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How an Anesthesiologist Can Use the Ethics Consultation Service

David B. Waisel, M.D.,* Robert D. Truog, M.D.†

ANESTHESIOLOGISTS have a tendency to frame conflicts in terms of either medical or legal judgments, without fully appreciating the ethical dimensions of the issues. The goal of the previous papers in this series was to heighten the sensitivity of anesthesiologists to these ethical dimensions and to discuss potential avenues for resolving these conflicts. Many of the ideas presented can be difficult to implement in practice, however, particularly if an anesthesiologist is not experienced in these matters. For example, determining if a patient retains sufficient decision-making capacity after receiving midazolam is not easy. Nor is it always clear how to delineate the obligations owed to the patient who wishes to retain do-not-resuscitate (DNR) status during surgery. Matters that involve other professionals may be more complex. How does one resolve an operating room disagreement about when to transfuse blood?

Although education in ethics may help anesthesiologists recognize ethical dilemmas, they may still be unable to define and articulate the issues authoritatively. Ethics consultants help resolve dilemmas by providing a structured way of thinking about problems, clarifying

the positions of individuals with a moral interest in the decision, and simplifying communication. After consultations, clinicians feel greater satisfaction in managing cases with ethical conflicts, not only because of their awareness of the expert consulting services available but also because of their increased knowledge and comfort in dealing with these issues.¹⁻³ One study found that after the conclusion of an ethics consultation, more than 95% of physicians would request another.⁴

There are at least two levels of ethics consultations available for anesthesiologists: institutional ethics committees and national professional ethics committees, such as the American Society of Anesthesiologists Committee on Ethics.

Institutional Ethics Committees

During the earliest years after the introduction of ethics committees into hospital practice, they were sometimes considered the vehicle for ensuring that the physician's choice of clinical options was the one offering the least legal risk. These ethics committees tended to be bureaucratic organizations with "all the right answers." In recent years, however, ethics committees and the process of ethical consultations have evolved into a constructive service that benefits the clinician and patient. An ethics service should not view itself as the sole arbiter of right and wrong. Rather, the goals of the ethics consultation should be, simply, to "assist the primary physician, the patient and the family to reach a right and good clinical decision."⁵ The usefulness of such a process has been recognized by The Joint Commission on Accreditation for Healthcare Organization, whose guidelines require hospitals to have "a functioning process to address ethical issues."[‡] Ethics committees and their consultation services fulfill this requirement.

Institutional ethics committees are usually hospital-based and can help with ethical dilemmas involving individuals, departments, and third-parties such as managed care organizations. Traditionally, cases presented

* Attending Anesthesiologist, Wilford Hall Medical Center.

† Director, Multidisciplinary Intensive Care Unit, Children's Hospital, Boston, Associate Professor of Anaesthesiology & Pediatrics, Harvard Medical School.

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Address reprint requests to Dr. Waisel: 59th MDW/MKAA, 2200 Bergquist Drive, Suite 1, Lackland Air Force Base, Texas. Address electronic mail: waisel@texas.net

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‡ Joint Commission on Accreditation of Healthcare Organizations: 1995 Comprehensive Accreditation Manual for Hospitals. Oakbrook Terrace, IL, 1994.

for consultation centered on individual patients and physicians and involved questions about resuscitation status, informed consent, decision-making capacity, confidentiality, and withdrawing and withholding care.^{4,6,7} Given the dramatic way health care and reimbursement changes have intruded on the patient-physician relationship, ethics committees have started to take a broader role in participating in difficulties involving institutions. Anesthesiologists may find ethics consultation useful in any of these situations.

Take, for example, the patient with early Alzheimer's disease who arrives in the preoperative holding area and needs to give informed consent. The anesthesiologist recognizes that the patient's decision-making capacity is not at a usual level, but may not feel adept in determining if it is adequate. The ethics consultant establishes the necessary framework for resolving this problem, beginning, perhaps, by establishing the needed extent of the patient's decision-making capacity. For example, a patient may need more capacity when making one decision (thoracic epidural) compared with another decision (arterial pressure monitoring). The consultant then helps ascertain the patient's decision-making capacity, in part by looking for articulation of a cohesive expression of preferences using consistent and rational logic. After a decision about the patient's capacity is made, it is natural for the anesthesiologist to feel some discomfort. This may be a result of limited experience with ethical dilemmas, the lack of absolute certainty in making these determinations, or the recognition that he or she may be intentionally or unintentionally influenced by production pressures. The consultant's support allows the anesthesiologist to feel more confident in his or her decision to proceed or, alternately, to provide an anchor for the anesthesiologist battling internal or external production pressures.⁸

This consultant is acting mostly in the role of an expert, similar to the manner of a traditional medical consultant who interviews and examines the patient, researches the situation and options, and supplies a specific recommendation supported by ethical and legal opinions.^{9,10} This role presumes the ethics consultant has extensive knowledge in bioethics, institutional requirements, and proper documentation. This role also appreciates the consultant's greater experience in resolving ethical dilemmas. For example, a consultant who frequently helps patients reevaluate their desires for resuscitation in the operating room is more likely to be aware of potential pitfalls and to navigate a more successful course. Ethics consultants also act as facilita-

tors. The use of facilitation presupposes that if the participants in the case can communicate, most issues can be resolved. Conventional wisdom suggests that the majority of ethics consultations are more about improving communications than about abstract theoretical concepts. Most of the work of those who do clinical ethics "turns on trying to get the facts straight, clearing up misconceptions and misunderstandings, [and] trying to overcome emotional confusion . . ."¹¹ The consultant clarifies considerations and therapeutic goals and brings together those who have a moral interest in the case. Successful facilitations seek to attain an ethically acceptable resolution consistent with the patient's well-considered goals rather than a specific solution. The consultant can usually achieve such because he or she is usually perceived as an unbiased newcomer to the disagreement who is unaffected by rancor or prejudice.

For the most part, ethics consultants function as an expert and as a facilitator. Consider a surrogate who insists on general anesthesia for the débridement of leg ulcers for her father who has severe chronic obstructive pulmonary disease. The anesthesiologist believes the patient would be better served with a spinal anesthetic. The ethics consultant can assist in resolving this dilemma by helping the anesthesiologist clarify his or her concerns about general anesthesia for this patient. For example, is the harm to the patient substantial, minor, or unclear?¹² On what kind of information is this opinion based?¹³⁻¹⁵ The consultant then facilitates discussion between the surrogate and the anesthesiologist. For example, the consultant may find that the patient had always expressed disdain for spinal anesthetics after his brother received one during World War II and returned home paraplegic. The consultant and anesthesiologist can then address the differences between spinal anesthesia then and now and elucidate for the surrogate the true risks and benefits of each procedure. This explanation gives the surrogate psychological permission to go against her father's previous statements by understanding that her father was rejecting an uninformed view of spinal anesthesia. The consultant may ask the surrogate to imagine what her father would do with the new information. If the surrogate chooses in the end to act contrary to the anesthesiologist's advice, the consultant can help the anesthesiologist clarify where the choice lies on the continuum from choices that are acceptable but undesirable to those that constitute abuse. If there is a need to pursue other channels, the consultant can provide direction.

Ethics consultants can help facilitate disagreements

within professional relationships, too. Consider the problem of a surgeon who demands the administration of a blood transfusion when the anesthesiologist does not believe one is indicated. It is difficult to fruitfully address this disagreement in the middle of an operation if a working relationship is not already established. As such, the ethics consultant may use preventative ethics, which centers on resolving conflicts before they happen, particularly if they can be identified as being repetitive.^{16,17} In this case, the ethics consultant's goals are to clarify and evaluate blood transfusion practices and to maintain professional relationships.

To accomplish the first goal, the consultant would encourage the participants to discuss each physician's transfusion practices in light of published recommendations and the practices of trusted colleagues. Equally important is the second goal, which is for the anesthesiologist and surgeon to develop a working relationship capable of successfully addressing differences of opinion. Preserving or developing this kind of relationship benefits patients who deserve to receive the expertise of both physicians. The consultant may also be able to recognize that common ground cannot be reached and that the participants should seek to work with colleagues who have more similar transfusion practices.

Similarly, "turf battles" between departments can be addressed. For instance, the departments of anesthesiology and emergency medicine may bicker about who manages the trauma patient's airway. Several advantages may allow the ethics consultant to broker a successful compromise. The consultant is presumably free from financial considerations, peer pressures, and the antagonism that has developed between the physicians in the two departments. This fresh view allows the ethics consultant to separate and define the individual issues, often a first and necessary step toward resolution. In this case, issues may include residency training needs, financial considerations, and hubris, all of which may have resulted in a failure to communicate. The consultant can refocus the discussion toward the priority of patient care, while acknowledging substantial ancillary issues of finances and resident training. He or she may also be able to temper the discussion. This alone may allow the principals to communicate with each other to the point of amicably devising an agreement that satisfies both departments.

Ethics consultation and hospital ethics committees can also assist departments and hospitals in establishing workable policies for complex issues.¹⁸ Consider an obstetric department that wants to provide increased ser-

vices to Jehovah's Witnesses. Part of their preparation would include gaining support with the department of anesthesiology. Up to this point, only a few of the 20 anesthesiologists have been providing anesthesia for Jehovah's Witnesses, and this care has been primarily for elective procedures. The ethics consultant can educate the caregivers about the pertinent issues, and in doing so can help them clarify their beliefs and their ability to deliver agreed-on care. The ethics consultant may identify two mechanisms that are necessary to honor the patients' treatment preferences while also protecting the integrity of the caregivers. The first is to design a preoperative consultation that sufficiently discusses and clearly documents the desires of patients to the satisfaction of the caregivers. The second is to develop a system to allow certain anesthesiologists not to provide care. This may be a difficult task for the mostly unscheduled and occasionally emergent needs of an obstetric service, particularly in a department in which all the anesthesiologists usually provide obstetric anesthesia at night and on weekends. The ethics consultant would, like other consultants, follow the implementation of the proposals and suggest adjustments and help resolve differences as needed.

This is just one example of how ethics committees fulfill an obligation to coordinate continuing education in ethics. Many ethics committees invite speakers, hold conferences, and even present didactic sessions to acquaint colleagues with significant issues. Some ethics committees organize educational programs to inform the community about relevant ethical issues such as completing advance directives. Anesthesiologists should be aware that most ethics committees are pleased to provide focused education to any group, such as a department, that requests it.

Ethics consultations involving difficulties with administrators and third-party payers are likely to become more prominent given that 90% of privately insured Americans undergo some sort of utilization review for their medical care.¹⁹ "Significant anecdotal evidence suggests that doctors perceive managed care regulations as preventing them from behaving in an ethical manner."²⁰ Concerns about third-party payers may center on policies for patients and policies pitting patient care against physician finances.²¹⁻²³ Caregivers are often frustrated by health care plans that appear to be penny wise and pound foolish.^{20,24}

Prominent disputes between physicians and third-party payers have included pressure on physicians to discharge patients from the hospital quickly and to limit

consultations.²⁰ Anesthesiologists are not unaffected by these disagreements. For example, anesthesiologists may be faced with pressure to perform anesthesia for a postpartum tubal ligation several hours after delivery instead of the next day. If an anesthesiologist's normal practice is to wait until the next day, should he or she provide care earlier? Such a delay may cause the patient to stay in the hospital an additional day. This is particularly difficult because there is no clear consensus in the literature on this situation, and the anesthesiologist may have difficulty responding to an administrator's request to show that this practice is unsafe.²⁵⁻²⁷ Or, consider a child with multiple congenital anomalies who needs bilateral myringotomy and tubes and tonsillectomy. Because it is only "tubes and tonsils," the managed care organization refuses to authorize the otolaryngologist to do the procedure at the more expensive children's hospital and requires the procedure to be done at the local community hospital. The anesthesiologist may believe such a case is "slightly" out of his or her reach. How does an anesthesiologist determine if a case is too difficult? And how should an anesthesiologist approach such an issue, particularly if the hospital administration is not sympathetic?

Other questions may arise as anesthesiologists are held more accountable for costs.^{19,23,28} How should an anesthesia group respond to a health plan that refuses to authorize postoperative epidural analgesia? Should an anesthesiology group not use more expensive and possibly more effective drugs in the patient with capitated reimbursement?²⁶ Such policies may be dangerous. Consider a third-party payer that will not authorize anesthesia for gastrointestinal endoscopies. Anesthesiologists may then be placed in the undesirable position of having to provide otherwise avoidable emergent airway management for oversedation, for example, and such emergencies may cause patients harm.

An ethics consultation can provide a sounding board for the appropriateness of the anesthesiologist's discomfort with the system and can help determine whether to appeal the third-party's position.¹² The same experience that benefits the ethics consultant when dealing with difficult situations involving patients and physicians can help in dealing with third parties. Ethics committees may be able to give a voice to the anesthesiologists so that they can "participate in political give-and-take with nonphysicians."²⁹ This may allow anesthesiologists to put research in the proper light and not let it be used in an inappropriate way to limit the therapeutic options of anesthesiologists.²⁹ Because chairs of ethics commit-

tees often command respect, they tend to have significant unofficial authority with hospital administrations and other third parties and thus may be more successful in addressing certain policy issues. Third-party payers may also have their own ethics committees that may provide another avenue toward affecting policy.

Practicalities of Ethics Consultation

A colleague is easier to call for a consultation than a stranger. As such, we suggest anesthesiologists become familiar with their institutional ethics committee before needing help in a crisis. Requesting an ethics consultation is somewhat different than requesting a medical one. Anesthesiologists are taught to ask a specific question when requesting a clinical consultation, such as "Can this patient's pulmonary status be better optimized before this 8-h general anesthetic and upper abdominal surgery?" rather than "Please clear this patient for surgery." Anesthesiologists may not have the background necessary to ask for a specific recommendation from an ethics consultation. Fortunately, ethics consultants are comfortable with vague requests. Part of their job is to help define the question.

Origination of ethics consultations can vary. Some hospitals allow any person involved with the patient, including physicians, nurses, dietitians, physical therapists, technicians, family members, and loved ones to initiate an ethics consultation. Others require the attending physician to initiate the consultation, and most require the attending physician to at least agree to the consultation. Assent of the attending physician is pragmatic. The physician-patient relationship is the hallmark of medical care, and this relationship should not be intruded without the attending physician's concurrence. Further, ethics committees are for the most part advisory, and beginning the consultation with an adversarial relationship with the attending physician is counterproductive. It is important for the anesthesiologist to remember that by virtue of caring for a patient perioperatively, he or she is one of the patient's attending physicians and has the right and responsibility to obtain ethics consultations when appropriate.

In many cases the consultant will be a physician who is familiar with medical problems and the hospital milieu. A physician also has a greater likelihood of being acknowledged as an authority by other physicians. For these reasons, some argue all consultants should be physicians. Because the skills of recognizing dilemmas

and helping patients and clinicians think through these concerns are not limited to physicians, others hold that clinical consultation should be open to other professionals such as nurses, clergy, and philosophers.³⁰ For example, nurses may have closer relationships with their patients than do physicians. Moreover, not all ethics consultations originate at the physician level, and some ethical dilemmas center primarily on nursing concerns. Philosophers and clergy also have become effective ethics consultants, perhaps because of their ability to critically analyze issues from a perspective outside of the medical profession. A number of different models exist for ethics consultation.³⁰ Ethics consultation may be performed by an individual or by small groups who may interact with a larger group providing some oversight.³¹ Some institutions have formalized these differences by having an overall more inclusive ethics committee and a smaller, more specialized, ethics consultation service to provide clinical consultations.

Ethics consultation has developed in a manner similar to new clinical specialties as consultants interested in medical ethics take courses and self-educate themselves in bioethics. As a result, no formal credentialing process for ethics consultants exists, and patients are not protected from "practitioners who lack expertise in clinical ethics but who may promote themselves as qualified."³² However, leading individual consultation services have their own certification processes, and mechanisms to define certification are actively discussed in the literature.^{32,33} It is reasonable to expect a more uniform certification process in the near future.

Ethics committees and ethics consultation services should include a cross-section of hospital personnel such as physicians, nurses, social workers, clergy, and nonhospital personnel with either an interest or some expertise in bioethics. Former patients often bring a useful and interesting perspective to the committee. Lawyers with a special interest in bioethics may be more helpful to the committee than perhaps an institutional lawyer whose responsibility is to the institution. This paradigm presumes that ethical views are heavily influenced by societal constructs, and thus committees should include individuals from a broad cross-section of society. It is unusual for this pluralism to be fully achieved, even with attempts to include lay people in the group.

Committees may be subject to standard committee problems: the dogma of one forceful member, the desire to cooperate and avoid controversy, the inability to pursue different perspectives, or tendencies leading

to premature agreement.³⁴ Studies have shown, for example, that sometimes groups will arrive at a consensus decision that no individual in a group would support, such as when subgroups who advocate extreme positions agree to a middle-ground compromise.³⁵ Because committees work closely together, long-time members may easily and uncritically accept the views of their colleagues. Sometimes committees strive for "the brass ring of consensus," believing that consensus itself is proof that the decision is morally good.³⁶ This consensus may be unintentionally contrived. Recognition of these issues may help committees avoid such pitfalls. Other ways of preventing these oversights are to publish the results so others can examine them, to have the full ethics committee evaluate pertinent issues, or to have an outside ethicist evaluate the proceedings and provide critical review. One problem with having the ethics committee review the consultant's work is that as one of the more senior members of the committee, the consultant usually has a great deal of unofficial authority that may render the review impotent. Outsiders reviewing ethics consultants and committees may provide less biased feedback. One major risk is the acquiescence to authoritative power, frequently as a result of seniority or profession.³⁷

Ethics committees are nearly always advisory bodies with no formal authority beyond the ability to make recommendations. This respects the primacy of the relationship between the attending physician and the patient and is analogous to the recommendations made by other consultants. This, however, does not mean the suggestions are without weight. An opinion from an effective ethics committee with respected leadership carries a fair amount of moral authority that is difficult to ignore. If members of the ethics committee believe something so egregious is happening that they are compelled to intervene, then the committee notifies the proper administrative body. Although ethics committees can provide an alternative to the judicial system, they do not replace the courts. The courts have ignored, considered, or embraced various ethics committee recommendations, and the use of an ethics committee does not preclude further legal appeal.³¹ The lack of a uniform due process in the ability of committees to notify and subpoena witnesses or in the mechanism of appealing decisions does not permit ethics committees to function on the level of the courts.³¹ Some have argued that ethics committees need to pay greater attention to the requirements of due process.³⁸ For example, not all ethics committees require that the patient or family be

notified of the consult and not all ensure that the patient or surrogate has the opportunity to speak with the committee. Consultations that involve only the opinions and perspectives of the caregivers run the risk of being prejudiced and biased. Therefore, even though ethics committees should not be perceived as "minicourts," attention to certain features of "due process" is necessary for them to perform fair and impartial consultations.

Documentation for an ethics consultation varies. Ethics committees should record their efforts in the chart for several reasons: to communicate, to educate, to facilitate public review, and, perhaps most importantly, to force the consultant to be precise in his or her thoughts. Public documentation enhances the reception of the consultation and may increase the confidence of clinicians in the validity of the recommendations. The inclusiveness of the consultation may vary. An ethics consultation may either mimic a standard clinical consultation, including physical examination findings and laboratory values, or provide a brief introduction to the clinical situation followed by a more thorough discussion of the ethical issues.³⁹ This discussion should include questions asked by the originator of the consultation, pertinent issues, ethical analysis of the issues, recommendations, and references to the literature, if appropriate. Because ethical dilemmas are typically complex, it may be difficult to always apply the same components and reasoning to every case. In any given case, "intuition, metaphor, common sense, religious tradition, hospital policy or state law could be the crucial factor."³⁹ Outcome studies documenting the benefits of ethics consultation are lacking, in part because of the ill-defined goals of ethics consultations.^{30,40,41} Although this paper defined the goals of ethics consultation as to "assist the primary physician, the patient and the family to reach a right and good clinical decision,"⁵ this definition is not as easy to quantify as many clinical endpoints. One problem may be that the definition of a "successful consult" varies by participant, situation, and institution. How is the

determination of "assistance" or of a "right and good clinical decision" made?⁴² Most studies focus on clinician satisfaction and knowledge that are, at best, a mediocre indication of quality and indicate little about outcome. Further, rightness is difficult to define.⁴¹ Is rightness the happiness of the patient, family, or clinician? An equitable distribution of resources? The avoidance of litigation? Or based on a more ethereal concept such as ethical correctness? Assuredly, it is hoped that these definitions will tend to merge into a single process and solution, but that is not always so. Befitting a specialty in its infancy, a great deal of attention has been devoted recently to promoting and designing outcome studies to begin to remedy this undesirable situation.^{43,44}

The American Society of Anesthesiologists Committee on the Ethics

An often overlooked resource for the anesthesiologist is the American Society of Anesthesiologists Committee on Ethics. The committee on ethics performs three primary functions. The first is policy and statement development, which most prominently has included a forward-looking policy on DNR orders in the operating room and an update of the Guidelines for the Ethical Practice of Anesthesiology. These policies provide a substantial touchstone for anesthesiologists to refer to when faced with ethical dilemmas.

The Ethical Guidelines for the Anesthesia Care of Patients with Do-Not-Resuscitate Orders or Other Directives that Limit Treatment was approved by the American Society of Anesthesiologists House of Delegates in October of 1993.[§] This was the first statement of a professional body to embrace the now well-accepted practice of having patients reevaluate instead of withdraw their desire to limit resuscitation when receiving anesthesia and surgery. After Society approval, the Committee on Ethics coordinated with the American College of Surgeons to have them endorse a similar statement.|| This unified effort advanced patient care by providing a common basis of practice for anesthesiologists, surgeons, and other caregivers.

The most recent update of the Guidelines for the Ethical Practice of Anesthesiology was approved by the House of Delegates in October of 1995. It reflected modern principles of bioethics, especially in its formal recognition that "There may be specific circumstances in which the following guidelines may not apply and wherein individualized decisions may be appropriate."[#]

§ American Society of Anesthesiologists: Ethical Guidelines for the Anesthesia Care of Patients with Do-Not-Resuscitate Orders or Other Directives that Limit care, American Society of Anesthesiologists 1997 Directory of Members. Park Ridge, IL, American Society of Anesthesiologists, 1997, pp 400-1.

|| Fine PG: DNR in the O.R. — Anesthesiologists, medical ethics and guidelines. American Society of Anesthesiologists Newsletter 1994; 58(8):10-4.

American Society of Anesthesiologists: Guidelines for the Ethical Practice of Anesthesiology, American Society of Anesthesiologists 1997 Directory of Members. Park Ridge, IL, American Society of Anesthesiologists, 1997, pp 401-3.

Whole sections were added addressing the ethical responsibilities of anesthesiologists to themselves and to society. Other additions urged anesthesiologists to participate in the management of their health care facility and to be honorable in financial dealings.

The second function of the Committee on Ethics is education. The committee sponsors yearly educational events at the annual meeting discussing such issues as the ethics of geriatric care, pediatric care, physician-assisted death, pharmaceutical company-sponsored research, and what to do with the HIV-positive anesthesiologist. The members of the committee participate in other educational efforts such as problem-based learning discussions and regional refresher courses.

The third, and perhaps most important, function for the clinician is to respond to questions and problems posed by anesthesiologists or other professionals involved in the delivery of health care. The Chair of the committee receives one or two calls each week. Questions have included the appropriateness of a married surgeon and anesthesiologist working together, of anesthesiologists leaving the operating room under certain circumstances, and, more frequently, of certain billing practices. The Committee on Ethics may choose to investigate more thoroughly concerns brought to their attention. For example, the committee is currently examining the intersection of business practices, business ethics, and medical ethics, particularly as it pertains to hiring practices. For example, at what point is a partner in an anesthesiology group taking advantage of a prospective employee because of an overabundance of anesthesiologists? Or, is the market by definition fair as long as participants are forthright with terms? Anesthesiologists should view the committee as an appropriate forum to bring forth any concerns relating to the practice of anesthesiology.

Conclusion

With our heterogeneous society,⁴⁵ increased health care costs, and massive growth in technology, "physicians find it more difficult than ever to make clinical ethical decisions."⁴⁶ Identifying patients' preferences is even more difficult when choices seem contrary to those of providers. Patients may communicate in a manner different from their care providers, resulting in misunderstandings. Caregivers who are required to consider societal uses of resources when determining patient treatment may have difficulty balancing various

obligations.⁴⁶ With more economic upheaval and technologic advances in health care anticipated for the near future, and especially in the milieu of a steadily increasing population of critically ill patients occupying hospital beds, ethics committees assuredly will continue to have an important role in the daily life of the hospital. In these confusing and stressful times, anesthesiologists would be well advised to master the use of ethics consultation to provide the care they want to give and their patients want to receive.

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