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We should move away from a focus on individual resilience towards building resilient systems

Too much emphasis has been placed on the resilience of individuals and too little on the resilience of the health system, argue Harleen Kaur Johal and colleagues

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Resilience has long been considered a desirable quality in healthcare professionals. It describes the ability to “bounce back” and continue working, when the inevitable “losses” encountered in a healthcare career outnumber the “wins.” Critical care staff readily appreciate the need for resilience, as they navigate the demanding working conditions created by surging admissions, staffing shortages, long working hours, and pressures to meet targets. The covid-19 pandemic has further amplified this need, as critical care professionals have had to work above and beyond what their duty of care usually requires. Yet too much emphasis has been placed on the resilience of individuals and too little on the resilience of the health system—specifically the NHS—in which they labour. A resilient system is resilient in its own right; it does not require unsustainable commitments from healthcare professionals to avoid decline. Rather than burdening critical care staff with a need to become more resilient, the focus of healthcare policy should shift towards building a more resilient system.

Redeployment improved staffing in critical care units early in the pandemic. This was later reduced to meet other priorities, such as providing postponed elective services and preventing further disruption to training.¹ Critical care clinicians have subsequently treated more patients, but without sufficient additional staff. A recent report from the Faculty of Intensive Care Medicine confirmed that doctors in critical care work additional hours to support colleagues and ensure patient safety.² Such discretionary locum work is usually remunerated, but it reduces the quality and quantity of time that clinicians have to rest, or spend with loved ones. The psychological impact of work strains clinicians’ personal relationships, and family members may be concerned about occupational SARS-CoV-2 infection risk—especially over recent months with the emergence of new variants. These risks to professionals (and their loved ones) might be considered secondary to their primary responsibilities towards patients. However, staff fatigue also jeopardises the ability to care for patients safely.³

Substantial rates of probable mental health disorders, including thoughts of self-harm, were seen in critical care staff after the first wave of the pandemic.⁴ Worsening workplace pressures risk increasing burnout among doctors, which was recognised as a global public health crisis before the pandemic.⁵ A 2021 Medscape survey showed that burnout was highest among critical care doctors.⁶ Three strategies have been described to prevent burnout: modifying the organisational structure and work processes;

improving adaption to the work environment through professional development programmes; individual actions to improve coping and reduce stress.⁷

Policymakers and insurers have placed considerable emphasis on the second and third of these strategies, which aim to build individual resilience for example, (through debriefing and counselling opportunities, alongside self-care exercises). Rather than encouraging professionals to tolerate what might be considered intolerable working conditions, however, more attention should be directed towards the first preventive strategy, by looking at the system at large and improving deficient organisational structures, work processes, and funding. Working consistently beyond capacity is unsustainable, and interventions to build resilience impose additional burdens.

We need to reconsider the obligations that are owed by professionals and in turn owed to them. What was characterised as “heroic healthcare” in 2020 has become the norm for many clinicians in critical care units in 2021. Ordinarily, these clinicians are exposed to communicable diseases and risks of personal injury (such as workplace accidents and physical assault). Rota organisers will usually look to existing team members to cover rota gaps, as this is more cost effective than hiring external locum cover.⁸ The argument is, consequently, that the work of critical care staff has always been heroic. Yet, these heroic acts are likely to be supererogatory—that is, “beyond the call of duty”—insofar as they are morally laudable but not morally obligatory. Doing less—such as taking on only managerial work that is properly compensated or not taking on additional shifts—would still be morally acceptable, particularly if we recognise that such heroism is neither sustainable by, nor should it be requisite for, healthcare professionals.⁹ Some ethicists further argue that professionals deserve additional compensation to account for the added burden of the work undertaken during the pandemic.¹⁰ However, change is needed that is more profound than “payment for risk.”

Cruess and Cruess depict a tripartite, reciprocal social contract between the medical profession, patients, and government.¹¹ Medical professionalism outlines the expectations that patients and the government legitimately have of doctors, who are correspondingly owed obligations by patients and the government.¹¹ The very least that professionals should expect from the government is adequate funding for, and staffing of, the healthcare system—neither of which the NHS in general, and critical care units in particular,

currently have. One former minister has acknowledged failures to build sufficient reserve into the NHS workforce.¹² Furthermore there is a risk that—by requiring individual professionals to “cope”—clinicians cover for the failures of healthcare leaders and politicians, to learn from, and act on, the organisational failures at the root of staffing shortages, insufficient bed numbers, IT failures, and restricted patient flow from admission to discharge. The onus—and anguish—of resource allocation and ethical decision making has also fallen on the medical profession, in the absence of clear national leadership.¹³ The government must now fulfil its role in the social contract by providing sufficient funds and leadership to develop sustainable working processes and organisational structures.

Although we have focused on critical care, burnout afflicts many specialties. Within the UK, the number of foundation year doctors moving directly on to specialty training has dropped annually, with junior doctors instead seeking opportunities abroad or in non-medical professions, having become disillusioned by their experiences working for the NHS.¹⁴ The proposed 3% pay raise for NHS workers and the uncertainty surrounding the NHS pensions scheme have left many staff feeling undervalued and unsure of their future within the NHS, and the British Medical Association has expressed concerns about the future of medical staffing.

Individual resilience was insufficient to prevent burnout and attrition rates before the pandemic. It is unlikely to be sufficient going forward. Consistent undervaluing has caused incremental harm to the relation between critical care workers and the government, which directly threatens the longevity of the critical care workforce. It is therefore imperative that the government rebuilds the relation and focuses on building a resilient healthcare system, lest we lose these workers’ valuable contributions to the NHS and to the patients it serves.

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- 1 NHS England. Advice on acute sector workforce models during COVID-19. 2020. <https://www.england.nhs.uk/coronavirus/publication/advice-on-acute-sector-workforce-models-during-covid-19/>
- 2 Faculty of Intensive Care Medicine. Voices from the Frontline of Critical Care Medicine London; 2020.
- 3 Maltese F, Adda M, Bablon A, et al. Night shift decreases cognitive performance of ICU physicians. *Intensive Care Med* 2016;42:393-400. doi: 10.1007/s00134-015-4115-4 PMID: 26556616
- 4 Greenberg N, Weston D, Hall C, Caulfield T, Williamson V, Fong K. Mental health of staff working in intensive care during Covid-19. *Occup Med (Lond)* 2021;71:62-7. doi: 10.1093/occmed/kqaa220 PMID: 33434920
- 5 The Lancet. Physician burnout: a global crisis. *Lancet* 2019;394:93. doi: 10.1016/S0140-6736(19)31573-9 PMID: 31305255
- 6 Medscape. National Physician Burnout & Suicide Report 2021. 2021.
- 7 Kumar S. Burnout and Doctors: Prevalence, Prevention and Intervention. *Healthcare (Basel)* 2016;4:E37. doi: 10.3390/healthcare4030037 PMID: 27417625
- 8 Rimmer A. Trusts spend 25 times more on locum fees than on recruiting for permanent posts. *BMJ* 2016;354:i4370. doi: 10.1136/bmj.i4370 PMID: 27506921
- 9 Singer PA, Benatar SR, Bernstein M, et al. Ethics and SARS: lessons from Toronto. *BMJ* 2003;327:1342-4. doi: 10.1136/bmj.327.7427.1342 PMID: 14656848
- 10 Giubilini A, Savulescu J. Stopping exploitation: Properly remunerating healthcare workers for risk in the COVID-19 pandemic. *Bioethics* 2021;35:372-9. doi: 10.1111/bioe.12845 PMID: 33550626

- 11 Cruess RL, Cruess SR. Expectations and obligations: professionalism and medicine’s social contract with society. *Perspect Biol Med* 2008;51:579-98. doi: 10.1353/pbm.0.0045 PMID: 18997360
- 12 Iacobucci G. Jeremy Hunt: I was too slow to boost the NHS workforce—the government must, and can, act now. *BMJ* 2021;372:n335. doi: 10.1136/bmj.n335 PMID: 33568341
- 13 Fritz Z, Huxtable R, Ives J, Paton A, Slowther AM, Wilkinson D. Ethical road map through the covid-19 pandemic. *BMJ* 2020;369:m2033. doi: 10.1136/bmj.m2033 PMID: 32439751
- 14 Rimmer A. Number of FY2 doctors moving straight into specialty training falls again. *BMJ* 2019;364:l523. doi: 10.1136/bmj.l523 PMID: 30705031