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# *Nonpatient Care Obligations of Anesthesiologists*

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MODERN ethical discourse tends to focus on the concept of rights, which are entitlements that an individual can legitimately claim. Indeed, the concept of rights has been the presumptive ethical touchstone of contemporary medical decision-making. For instance, it is common to center discussions on the right of the patient to refuse life-sustaining treatment or the right of the physician to refuse to do certain procedures. Less emphasis has been placed on what may be considered the obverse of rights: obligations. Obligations describe the duties and responsibilities of the individual.

Recognizing and balancing obligations is essential for ethical decision-making, particularly about the use of limited resources such as time and money. For example, most agree that physicians working in a hospital have some obligations to that hospital, however minimal.[1–4] But to what extent are these obligations? Should a practice accommodate a colleague who wants to participate on the medical staff, and if so, how? Such activities take time, often time that could be used to fulfill other obligations such as generating revenue for the department, decreasing the workload for colleagues, or providing charity care. In the same vein, resident training brings forth dilemmas. Anesthesia residency programs and its attending physicians have an obligation to teach residents to insert central venous catheters. But to what extent should a resident be allowed to attempt the procedure? The requirement to teach the resident needs to be thoughtfully balanced with the obligation to the patient to provide high-quality care and service with an eye toward cost and efficiency. An understanding of the concept of obligations helps anesthesiologists identify such dilemmas and to develop strategies to prevent or resolve them. This article focuses on the basis for obligations not related to direct patient care, such as participating in governance, performing research, providing education, and promoting professionalism.

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## Understanding Obligations

Obligations arise from relationships.[5] These relationships ensue from social, legal, or moral mores, may be based on the role of the individual or based on reciprocity, and are often defined by overt agreements, implicit understandings, circumstances, individual interpretations, or convention. Ethical theory discusses different levels of obligations.[5]

*Perfect obligations* are obligations that have a corresponding right and should remain unfulfilled only when one perfect obligation clashes with another. Informed consent is a good example of a perfect obligation. Anesthesiologists have an obligation to obtain informed consent, while the corresponding right is the right of the patient to give informed consent before receiving care. In an emergency situation, the perfect obligation to obtain informed consent may be trumped by another perfect obligation, to save the patient's life. Most patient care obligations are perfect obligations. *Nonperfect obligations* do not arise from a corresponding right and may be conventionally considered "charity." Nonperfect obligations are, by definition, less obligatory and are fulfilled by individual choice. (It is important to note that although there may be a moral obligation to be charitable, embodied in the definition of charitable is that it cannot be compelled, however "charitable actions" are defined.) *Self-imposed obligations* do not have a corresponding right but are taken on willingly by the individual and, therefore, are more obligatory than nonperfect obligations.

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Philosophers are not uniform in their opinions about what constitutes different types of obligations. By way of example, consider the extremes exemplified by the views of Ayn Rand and her philosophy of objectivism and John Rawls and his philosophy of egalitarianism.[6,7] Objectivism holds that the moral purpose of a human's life should be his or her own happiness and productive achievement. Objectivism rejects the idea that humans owe another human anything outside of a contract and, therefore, holds that the only perfect obligations are to oneself. On the other hand, egalitarianism holds that because individuals within a society have been given certain advantages and disadvantages purely by chance, each member of society is obligated to smooth out the effects of this lottery. As such, the fact that an individual lives in this community means that they automatically have higher-level obligations to other members of the community.

Although the aforementioned construction provides a neat theoretical framework, it does not provide a very functional process for recognizing and resolving competing obligations. Individuals need to be able to define obligations, rank obligations on a continuum, and determine how to fulfill these obligations. From this more practical perspective, contextual factors play a significant role in estimating the importance of specific obligations. Distinguishing features include the potential harm to the giver, potential benefit to the receiver, otherwise availability of that which is given, and the relationship between the giver and receiver. In general, the requirement to fulfill obligations gains weight as they reduce greater harm, as their completion becomes less burdensome to the giver, and as the scarcity of what is given increases. For example, a bystander has less of an obligation (if any) to donate a kidney to an unknown person, whereas a brother may have a greater obligation to donate to his sister because of the sibling relationship. On the other hand, a physician bystander at a car accident has more of an obligation to become involved than a nonphysician bystander because of limited harm to the bystander, significant benefit to the recipient, and the limited availability of the resource of being able to provide skilled medical help.

Obligations can be fulfilled in increments and in different forms, and fulfillment may be time-sensitive. This allows individuals both to bank fulfillment of obligations during times of comparative wealth and to make reparations when the account falls into arrears. For example, as a teacher of anesthesia, I have an obligation to give a resident timely and pertinent feedback. This obligation arises primarily from the student–teacher relationship and is preferably fulfilled at the end of the work day. But what do I do with this obligation if, toward the end of the day, I am notified that my arrangements have fallen through and I need to pick up my daughter from daycare? I now have two conflicting obligations, an obligation to engage the resident in a feedback discussion and an obligation to get my daughter. As I rank these conflicting obligations, my primary obligation is to retrieve my daughter for the following reasons: (1) my obligations to my daughter based on the familial relationship are, in general, greater than my obligations to the resident; (2) my daughter likely will be more harmed by being stranded at daycare than the resident will be by not receiving feedback at the end of the day; and (3) the obligations to my daughter are time-sensitive, in that it needs to be performed within a specified amount of time; the obligations to the resident can be filled the following day or even by telephone that evening. Thus, I can mitigate the harm to the resident. To be able to rank obligations, one needs to understand their origins, why they exist, and the ramifications of not fulfilling them.

## Obligations of Anesthesiologists

The obligations of anesthesiologists may be divided into personal and professional obligations (fig. 1). Dividing obligations in this way facilitates discussion but is arbitrary and does not convey the complex overlapping of obligations. As such, it is proposed as a framework to illustrate broad distinctions rather than as an in-depth taxonomy of obligations. Personal obligations of anesthesiologists include physical, familial, financial, and societal obligations. Professional obligations include business and practice obligations, direct patient care obligations, and nonpatient care obligations. Business and practice obligations are often defined by contracts or rules that are fairly explicit and to which there are consequences if the obligations are not kept. Patient care obligations refer to obligations an anesthesiologist has toward the individual they are or will be anesthetizing or otherwise caring for and are those most often discussed when considering ethics and anesthesiology. When an anesthesiologist agrees to care for a patient, the obligation to care for the patient is, for the most part, medically, ethically, and legally mandated and well described; failure to complete the obligation is apparent. In contrast, nonpatient care obligations are rarely dis-

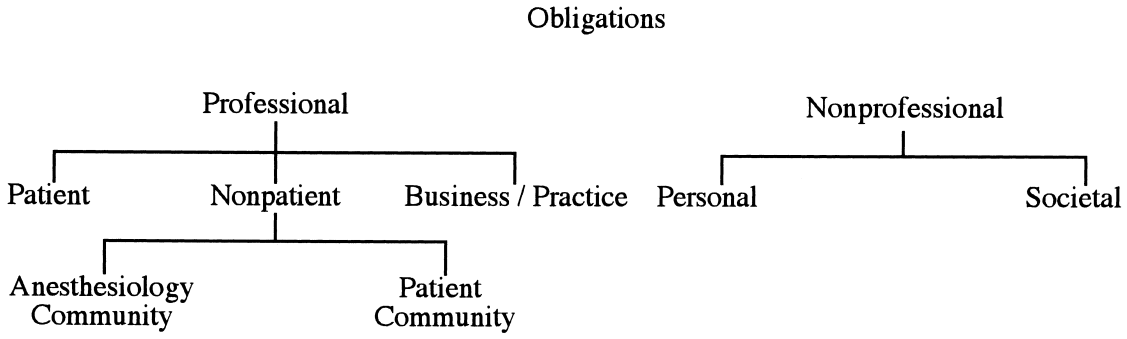


**Fig. 1. Obligations of anesthesiologists.**

cussed, poorly defined, and there are few obvious consequences to not fulfilling them.

Two important nonpatient care relationships of anesthesiologists are to the anesthesiology community and patient community. Note that a nonpatient care relationship does not refer to the relationship an anesthesiologist has to an individual colleague or patient; instead, it refers to the relationship an anesthesiologist has with the community of anesthesiologists and community of patients *en masse*. The anesthesiology community consists of past, present, and future anesthesiologists and their collective knowledge and skills.[8] The relationship to the anesthesia forefathers is rooted in what they have given to present-day anesthesiologists: the development and preservation of the profession of anesthesiology. These endowments include the ability to be part of a recognized specialty, to provide safe anesthesia, and to receive ample remuneration.[9–11]

The patient community consists of the society of patients, and the trust society has placed in anesthesiologists, and the anesthesiology profession to be custodians for the skills, knowledge, and future of anesthesiology. In addition to this foundation of obligations based on the role of the anesthesiologist, there are also mostly unvoiced obligations based on the idea of reciprocity. Society has chosen to invest its resources to develop a medical infrastructure of materials, expertise, training, and research, without which most physicians would be unable to achieve the status of physician or to practice the quality of medicine that they do. Society has invested its resources to make physicians the curators of medicine and its future. Some interpret this investment to mean that society has every right to consider physicians' skills a national resource.[1]

The obligations to the anesthesiology and patient communities require anesthesiologists to be the custodians of the present and future of anesthesiology. The importance of fulfilling these nonpatient care obligations is substantial and should not be underestimated. The profession of anesthesiology as represented by anesthesiologists, the anesthesiology community, and the patient community are inexorably intertwined. Simply put, if anesthesiologists do not honor the relationship to the anesthesiology and patient communities, the profession of anesthesiology falters. If the profession falters, anesthesiologists and other physicians will not be able to fulfill obligations. Such obligations include but are not limited to the training of new anesthesiologists, the advancement of anesthesia knowledge, the development of technology, the understanding of the basic science of anesthesia, and the continual march toward increased patient safety. Surgical advances in technique often depend on anesthesiology advancements to permit their clinical application.[12] Similarly, the ability to operate on sicker patients and patients at the extremes of ages are dependent not only on the skill of the individual anesthesiologist but also on the refinement, communication, and implementation of relevant advances. Applying the criteria of contextual factors to the matter at hand strongly suggests that the requirement for anesthesiologists to fulfill nonpatient care obligations is substantial. Fulfilling these obligations is not significantly harmful to the anesthesiologist, it is of great value to the recipient, it can only be given by a select few, and, furthermore, there is a relationship between the giver and recipient such that the recipient may have a legitimate expectation of the anesthesiologist to fulfill nonpatient care obligations.

## Fulfilling Obligations

Nonpatient care obligations to the anesthesiology and patient communities center on four areas: (1) participat-

ing in governance; (2) participating in research; (3) participating in education; and (4) promoting the profession of anesthesiology. What follows are a few examples of how individuals, practices, and organizations have acted to fulfill these obligations.

Participation in governance fulfills obligations to the patient and anesthesiology communities by enabling anesthesiologists to administratively address concerns, influence processes, and guide institutional decision-making to the communities' benefit.[13–16] Activities include holding elected positions, performing committee work, supporting the activities of anesthesia and nonanesthesia organizations, participating in institutional matters, and interfacing with those who manage the systems of healthcare delivery. For example, by taking part in the development of a same-day surgery unit, anesthesiologists are more capable of preventing design problems and more likely to develop a system that addresses and mitigates the production pressures intrinsic to ambulatory surgery.[17,18]

National committee work affects the anesthesiology and patient communities. A good example is the ongoing refinement by the American Society of Anesthesiologists (ASA) Committee on Ethics of recommendations for perioperative do-not-resuscitate orders. In the early 1990s, most physicians, hospitals, and professional societies did not recognize the right of patients to refuse resuscitation in the operating room.[19] In 1993, the ASA issued a statement emphasizing this right, and in 1994, the American College of Surgeons responded with a similar document.[20,21] As a result, in large part, of these statements, refusing resuscitation in the operating room is now accepted as a legitimate expression of a patient's right to self-determination.

Research advances the science and the art of anesthesia by improving patient comfort, decreasing morbidity and mortality, developing anesthesia techniques that enable advancement of surgical procedures, and identifying opportunities for wise cost savings.[22–27] Two examples of well-coordinated national efforts to fulfill this category of obligations are the Anesthesia Patient Safety Foundation and the Closed Claims Project managed by the ASA Committee on Professional Liability. The purpose of the Anesthesia Patient Safety Foundation is "to foster investigations that will provide a better understanding of preventable anesthetic injuries, to encourage programs that will reduce the number of anesthetic injuries, and to promote national and international communication of information and ideas about the causes and prevention of anesthetic injuries."[28] They accomplish this through a newsletter, patient safety videotapes, and the awarding of research grants. The newsletter has examined important topics such as the role of leadership in high-quality anesthesia practice, causes of medication errors, programs of organized safety research, risk-modification strategies, and clinical competence.[29] By the same token, the profession of anesthesiology is addressing perioperative morbidity and mortality through the Closed Claims Project. Closed claims analysis examines malpractice claims that have been resolved and provides information about adverse outcomes and their costs. Closed claim analysis has studied, among others, eye injuries, ulnar neuropathies, problems resulting from gas delivery equipment and warming devices, and, perhaps of foremost impact, adverse airway events.[30–34] By determining that recognition and management of the difficult airway was a prevalent and highly preventable cause of morbidity and mortality, the "ASA turned its attention to developing protocols, algorithms, lectures, and videotapes to further knowledge about the management of the difficult airway."[31,35,36]

Educational obligations to the anesthesiology and patient communities center on preparing anesthesiologists to maintain the profession of anesthesiology.[37–39] Academic anesthesia departments achieve this by choosing to structure, protect, and promote the learning experience.[40,41] For example, if desired, coverage systems may be designed to enhance teaching, service requirements may be monitored to minimize their encroachment on education, and attending physicians may be prompted to provide precise, honest, and fair feedback to residents. These actions improve morale and motivation, create better anesthesiologists, focus the learning experience, and inculcate the residents in the culture of anesthesiology, all of which helps to fulfill nonpatient care obligations of anesthesiologists.[40,42] Other education obligations may include teaching nonanesthesiologist physicians and other caregivers about pain management, sedation, blood utilization, and preoperative and postoperative care.[36] Anesthesiologists should also educate the public, partly to explain what anesthesiologists do and partly to put research and advances in the proper perspectives.[43]

Anesthesiologists also fulfill obligations to promote the profession of anesthesiology by providing financial support to worthy anesthesiology-related organizations, extending the range of clinical services, and conducting business with integrity. These actions strengthen the profession, which, in turn, bolsters the opportunities

and resources that individuals, departments, and organizations use to fulfill obligations and preserve the life cycle of anesthesiology.[44,45]

## Resolving Conflicting Obligations

It is wholly appreciated that the actions detailed in the previous sections are not without cost and may conflict with the fulfillment of other obligations or desires. Fulfilling obligations becomes increasingly more psychologically, economically, and pragmatically sustainable if the activities are chosen with care. What follows is a generic introduction to determining how to fulfill nonpatient care obligations through sounding, institutionalizing, and sustaining.[2–4]

The purpose of sounding is to determine the group's desires and feelings. Anesthesiologists must actively evaluate their priorities in light of their values and situations and decide if they desire to fulfill nonpatient care obligations. There are many ways to initiate this discussion, including the use of surveys, internal discussions, formal review of policies and practices, interviews with individuals and small groups, and larger meetings or retreats. In a larger group, using smaller committees to present to a larger group is valuable, and the process is well described by Lubarsky *et al.* in their article about implementation of pharmaceutical practice guidelines.[46] Important conceptual decisions to be made include the level of interest in fulfilling obligations, which obligations should be fulfilled, who is going to do it and how, and the priority of these actions.

When choosing which obligations to fulfill, and perhaps what to forego in its stead, anesthesiologists should consider their perceived responsibilities, their own interests, the available resources, and the associated costs. Identifying and ranking relationships may better enable anesthesiologists to identify and rank obligations. For example, the obligations that anesthesiologists have at a small hospital may be unlike the obligations anesthesiologists have at an academic center.

Using strategies such as division of labor, conservation of energy, and economies of scale will better enable anesthesiologists to fulfill obligations. A division-of-labor strategy suggests that not every member of a group needs to fulfill every obligation. Groups should feel comfortable considering themselves as communities and, therefore, may choose to devote the group's resources toward having specific members fulfill certain obligations. Therefore, individuals within a group may claim to fulfill nonpatient care obligations by supporting the activities of an anesthesiologist who participates on the medical staff or other organizations by, for example, arranging time off without financial penalties.

Conservation of energy strategies suggest that anesthesiologists look for and take advantage of opportunities to perform actions that fulfill multiple obligations. In addition, anesthesiologists should consciously examine different ways to fulfill obligations and choose actions that are best suited to their situation, priorities, and opportunities. Or, if situations require the fulfillment of a potentially costly obligation that can only be fulfilled by a few (*e.g.*, the resident who needs to learn to insert central venous catheters), then anesthesiologists should look for ways to make it more palatable (*e.g.*, one-on-one coverage, opportunities to perform the procedure outside the operating room so as not to delay case turnover, *etc.*) Economies of scale and specialization strategies suggest that a concerted effort to address a more narrow range of obligations is more effective. A group may want to seek financial or other types of support from those who benefit from their involvement, such as the hospital community. By minimizing high-cost activities and maximizing easier, less expensive, and more desirable options, anesthesiologists can fulfill nonpatient care obligations in a more gratifying manner.

The purpose of institutionalizing is to bring the values and goals determined in the sounding process into reality. A written agreement clarifies expectations, encourages public justification of decisions based on the articulated priorities, and provides a beacon when other pressures intrude. Monitoring the effect of the interventions not only helps to determine if the desired endpoints are achieved and if the arrangements are satisfactory to the participants, but also provides tangible evidence that fulfilling obligations is a priority. Departments show their support by removing disincentives and establishing incentives. For example, departments who value participation in humanitarian missions may budget sufficiently to allow individuals to go on humanitarian missions and may even permit the time away not to count as personal time. On the other hand, the group may chose to permit its members to support humanitarian missions if time is available and may require the time away to count as personal time.

The purpose of sustaining is to maintain the culture and practice of fulfilling nonpatient care obligations. The sounding and institutionalizing processes should be revisited, not only because situations and people change, but also to reaffirm the desire to fulfill them. Continuing

to work and improve the process will maximize benefits, minimize burdens, and actively nurture the desire to fulfill obligations. The less material benefits of fulfilling nonpatient care obligations needs to be recognized and highlighted. The natural ebb and flow of the commitment that a group will have to nearly any project should be expected and greeted with aplomb. Intermittent setbacks should not be interpreted, either in public or in private, as indications that the program is a failure and should be abandoned. Hiring colleagues with similar values will decrease clashes about priorities and is one of the most effective ways of sustaining the desired culture.

How one chooses to define, prioritize, and address nonpatient care obligations and their associated dilemmas is truly an individual choice. True choices require being well informed. Thorough study and better understanding of the concept of obligations brings about a greater ability to draw distinctions, critically evaluate relationships, and put values into action. To make these choices in an ethical manner, an anesthesiologist must be aware of obligations, why they exist, diverse ways to fulfill them, and the ramifications of not fulfilling them.

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