To the Editor:

As described by Dalio in his book Principles, “Principles are fundamental truths that serve as the foundations for behavior…” (1). Depending on the discipline, definitions of success, and context, principles will vary. When problems and challenges arise, we return or rediscover our principles to guide our actions. As Dalio (1) describes, “to be principled means to consistently operate with principles that have been clearly explained.” The critical step of writing out principles serves to formalize them and allows them to be shared. Composing and distributing them translates into enhanced clarity, deepened understanding, iterative refinement of concepts, thoughtful reflection, and ultimately improvement through experience (1). Within any organization, the ideal scenario is to have individual team member’s moralities that are well aligned with the overarching principles for the group so as to ensure maximal engagement, productivity, and well-being (2).

As organizations go, healthcare institutions are among the most complex and deal with the most high stake outcomes—life and death. Furthermore, healthcare spending accounted for 18% of Gross Domestic Product in the United States in 2019; already in 2007, healthcare-affiliated positions surpassed retail and manufacturing as the largest source of jobs in this country (3, 4). Within this economic and social sector, the broad and overarching pillars of large healthcare organizations can feel distant and impersonal for those on the frontlines providing care. This reality makes the process of naming a mission that all stakeholders can get behind and excited about challenging, if not impossible. In these circumstances, principles (either for the entire organization or specified for distinct entities) can provide a structured way to cultivate, embrace, and advocate for the personal and collective values that serve to prioritize and guide all behaviors and choices.
WHY WE DEVELOPED PRINCIPLES FOR OUR MEDICAL ICU

In 1958, at Baltimore City Hospital, what is now Johns Hopkins Bayview Medical Center (JHBMC), Dr. Peter Safar created the first ICU. He described, “the purpose of this combined unit was to provide optimal medical and nursing care to all critically ill patients” (5). Sixty years later, these overarching goals continue to be relevant, but the complexity in the healthcare system including increasing subspecialty dominated critical care requires principles that are more specific. With iterative evolution of the preliminary ICU model by Safar et al (5), there have been tremendous advances in all aspects of care delivery, prompting the creation of subspecialized ICUs for advanced medical, cardiac, neurologic, oncologic, surgical, and burn ICUs.

Currently at JHBMC, a 400-bed hospital, there are five distinct ICUs; our sister hospital, Johns Hopkins Hospital (JHH) has nine. All 14 of these units are “high acuity systems that is designed to provide care to those who are critically ill using specialized medical and nursing care, continuous monitoring, and multiple modalities for sustaining life during periods of life-threatening organ failure” (6). Given the unique focus of the respective ICUs, it is understandable that the culture and philosophy within each are distinct—this reality may be explained by the differences in the divisions and departments from where the doctors, nurses, trainees, and staff working the units originate. Nurses and physicians who staff these units have different training backgrounds (anesthesiology, internal medicine, general surgery, and neurology) and the interdisciplinary staff (respiratory therapy, occupational and physical therapies, and social work) cluster in varying proportions in specific units. These distinctions allow for and facilitate optimal care of specialized patient groups, particular diagnoses, and the execution of specialized interventions and therapies. The nuances across different ICUs were not as pronounced in the early days as hospitals emulated the original model by Safar et al (5); today’s particularities and idiosyncrasies across ICUs make the case for thoughtful consideration of guiding principles to capture the unique features of the service and care.

Principles can also be used as a mechanism to generate grassroots changes or improvements that are needed in a clinical setting within a larger health system. Rather than steamrolling “harmonization” across all clinical setting, encouraging the articulation of distinctive principles extends autonomy and embraces the uniqueness of each unit while empowering those with the lived experience of working there. For example, when we identified inefficiencies in our rounding workflow in the medical ICU (MICU) at JHBMC, rather than framing the issue as “needing to be the same as JHH,” we looked to our principles that prioritize “teamwork” and “transparency” to garner support for the needed changes—unambiguous harmony. Prior to the principles being clearly documented and distributed, Pulmonary and Critical Care Medicine fellows rotating through the unit-experienced challenges fitting into the workflow and role, because of different routines and practices at the other hospitals. Now, when each fellow comes to the JHBMC MICU, they are oriented with the principles, and we frame their clinical experience around them. Unease has been replaced with belonging, and our unit is now the highest rated clinical rotation by the fellows.

Functionally, the ICU has a very high acuity that requires a high provider and nurse-to-patient ratio, and persistent continuous bedside vigilance; these consistently intense circumstances can result in interpersonal conflict, emotional exhaustion, and depersonalization (7, 8). The stress of working in an ICU is well documented; burnout rates have been noted to be as high as 47% among ICU providers (9). Burnout-reducing organizational strategies that have been recommended include cultivating community at work, aligning values, and strengthening culture (10). Our effort to develop principles for our unit, with input from all team members, provided us with a concrete framework to transform prioritized concepts into actionable behaviors and cultural expectations. When one of our nurses expresses frustration with an overnight resident who was “short with them,” what might be referenced when providing feedback to that trainee—the golden rule, religion, philosophy? That was where we had to reach in the past. However, such situations are best served and guided by a homegrown and context-specific framework relevant to that clinical setting. We knew that our principles would serve as a local roadmap, to be considered as decisions and behaviors would be reviewed and analyzed.

We anticipated that unit principles would also be beneficial to connecting with and orienting patients and families. For patients and loved ones in the ICU, critical illness is overwhelmingly stressful and alienating.
The rates of depression, anxiety, and post-traumatic stress disorder are highly prevalent among patients and family members exposed to intensive care; in fact, a specific diagnosis has been established for some who suffer following this exposure—postintensive care syndrome. It has been established that ICU staff behavior and characteristics of the communication between parties affect the risk of postintensive care syndrome for patients’ family members (11, 12). In this anxiety-laden environment, we hoped that our principles would provide detailed explanations about our goals for caring—perhaps translating into improved comprehension and satisfaction with ICU care (13). It was our belief that sharing printed unit principles with patients and caregivers would serve as a major step beyond the existent generic welcome packets by communicating the truths that underlie the functioning of our multidisciplinary team and the processes within our ICU.

The overwhelmingly nerve-wracking experience in the ICU is often further compounded by a lack of continuity of care and the absence of longitudinal provider-patient relationships. The rotating personnel challenges interpersonal trust, which requires repeated interactions over time between the provider and the patient. Our unit principles would create a consistent identity and point to our north star—irrespective of the constellation of providers who would be delivering the collaborative care on a particular day or shift.

The coronavirus pandemic is a prime example of the need for clear and engaging principles. When coronavirus disease 2019 (COVID-19) descended on our hospital, everything changed—the workflow, the patients, the diseases, our clothes and equipment, the staffing, and the physical space. Individuals who had not worked in an ICU for years were called on to serve the critically ill COVID-19 patients in the ICU. Administrators who had never worked in an ICU were involved in decisions about where and how to build additional ICU space. In this dynamically evolving environment, we looked to our “MICU principles” to preserve our culture of care while clarifying expectations. From our one-page document, individuals assigned to help as we escalated our capacity (like the plastic surgery attending who had been redeployed to a new hospital and the administrator tasked with assisting us to open a second MICU) could understand our foundational beliefs and deeply rooted culture. Beyond issues related to expansion, our principles were instrumental in directing our adaptation to the world that was changing around us. For example, when we tried to enact virtual rounds to limit the exposure of team members to coronavirus-infected patients, we revisited our principles to inform the consequences of such practices. Ultimately, our principles helped us to persevere and, in some ways, thrive during the pandemic.

**WHAT WE DID AND HOW WE DID IT**

The process for writing our unit’s principles involved a longitudinal multidisciplinary approach that extended over the course of many months. In order to recognize and understand the culture and truths of our MICU, we solicited perspectives from all of the individuals and teams that contribute to the care. A preliminary goal was to identify and describe the genuine beliefs that motivate the behaviors of the frontline providers. Our process started with group meetings with our nurse managers, charge nurses, and nurse educators to discuss the culture and history of the unit. In parallel, we met with our core group of attending physician providers to learn why these providers choose to work in our ICU; we also asked them to reflect upon recent patient encounters and experiences that were satisfying or otherwise moving. From these initial meetings, a first rough draft of principles was composed. After distribution of the preliminary version back to these primary informants, the MICU director met one-on-one with each of them to reiterate the purpose of composing written principles and sought input about the tone and language to be used. In addition, we reached out to other attending providers who work less frequently in our MICU, as well as the two former MICU directors for additional feedback. The iteratively revised document was again reviewed by and discussed with all our nurses, other staff working in the unit, internal medicine resident house staff, ICU clerical staff, pulmonary and critical care fellows, as well as the occupational, rehabilitation, and respiratory therapists who serve in the unit. As consensus built among our internal team, we engaged clinical leaders in the hospital to weigh in and provide perspective about how our principles fit with the mission and care philosophy of the institution. As the document evolved to the point where most were proud and excited, there was culmination with the draft being read aloud several times to the entire team at the unit meetings. The process of openly and publicly sharing of our values not only resulted in further modification, but it stimulated a nonhierarchical dialogue wherein all voice and opinions were equally considered, as the challenges, opportunities,
Principles for Johns Hopkins Bayview’s Medical Intensive Care Unit

The entire multidisciplinary team of Bayview’s Medical Intensive Care Unit is committed to clinical excellence in critical care medicine. Our collective experience and expertise is delivered through a systematic approach that ensures the provision of the highest quality care to patients who need to be served in the intensive care unit.

Our Unit Principles reflect our core values, and fundamentally influence our relationships. Our culture is built on respect, integrity, service, and caring. Our relationships are grounded in trust, collaboration, and open, honest communication.

- **Presence.** We value the time spent caring at the bedside. We are attentive while compassionately listening to patients, families, and each other.

- **Teamwork.** We understand that the best care is provided by collaborative multidisciplinary teams that demonstrate mutual respect, and are non-hierarchical.

- **Transparency.** We believe that openness and honesty are necessary for continual improvement.

- **Safety.** Together, we strive to prevent harm and promote the well-being of patients, families and staff in the unit.

- **Reflection.** Regularly, we assess behaviors and review performance so as to learn from both process and outcome measures. Introspection about emotions are also prioritized and we create opportunities for sharing.

- **Acceptance.** We expect and are mindful of differences in backgrounds and beliefs. We are inclusive and accepting of differences. Diversity is embraced and cherished.

- **Support.** We are holistic in our care. We know that only by truly learning who our patients are as people, can we serve them properly. Critical illness can be difficult on the mind and body of patients, families and caregivers. We unwaveringly support each other in the care of the critically ill. A key measure of success of our unit is the strength and quality of the relationships between people.

Figure 1. The principles for the medical ICU at Johns Hopkins Bayview Medical Center.

and goals were discussed. At this point, it became clear to all that we wanted to display the principles not just in the physician and nursing workrooms but also in patient rooms. The idea emerged to have a large version of the document prominently displayed on the wall near the unit entrance—signed by entire team, like a constitution.
As the principles reached this near final form, it was also shared with patients and family members of loved ones who were cared for in our ICU. It was critically important that the document reflected not just the beliefs of the staff but also the truths as seen from the patient perspective. After further amendments, the finalized version of our MICU principles (Fig. 1) was disseminated to all rotating house staff, fellows, nurses, and attendings. The principles were read and elaborated on in house staff orientation, medical grand rounds and copies are displayed in the physician workrooms and nursing rooms, and planned to be in patient rooms and hallway walls.

These principles reflect the current best representation of what our unit is about and why we are so committed. It is understood that the principles are likely to evolve as the unit work and people change over time. As such, we intend to revisit and reflect upon the fit of our principles on an annual basis. A few reflections on the process and outcome are shown below:

MICU nurse states, “Using a collaborative approach across all disciplines, we are focused on eliminating the potential harms that could affect our very sick patients while trying to improve their outcomes. Outlining our principles helps to promote the core values and behaviors we expect everyone to follow in our unit. With this newly clarified direction, we are better able to reliably provide the highest quality care.”

MICU fellow states, “I think the Bayview MICU was one of the best rotations of fellowship. I felt the unit had a welcoming atmosphere, which made it a great place to learn. It was clear that optimizing patient care and protecting staff morale were priorities for leadership. There was an authentic sense of shared mission and community.”

MICU attending states, “The MICU is a place where our sickest and most complicated patients are cared for in a way defined our unit principles. The entire team shares a genuine commitment to the values that are captured in the unit’s principles.”

Director of Palliative Care states, “The principles that were developed are powerful. When our team is consulted, it is helpful to know that all team members fully understand exactly what we are trying to accomplish together in supporting colleagues and caring for patients.”

CONCLUSIONS

Developing and formalizing the principles for our MICU has brought the team together and made us better. In developing our principles, we purposively and openly considered the perspectives of all stakeholders. With our principles provide explicit assertions about the expected norms, we have all witnessed improved communication and better interdisciplinary collaborations in the unit. Although the lofty institutional mission can sometimes feel remote and detached from the realities and stressors encountered daily in our ICU, the distance has been bridged by our principles that remind us of our purpose. Large organizations do not actively encourage individual clinical units to develop their own unique values. Few entities engage in thoughtfully rigorous methods to develop principles that are accepted by all, although many clinical teams or divisions establish a mission and vision. However, if any large organization discourages or does not permit a team to collaborate on an initiative that aims to enhance quality of care and collaboration within a unit, this represents a decision that is based on fear and weak leadership. Our group sincerely believes in our principles; we are utilizing them for grounding and as guideposts in the demanding, dynamic environment of caring for our patients in the ICU. The effort required to achieve consensus on developing meaningful principals with buy-in from all is significant; however, the return on this investment is worthwhile. Whether your clinical setting is struggling or flourishing, clear and continuous articulation of the fundamental truths that serve as the foundation for your team (or your principles) (1) will undoubtedly move you forward toward your goals.

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