Review
Bench-to-bedside review: Ethical challenges for those in directing roles in critical care units

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Abstract

Though much attention in the medical literature has focused on the ethics of critical care, it seems to be disproportionately weighted toward clinical issues. On the presumption that the operational management of an intensive care unit (ICU) also requires ethical considerations, it would be useful to know what these are. This review undertook to identify what literature exists with regard to the non-clinical issues of ethical importance in the ICU as encountered by clinician–managers. We found that in addition to issues of resource allocation, there exist many areas of ethical importance to clinician–managers in the ICU that have been described only superficially. We argue that a renewed focus on ICU ethics is merited to shed light on these other, non-clinical, issues.

**Keywords** critical care, clinician–manager, ethics, management

Introduction

As a specialized field of philosophy, ethics has demanded that more institutions self-assess their actions so as to implement and maintain ethical practice (see the Additional file for definitions of 'ethical practice' and 'ethics'). In healthcare, technological and bureaucratic complexities have created dilemmas never before encountered, at least on the scale in which they now occur. Nowhere are these two issues, a push to self-analyze critically and an increase in novel dilemmas, more present than in the intensive care unit (ICU). The ICU is a place both where patients are exposed to modern advances in health technology and where some of the most challenging questions for bioethicists occur. Because of the pervasiveness of ethical considerations, it is logical to assume that the ethics knowledge base would be well documented in the ICU. In fact, a cursory search of the phrase 'critical care ethics' in PubMed between 1966 and 2004 cited an impressive 1090 articles. Because a more focused search on 'end of life ethics' returned 986 articles, it seems that much of the published literature has a particular focus.

The assumption that end-of-life issues represent the only ethical issue in the ICU was challenged by DeVita and colleagues' review [1] of all of the ethics manuscripts published in *Critical Care Medicine*. Although they identified a spectrum of ICU ethical issues in addition to end-of-life care such as futility, research, resource distribution, informed consent, and resuscitation, three issues are apparent to us. First, the number of manuscripts that they classified as 'end-of-life' far exceeded all other ethical topics (45 more than the second most common topic). Second, most of the additional ethical topics identified are issues that occur in the context of patient–physician or patient–nurse interactions. Third, on the presumption that the process of managing an ICU requires difficult moral decisions to be made, there seems to be a gap in the published literature with regard to the process of non-clinical decisions of ethical importance in the ICU.

ICU directors and nurse managers are required to make difficult decisions with respect to protocols, staffing, and administration of the ICU. Arguably, these have equal, maybe even greater, ethical importance than decisions made at the bedside, because management decisions can affect multiple patients, in a less direct, and transparent, manner. Perhaps the bedside can be described as a simpler ethical environment in that it involves fewer external factors and

ICU, intensive care unit.

Figure 1
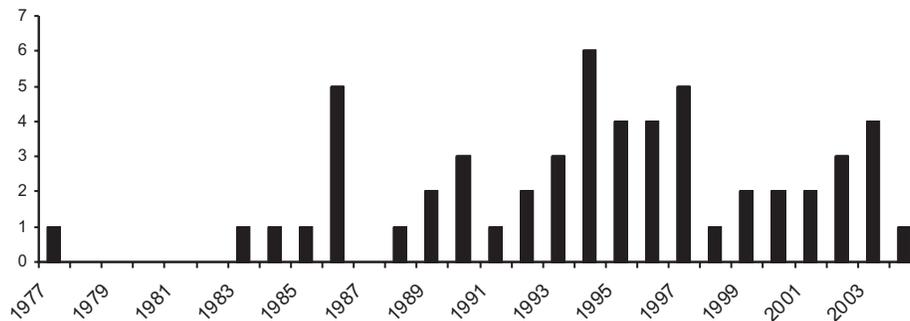
Distribution of articles that met screening criteria.

agents to consider, and the consequences of actions are immediately apparent to all.

If the dual roles that ICU physician directors and nurse managers occupy create unique ethical challenges that cannot be adequately captured by either the traditional principalism of medical bioethics because bioethics does not take into account the fundamentals of business, or the existing models of business ethics because these fail to account for the values of medicine, it is possible they should be addressed as a separate entity. The aim of this paper is to review briefly what ethical issues faced by ICU 'clinician–managers' have been described, and to understand the context in which they are addressed.

Method

To identify publications that focused on ethical issues faced by professionals who occupy both clinical and administrative roles in ICUs, abstract and title searches were performed in Medline/PubMed and CINAHL databases using combinations of the following keywords: Ethics, Clinician-Manager, Critical Care, Intensive Care Unit (ICU), Management, Leadership, Decision-making, Roles, Administration, Medical Directors, and Policy. Our search included primary literature, review, and opinion articles and the inclusion criteria were: 1966 to July 2004, English language, mention of critical or intensive care, direct mention of ethics OR discussed an ethical issue. An article was considered to have discussed an ethical issue if there was recognition of uncertainty about the correct choice of action in a given situation. Thus, any article that asserted one practice to be superior to another, whether anecdotally or as demonstrated by some research, was not considered to recognize an ethical concern. Articles were excluded if managed care was the source of the ethical dilemma and/or the ethical issue was strictly clinical in nature, not including the use of treatment policies because clinician–managers were considered to have a special interest in policy; that is, any ICU physician dealing with the issue was qualified to decide on the appropriate course of action.

In addition, references from captured articles were searched to identify additional literature that might not have been captured in the initial search. We also hand-searched the following journals: *Bioethics* (1997 to present), *Critical Care*, *Critical Care Clinics*, *Critical Care Medicine* (1985 to present), *American Journal of Respiratory and Critical Care Medicine* (1994 to present), and *Intensive Care Medicine* (1993 to present). Finally, the following key authors, identified by their previous ethics-related literature, were contacted to identify any articles that our search did not capture: Martin Strosberg, Kurt Darr, Dr G Rubenfeld, Dr C Sprung, and Dr J Luce.

Results

Of the roughly 1500 articles identified in our search, only 55 met the screening criteria that identified them as concerning an ethical challenge for clinician–managers in critical care. A distribution across time of these articles can be seen in Fig. 1. After an initial review of all the articles that met the screening criteria, broad categories were arbitrarily chosen to sort the results as follows: resource allocation; organizational ethics (namely, how intensive care ought to be organized); policies and protocols (formulation and implementation); professional roles (namely, what the role of 'directors' should be); ethics and law; general ICU ethics (ICU ethics in the broadest sense); and other (Table 1). PubMed categorized 23 (42%) of the 55 articles that met all screening criteria as either review articles or editorials; these review articles and editorials were evenly distributed between our categories.

Articles classified as 'resource allocation' papers mostly included discussions on which principles (such as justice, reasonableness as fairness) ought to apply when distributing scarce resources in the ICU. Some articles were more detailed, and described dilemmas such as age-based rationing [2] while still framing the question in terms of specific ethical principles and how they each affect the decision. One article sought to use cases to identify the ICU physicians' ethical role in distributing scarce resources [3].

Table 1

Distribution of articles that met screening criteria

	Source				
Type	Keyword search	References	Hand search	Key authors	Total
Resource allocation	19	2	1	0	22
Organizational ethics	6	3	1	0	10
Policies and protocols	3	1	0	0	4
Professional roles	2	0	0	0	2
Ethics and law	0	0	1	0	1
ICU ethics, general	10	0	3	0	13
Other	2	0	1	0	3
Total	43	6	7	0	55

By focusing attention on the physicians' role and not the ethical principles themselves, a whole new series of questions arose. It is noteworthy that the American Thoracic Society addresses the issue in a consensus statement outlining ethical guidelines for fair resource allocation [4], and the American College of Chest Physicians and the Society of Critical Care Medicine similarly discuss the ethics of resource allocation in their moral guidelines regarding the withdrawal of intensive care [5]. Articles classified as 'organizational' had a scope that ranged from what makes an ICU safe, to what should be taught to students in the ICU, to the ethical issues surrounding the use of restraints. Nelson describes an organization issue by illustrating how ethics is an everyday concern, with regard to issues like collaboration, staff conflict, and moral burnout [6]. This view is in contrast to the assumption that bioethics matters only when there is a specific dilemma. Additional articles on the use of restraints were classified as 'protocols and policies' because their focus was primarily on the policies themselves. Also in 'protocols and policies' was a discussion on the value of having a family presence protocol for life-saving procedures [7]; that is, is allowing families to witness resuscitation the right thing to do? The two articles under the heading 'professional roles' discussed the changing roles of ICU physicians, especially with regard to a transition to managerial duties; this issue is discussed below. 'General ethics' articles included all papers that discussed ICU ethics in the broadest sense with less attention to the details; many of these articles were brief reviews of the numerous ethical considerations in an ICU.

Discussion

Ethical issues are usually expressed as a conflict of ideas, values, and/or norms that are often role dependent. It should therefore be expected that ICU physician directors and nurse managers, who have both clinical and non-clinical duties, should face some of the more difficult moral conflicts in the ICU. In one respect, these professionals follow a patient-centered code of conduct, either the Hippocratic oath or the Nursing Professional Code, which in part defines them. At the same time, they are also agents of the hospital as 'a business', and implicitly society as a whole. Although some clinicians completely relinquish their clinical duties on transition to management, most do not; the professional nature of medicine therefore gives the clinician a patient-centered outlook that is not as easily set aside: once a doctor or nurse, always a doctor or nurse. In summary, the physician director and nurse manager will always be in the unique position of having two separate professional standpoints from which to assess situations, which can therefore lead to unique ethical challenges.

We have begun to characterize the scope and uniqueness of ethical issues that are raised by the dual roles of clinician–managers in the ICU. In reviewing the health literature, we found that almost half of the articles identified that discussed ethical concerns for ICU clinician–managers were concerned with resource allocation. This is probably not surprising given that ICU clinicians are increasingly adopting the role of economic rationalist [8]. Perhaps the real surprise of these results is how many articles concerned issues other than resource allocation. Although DeVita and colleagues pointed out that 'end-of-life' was not the only ethical concern in the ICU [1], which they took to be a common assumption, we argue that there is more to the ethics of directing roles in the ICU than issues of resource allocation.

In this initial survey of the ethical issues experienced by those in dual management–clinician roles in the ICU, important to our conclusion was the development of a categorization scheme. In the absence of any unique approach, we were arbitrary in our definition of categories. Although some of the articles we identified could have been placed in more than one category, or in categories not used, we believe our

approach to be valid for the modest purposes of this survey. Additionally, some articles that discussed issues of clinical ethics in the ICU might have contained less prominent opinions or notes relevant to clinician–managers and therefore might have been missed by our search. In spite of these potential issues, the articles selected were distributed to give both a clear and defined picture of what currently exists with regard to ICU ethics for those in both clinical and directing roles at the same time. We also believe it is likely that there were many articles that discussed ethical issues relevant to our review, yet failed to recognize the issues as being 'ethical' in nature. For example, many articles described the nuances of resource allocation in the ICU (see the Introduction), yet neither mentioned ethics or recognized any uncertainty with regard to the 'right' thing to do. The fact that many articles fail to address their ethical components might indicate a lack of awareness of what constitutes an ethical dilemma, but even if this is not so, the goal of better recognition and acknowledgement of the ethical issues that suffuse the operational management of the ICU is desirable.

Resource allocation is a well-defined topic of ethical interest that has stimulated much discussion. However, it is important not to perceive resource allocation as the beginning and end of the ethics discussion for clinician–managers in critical care. Perhaps it is also time to move beyond the commentary on resource allocation and devote more research initiatives toward this topic (for example by studying the different approaches to resource allocation).

The term 'organizational ethics' is used to denote how a business or institution ought to be organized in any number of ways, including management functions, working environments, and its infrastructure. It should not come as a surprise that organizational ethics should constitute a concern for either an ICU director or a nurse manager, yet over the past 20 years only a handful of articles have been written about the organizational ethics of intensive care and have recognized them as such. Although policies and protocols for an ICU could also fall under the heading of 'organizational ethics', we believe that determining and implementing policies might require ethical concerns that merit special attention. The use of any policy that deals with either patients or staff is to apply one rule to many different people, and necessarily ignores factors that make individual cases unique. Because policies tend to generalize in this way, they create unique ethical challenges. Little reflection is required to determine that both of these issues, organizational ethics and the ethics of policy, constitute ethical concerns for directors in the ICU in which further study is merited.

The role of the ICU physician director, or nurse director/ manager, is an ethical issue itself. Although two articles were identified that addressed this issue, we believe that the paucity of articles found indicate a need for greater consciousness of the ethical factors that influence and are influenced by clinical leaders in the dual roles of 'clinician' and 'manager'. Although healthcare leaders are familiar with the importance of ethics, they may be unaccustomed to thinking of their own role in terms of ethics [9]. Because the ICU director, or nurse manager, may engage in the decision making process from multiple professional standpoints (as both clinician and manager), the likelihood of conflicting rational and justifiable solutions, leading to ethical dilemmas, increases. The clinician–manager role, then, may require a higher level of ethical proficiency, or perhaps expertise.

Conclusion

In summary, we believe it is important that future study be directed toward understanding ethical issues surrounding the dual roles of clinician–managers in the ICU. Although it has been acknowledged that hospitals should pay as much attention to managerial ethics as to clinical ethics [10], it is not yet clear that this in fact occurs. One step in a research agenda would be to undertake a survey to determine if the published literature, identified by this review, is in fact an accurate representation of what is experienced. Understanding the scope of ethical issues experienced by clinician–managers in the ICU will foster a more complete dialogue. Further, although there are studies that describe the process of ethical reasoning in nurses and other clinicians [11–13], similar studies have not been performed with clinician–directors, be they nurses or physicians. These investigative steps toward a better understanding of the issues, and how they are understood and dealt with, ought to include direct input from ICU clinician–managers. Input from ICU clinician–managers with a background in, or special knowledge of, ethics would be particularly beneficial, because they would possess the language to describe what most feel by intuition. This experiential knowledge would best be conveyed in an open-interview or narrative format in which actual dilemmas can be discussed. Finally, the resulting data will require detailed qualitative analysis and might benefit from the support of a medical sociologist.

For all critical care leaders, there is now an opportunity to promote a better understanding of the complexity of the ICU environment and to prompt further learning.

Additional file

The following Additional file is available online:

Additional file 1

A complete list of categorized references for all articles captured in this review can be found here.
See http://ccforum.com/content/ supplementary/cc2979-S1.pdf

Competing interests

The author(s) declare that they have no competing interests.

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