Navigating the Future of Critical Care

By Kathleen Dracup, RN, DNSc, and Christopher W. Bryan-Brown, MD. From the School of Nursing, University of California, San Francisco, San Francisco, Calif (KD), and the Department of Anesthesiology, Albert Einstein College of Medicine, Bronx, NY (CWB-B).

If you don’t know where you are going, you will wind up somewhere else.

Yogi Berra

According to veteran airline pilots, plane crashes do not usually occur because of a single malfunction. Rather, a series of ominous events occur that lead to a “perfect storm” scenario with tragic consequences. For example, weather is marginal, visibility is poor, the flight crew is inexperienced or communicates poorly, and a piece of navigational equipment malfunctions. None of these factors in and of themselves lead to a plane crash, but in combination they can converge to create a disaster.

Many nurses and physicians working in critical care today are worried that a “perfect storm” is brewing on the horizon of our specialty. Although the forces pointing to a future system crash in critical care are many, we are going to focus on 3. These 3 forces have the potential to create a dramatic new demand for intensive care unit (ICU) services in the face of a decreasing ability to meet that demand.

First, an aging society with multiple comorbidities is poised to require intensive care when hospitalized. The oldest baby boomers are 58 years old, and they are quickly coming to an age when their need for critical care services markedly rises. As an increasing percentage of people in the United States qualify for senior discount rates and enter their eighth and ninth decades of life, we can anticipate an explosion of demand for healthcare services.

Second, we know from past research that between 13% and 35% of certain procedures are not indicated but are still performed. Some of these interventions are fueled by patients’ and families’ unrealistic expectations about what medical and nursing science can deliver. These unrealistic expectations can result in longer ICU stays or a reluctance on the part of physicians and nurses to transfer patients from the ICU to more appropriate settings (eg, hospice or skilled nurs-

Regionalizing Resources and Standardizing Care

When looking at the problem on a national level, the solutions appear straightforward. The most obvious solutions are discussed at length in the original FOCCUS document: regionalize services and standardize ICU care. But both recommendations have their costs as well as barriers to implementation. For example, although regionalizing neonatal and pedi-
Rethinking the Supply

We are in the midst of a national shortage of critical care nurses, intensivists, respiratory therapists, and pharmacists. The FOCCUS document has intriguing and dramatic recommendations. The panel reviewed the research to date on patient outcomes related to specialty care. It is clear that the outcomes for patients cared for by intensivists are better when compared with care delivered by generalists. These patients have less morbidity and mortality in the face of similar illness severity. Yet, only approximately one third of all patients transported to distant regional centers. (Raising teenagers has taught both of us that debates are most contentious in the absence of data.)

Perhaps more germane to the question of addressing future challenges is whether caregivers will implement the guidelines that do exist. Human barriers to changing behavior are vast. Much of the research to date suggests that it takes 5 to 10 years for evidence-based recommendations to move into common use; in critical care, that’s a lifetime.

For us, some of the most intriguing parts of the document had to do with restructuring the work environment of nurses and physicians. The FOCCUS authors recognized that the way to attract and retain talented individuals to the field, particularly nurses, is to provide them with autonomy in their practice (both in clinical and financial arenas), to have a zero tolerance policy for disruptive behavior in the workplace, to promote interprofessional collaboration and communication, to use technology to organize data and minimize medical errors, and to provide appropriate compensation and opportunities for career growth. Although more can always be said about how the future could be different for critical care teams, the document provides a wonderful blueprint for any administrator or educator thinking about the future of critical care.

Winding up Somewhere Else

Critical care has faced daunting challenges in the past. In the early days of the specialty, visionary and forceful leaders dared colleagues to create a new way to provide care to the acutely ill. Nurses and physicians taught each other, and ICUs were created from regular patient rooms and supply closets. It is time to rethink the way we are currently doing business in our specialty and bring that same sense of boldness to today’s challenges.

REFERENCES
