ICU’s most powerful tool will always be skilled staff

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Intensive care medicine is 70 years old. This birthday ought to include celebration and reminisces, but it also comes with nervousness about the future. Intensive care medicine started when a 12 year old girl named Vivi Ebert survived polio. In the space of what is now an average human life expectancy, intensive care medicine has become a nexus for complex care, and something society really cannot do without. We have a long way to go, but thousands of hard won gains mean that most patients survive what was, previously, unimaginable. These iterative advances started by addressing care in the intensive care unit (ICU), then pivoted to pre-ICU rescue, and are poised to tackle post-ICU recovery. Moreover, courtesy of covid-19, intensive care medicine now has a public profile, meaning we can better advocate for our patients, families, and communities.

The problem is that there seems to be another pandemic: if we use the broad definition of “a widespread issue that crosses international boundaries and affects large numbers of people.” We are not referring to an emerging (or re-emerging) virus but rather to an emotional contagion resulting in record levels of staff walkouts and despondency. The “great resignation” appears to be real in both senses of the word—as is the concept of “quiet quitting” (where people still turn up, but with little passion).

There has always been staff turnover, burnout, and discontent in healthcare, but never to this extent.

Although we know more than ever how to treat critical illness, we have fewer and fewer people to do the treating. Paul Simon sang about 30 ways to leave your lover, and many have witnessed a similarly diverse exodus from our clinical ranks. Healthcare workers are retiring, transferring, decamping, and otherwise vacating already dwindled ranks. And who can blame them? Few would apply to a job posting that included: “Frequent nights and weekends, complaints, bureaucracy, pay disputes, and pleading calls during your off time.”

While we are struggling to staff the current hospital beds, some governments are demanding expansion. We would normally be thrilled to add more beds. After all, we know the need is there, we want to be ahead of the next virus or mutation, and we want to help as many as possible. But—and it’s a very large but—where are the staff? Expressed another way, beds do not treat patients: people treat patients.

Our machines and potions are impressive, but the most powerful ICU tool is—and likely always will be—skilled bedside staff, working in experienced teams, taught by experts, and supported by skilled colleagues. In other words, teams take time and need to be nurtured. Attracting, but especially retaining, healthcare workers is harder than building more beds, buying more kit, or conducting more research.

It is our number one priority. Let’s start by accepting that healthcare is a profession for humans, and also by humans.

Let’s also obliterate that common misconception—namely, that you can just pop in any nurse (or doctor) into the ICU workforce. It’s a highly specialised area and requires in-depth training, lengthy experience, and the right personality. It requires years to create teams, but only weeks of mistreatment to lose them. Just like a viral pandemic, this staffing crisis needs widespread cooperation and nuanced thought. We cannot just sub in a few temporary workers, or keep squeezing more from the remaining few. Without sounding ungrateful, we need the right kind of help. To quote an anonymous and exasperated colleague, “this boat needs more sails not more anchors.” To quote another, “you cannot simply have one body care for another.” This is not just the case in ICU. As healthcare becomes more compartmentalised, so too do the skills and training needed to meet that need.

Healthcare budgets are spent, and nerves are frayed. Therefore, let’s start by doing something inexpensive and overdue: let’s engage healthcare professionals. Next, let’s have nationwide dialogue rather than piecemeal efforts. So far the plan seems to centre on poaching healthcare workers from other hard-up areas. This doesn’t help resolve the overall problem. It could also build resentment in those places left even more understaffed—and local resentment if new staff are attracted with higher wages than those who stayed. It’s time for a deeper discussion about how healthcare staff are nurtured, created, maintained, scheduled, rested, and remunerated, and how they are valued. And healthcare workers are already leading this conversation, sometimes with their feet through industrial action. We all now need to listen.

There are some bright sparks illuminating the type of future that may help. The Intensive Care Society’s Peer Support and Thrive at Work Programmes are solid, helpful, practical toolkits written by people who really know and understand the issues. Let’s hope that the institutions that employ and recruit staff can match these proactive campaigns within what they can offer.

And there are some solid things that could be done. Nicki Credland, Chair of the British Association of Critical Care Nurses, has set out three requests—ensure pay is commensurate with knowledge and expertise, support career progression routes, and avoid relying on ICU nurses to be the default to cover hospital staff shortages.

Talking about dialogue, any ICU staff worth their saline knows that the first thing you do after a crisis is debrief. This gives everyone a chance to be heard, believe they matter, and feel things could get better. Instead, there has been no obvious covid-19 debrief, pause, or timeout. Governments are writing their...
reports, but healthcare staff too need this to regroup and recharge. Instead of learning from the hive mind, we have moved on to the backlog—albeit with fewer staff and seemingly no less red tape. For all these reasons we believe that our septuagenarian specialty is at a crossroads. Like a similarly aged patient, intensive care medicine should face a noble future but could experience a rapid decline. Intensive care medicine has always been about caring for people in crisis. Right now, that includes the staff.

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