads since the physicians I asked about the patients always knew what was wrong with them, without ever having to look at the chart, both in London and in Essen. Yet again this principle promotes the working alone technique cherished in Germany, meanwhile the rotation process once more welds the staff together.

One last aspect to mention about the patient care is the handling of technical equipment. The NHS is infamous for its slow bureaucracy and cliché horror stories about waiting for a donated organ much longer than in Germany. Although this is neither place nor time to describe the NHS in detail, I would like to come to one aspect that affected the daily routine significantly.
In Germany ordering an X-ray test or another method to show the human body in detail is part of the common process of finding the diagnosis. Often you do not even have to explain your request any further; it is enough to say something like "I think there might be something there". That way, even if it is no emergency, the attending doctor has all the information together rather quickly to make up his mind about the diagnosis.
In London it takes rather long to get something done. It has to be explained in detail why this X-ray test is needed and what will happen if it is not done. This is of course exhaustingly stressful in comparison to Germany, yet there is an advantage: That way the doctors at St George's are forced to think about the advantages and disadvantages of every detail from every possible angle and the focus of the therapy lies not within using all technical instruments that are accessible. A simple aspect like this has formed a different mentality of treatment.

Finally there are two people I would like to mention in detail: First Dr Patel, my work experience coordinator and supervisor, and second another local student visiting the St George's for a work placement, Meneshka. Both of them represent the team spirit I was so pleasantly surprised of in a different way, including me into the dynamics of the ICU and making me a part of the system.
Dr Patel is a very accomplished Consultant gastroenterologist, graduated from London's colleges and Oxford, and holds a seat in several national leagues of this speciality. Reading his vita on the Internet I was so impressed by his academic skills I did not know how to behave around him.
At the end of my first day, I awaited our first conversation with a mixture of amazement and humbled nervousness. However, my first impression of him could not be more different: he was the personification of modesty and affection, making me feel welcome and encouraging me to talk about my day and whether I am enjoying my stay or not. He gladly answered all my (numerous) questions and even encouraged me to take a day or two off to go and see Wimbledon and visit his favourite town in England, Oxford. Although my work experience was very informative and interesting anyway, I would not have felt as save and appreciated if Dr Patel would not have been there.

Since I was the youngest person there, I often felt like a pupil at school, especially when I had to ask some questions again because the answer still was too complex for me to understand. Meneshka was a real help at those moments and beyond, explaining even the smallest things with great enthusiasm. She did this work experience because she wanted to study medicine too and become a paediatrician.

She came when I had already been there for a week, putting me in the position of her supervisor and giving me the chance to make her acquainted with the routine and dos and don'ts at the ICU.
It was very interesting to hear a different motivation than mine for becoming a doctor, and getting an insight within another career path than the one I planned for me. We suffered together during the endless hours of the morning meeting and were both fascinated and disgusted by the view of an open thorax in theatre (I ended up being more fascinated while she was so irritated she had to leave the room).
The important thing was that we went through this together, gained more knowledge about our future career and shared this experience with someone who knew exactly what you meant. What I got from the doctors and nurses that first welcomed me I was now able to pass on within the meaning of the team spirit.

4. Outlook

Becoming a doctor still is my dream job. I never romanticised the image of medicine, being aware that it requires more than probably any other subject at university. This work experience and my project comparing different work atmospheres could not drive me away from it, yet I wanted to recapitulate why becoming a doctor is so important to me.

Sadly, I cannot provide a heart-warming story such as one I heard in London by a Specialist Registrar, Tas. She originally came from South Africa from a small village where her grandparents and large parts of her family still live. When she was a small girl her grandfather became very sick, but no medical care was within a radius of several hundreds of kilometres. I have to admit I do not remember whether her grandfather survived, but this traumatic incident of searching desperately for help when there was no one to offer any shaped her so much she almost instantly decided to become a doctor. When she has finished her training she plans to go work for the International Red Cross and Doctors Without Borders. I remember that I admired her spirit and that I somehow felt like, because she had such a superior and morally valuable motive, she would be a better doctor than I would ever become. I even think I envied her for that background story.
On the other hand, right on my first day in London a F2-doctor came to me and told me about how awful being a physician is and that I should reconsider the idea of studying medicine. He thought being a doctor equals big cars and bigger pay checks and was disappointed when finding out that it is about treating people, too.
Those are two extremes I personally cannot really connect with – I had no essential experience that put that ideal into my head and I do not have making money as my first priority, otherwise I probably would become a manager. I am somewhere in the middle.

Reflecting on myself I would not characterise me as someone to be cut out to be a doctor. To be honest I often tend to be moody and procrastinate issues rather than dealing with them immediately.
The essential trait about me is that this person I represent today is not enough for me. Everyone has certain characteristics they are unhappy with and would like to change, and that is the most vital thing: I want to study medicine and welcome the challenge it

is for me because the challenge is the most attractive aspect. I am fascinated by the biological processes that form and change the human body, I am ambitious to look into the origins of diseases, I am open for every information that helps me understand the human body and mind. And most of all, I am interested in the people. When reading through these pages, I realise the key issues I concentrated on were about the people, their relationships, how they felt and what affected them. Becoming a doctor is my own personal approach to all their problems.

In the future I could well imagine working in London. The team spirit and community feeling appealed to me very much because at first I would be horrified by the thought of being responsible all alone for a human life that depends on my skills. This system makes sure that there is hardly any possibility to fail, since you are always a part of a group, having someone to look out for you and as well as being able to look out for someone else. There was for example an Austrian doctor working there, not only fallen in love with the city but also staying for the work. It is impossible for me to say whether I would stay or not, but working in London now is another dream of mine to be fulfilled.

Nevertheless I also found out what I do not want to do in future, namely work in intensive care. At the beginning I described the significance of the ICU: that the first priority is to stabilise the patients enough so they can move to a ward which then actually cures them. Although I understand the necessity of this system and I did find the ICU a very interesting and special place to do a work experience there, I felt like the treatment was insufficient and it was not a satisfying sentiment to see the patients move somewhere else where someone else would finish the treatment I, for example, originally started.
Often the patients brought the diseases on themselves, because of excessive smoking, heavy drinking or an unhealthy diet. The real challenge in curing those people lies within the therapy, talking to them, clarifying which aspects in their lives they have to change in order to stay healthy. Being a doctor does not only mean filling out prescriptions to me, but working together with the patients on their health. Reaching someone on that level is a very difficult mission to fulfil since people are usually stubborn when talking about health. It often enough happened that patients or their relatives became angry or even offensive and rejected any help or reasonable arguments about changing old habits, which became hazardous to their health. But in the end the important characteristic to keep in mind is that those people are scared and they need help, even if they do not admit they do.
Before I used to disclaim the idea of owning a private practice like my parents, but they often treat their patients over years and get the chance to really make a difference in those people's lives and really heal them. A hospital may offer too little time for that, although it offers other benefits: A large variety of cases and the chance to do scientific research for example.

In the beginning I was eager to find out more about the system and the work atmosphere. The team spirit was the crucial idea I centred my project around. Finally the people I met and talked to were the ones that made a lasting impression on me and my future plans: My choice to study medicine is more important to me, is more "me" than I have thought before.

5. Appendix

Declaration of independent work

I hereby declare that I have written the project documentation on my own and only used the listed references and aids.

Permission for anonymous publication

It is planned to make the project documentations available for scientific research and for the CertiLingua network by publishing examples of best practice on the CertiLingua website. This will be done anonymously. The author's consent is nevertheless necessary.

- o I hereby authorise the anonymous publication of my project documentation.
- o I hereby deny the anonymous publication of my project documentation.