MOVING BEYOND “ON THE JOB TRAINING”:
PREPARING HOSPITAL ETHICS CONSULTANTS FOR
INTENSIVE CARE UNIT (ICU) ROUNDS

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Overview

Hospital ethics consultants are rarely trained for their participation in the intensive care unit (ICU). In what follows I address the need for improving the preparation of clinical ethics consultants (including healthcare ethics committee (HEC) members) for participation in critical care medicine. I outline several strategies to orient ethics consultants to the ICU and ICU rounds. Section 1 includes a brief historical overview of critical care medicine and the modern ICU. Section 2 discusses the general organization/structure of the ICU and the key role of “ICU rounds” in the ICU. Section 3 examines both the ethics consultants’ and ICU staff members’ motivations and expectations regarding ethicists’ ICU participation in rounds. Section 4 offers concrete strategies for ethics consultants participating in the ICU regarding: [1] understanding medical vocabulary, [2] identifying “ethically teachable moments,” and [3] general guidelines for participation the ICU. The conclusion seeks to encourage more effective preparation of ethics consultants for participation during ICU rounds and to stimulate further discussion of these training issues within the field of biomedical ethics.

Introduction

For most of us, an intensive care unit is a foreign and frightening land…. The patients are pale, possibly unresponsive, and naked, save for the scant covering of a hospital smock and a welter of tape, tubing, and monitoring equipment. Intravenous bottles with tubes dangle from the ceiling like surreal clusters of lamps and cords. We feel that we should be quiet, as though we were in church. We must not disturb the patients or keep busy staff from their appointed chores. Many of us feel as though we were children again (1).

Raffin poignantly describes the experience of entering an intensive care unit (ICU). With the rapid growth of both clinical ethics and critical care
medicine\textsuperscript{1}, more clinical ethics consultants or bioethicists (including HEC members) find themselves routinely involved with cases in the ICU. Also, it is becoming common for clinical ethics consultants to routinely participate in ICU “rounds” for purposes of teaching, education, and/or consultation (2). However, since the majority of ethics consultants have not been trained in critical care medicine, it is unlikely they have been oriented or prepared for the intense and unfamiliar ICU environment (3). As a result, most ethics consultants have an immersion experience of “on the job training” to prepare them for their involvement in the highly charged, clinically complex, action oriented environment of the modern ICU.

1. **History and definition of critical care medicine**

Modern emergency cardiac resuscitation, respiratory resuscitation, and cardiac intensive care monitoring were initiated in the late 1950s and early 1960s with the advent of technical advances like mechanical ventilation, cardiac monitoring, and the philosophy that patients with similar problems can be treated more efficiently in a single location. During this period, intensive care techniques were used extensively by the military in their field operations resulting in significant reductions in avoidable morbidity and mortality (4). Basically, intensive care medicine developed by concentrating three critical components: the sickest patients, the technical equipment, and the knowledgeable staff who could treat the patients using the equipment (5).

The founding of the Society for Critical Care Medicine (SCCM), in 1970, marked a coalescing of a number of different efforts directed toward developing the subspecialty of critical care medicine (6). Today, the ICU has developed into a major component of the U.S. healthcare system (4). As of 1989, more than 6,000 ICU beds existed in the U.S. In economic terms, over $50 billion dollars or approximately one percent of the U.S. gross national product was devoted to intensive care medicine (1).

In order to define the rapidly developing field of critical care medicine, the National Institutes of Health sponsored a consensus development conference in March, 1983. The conference attracted a multi-disciplinary group of professionals committed to developing and defining the field. The conference proceedings defined critical care medicine as: a multi-disciplinary and multi-professional medical/nursing field concerned with patients who have sustained or are at risk of sustaining, acute life threatening single or multiple system organ failure due to disease or injury. These conditions necessitate prolonged minute-to-minute therapy or observation in an ICU which is capable of providing a