Recent developments concerning the organization of intensive care medicine have prompted an editorial analysis of the relationship between intensive care medicine and the media in the Netherlands. The direct reason for this was the discussion in NOVA – a Dutch political news programme broadcast on November 17th 2007, in which an item on the issue of volume-outcome relations was presented and subsequently discussed by authorities in the field. What are the relevant issues?

**Issue 1: volume-effect relations in the ICU**
The volume-effect relationships of a wide range of surgical procedures have been known for several years. The discussion in the Netherlands and other countries concerning oesophageal resections is widely known. However, there are several other factors that determine whether a low-volume hospital is a bad or good performer [1,2]. What are the data about the volume effects of mechanically ventilated non-surgical critically ill patients [3-7]? All studies describe a better performance or outcome of complex patients in high-volume centres than in low-volume centres, although some low-volume ICUs have been shown to perform well. A recent study on in-hospital resuscitation again describes the relationship between volume, organization and outcome [8]. Given these volume-outcome relationships, it has become clear that the outcome of complex medical care is not solely determined by individual medical expertise but is also determined by both organizational factors and the total chain of care in a hospital. Figure 1 summarizes these three determinants. Accepting this concept may relieve the feelings of anger and hostility that have recently developed in reaction to the open discussion of this subject [9]. In addition, this concept distributes part of the responsibility for an optimal outcome from the bedside professionals, to managers and to other departments in the hospital. And, as a consequence, it creates opportunities for improvement.

**Issue 2: publicly available outcome data**
Performance data concerning cardiac surgery have been publicly available in some countries for several years [10]. The availability of outcome data from open access sources is not the best way to improve quality of care and potentially carries risks [11]. How to proceed given these three issues?

**How to proceed given these three issues?**
The current situation in Dutch intensive care is characterized by a relatively large number of locations with a relatively low number of patients. In the areas of industry and aviation, it has been evident for years that focusing is the way towards improved performance. For less complex health care, individual medical expertise will be sufficient to obtain a high standard of care. In contrast, the high complexity of intensive care needs to be focused to achieve quality improvement. By focusing on all details of the total process of care the outcome will improve. In my opinion, there are ways of achieving this goal that will benefit all ICUs and intensivists, from small and large intensive care units. As intensivists we render a service to our patients and
we are obliged to them to improve constantly. Currently, this implies concentration of complex care, external (publicly available) and internal (not publicly available) monitoring of performances and sophisticated use of the media. Many expect the Dutch Society of Intensive Care to take the leading role in guiding the way towards a high standard of care respecting the interests of both patients, intensivists and other professionals at the bedside.

Figure 1. Determinants of outcome

References


