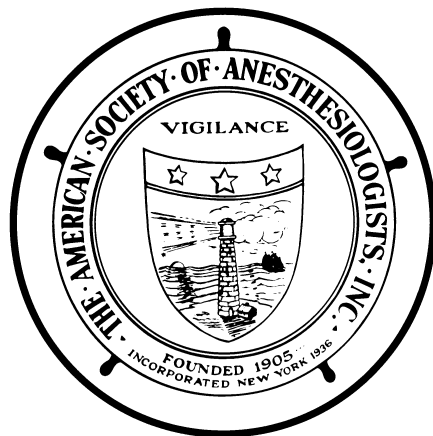


Syllabus on Ethics (1999)



*American Society of Anesthesiologists
Committee on Ethics*

Syllabus on Ethics

(1999)

End-of-Life Care

Committee on Ethics of the American Society of Anesthesiologists

This document has been developed by the ASA Committee on Ethics, but has not been reviewed or approved as a practice parameter or policy statement by the ASA House of Delegates. Variances from the recommendations contained in this document may be acceptable based on the judgment of the responsible anesthesiologist. The recommendations are designed to encourage quality patient care and safety in the workplace, but cannot guarantee a specific outcome. They are subject to revision from time to time as warranted by the evolution of technology and practice.

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Syllabus on Ethics

Informed Consent

Committee on Ethics of the American Society of Anesthesiologists

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Gail A. Van Norman, M.D.

PREFACE

The cataclysmic transformation of the practice of medicine has reflected the accelerated rate of change in both its own scientific foundation and the conglomerate nature and values of the heterogeneous society it serves. This baleful upheaval has, with increasing frequency, confronted physicians with complex ethical and moral dilemmas that impact not only our professional lives — and by extension those of our patients — but also our personal lives. Indeed, it has become necessary to respond to these challenges in an informed and effective manner based on an expanded awareness and knowledge of biomedical ethics.

The Accreditation for Graduate Medical Education (ACGME) acknowledged that a variety of factors — the ascendancy of patient rights, the technical advancements in medical care, the extension of both extremes of our patients' life span, the ever-expanding costs of providing care within a setting of limited national resources, to name a few — are bringing an enlarging list of ethical dilemmas to the arena of clinical practice. In order to empower physicians-in-training to better understand and manage the perplexing ethical problems inherent to our profession, the ACGME mandated that all accredited residency programs provide an education in the ethics of the practice of medicine.

A survey of residency programs conducted by the ASA Committee on Ethics in the spring of 1996 revealed that many programs were experiencing some difficulty in incorporating the teaching of medical ethics into their residency curriculums. Most programs were providing sporadic lectures, but few claimed to have an organized approach to teaching the relevant issues. Indeed, a majority of respondents indicated that they welcomed assistance in establishing an ethics curriculum for our specialty.

In response to these exigencies, the ASA Committee on Ethics undertook the daunting task of creating a model curriculum for teaching ethics. The linchpin of this project is the publication of a yearly Syllabus on Ethics. Each Syllabus will concentrate on one fundamental area of bioethics relevant to the anesthesiologist. The contents will include anesthesia-specific educational material: informational background, references and guided case studies. There also will be articles that address the challenges that faculty encounter in the teaching of ethics to residents.

We offer the Syllabus with the suggestion that it can serve as a valuable resource for faculty. Furthermore, our committee stands readily available, upon request, as personal resources for assisting faculty in orchestrating the teaching of ethics. We are also open to feedback and suggestions for improving this and any future Syllabus.

Bioethics occupies the interface of the absolutism of ethical theory and the relativism of clinical medicine. However, in the final reckoning, the hallowed and time-honored patient-physician relationship, now housed in a relentlessly dehumanizing milieu of hostile influences, is the ultimate context in which most clinical decisions and actions are made. It is in this noble relationship of trust and caring that the physician's moral obligation to serve as the patient's protector and advocate must emerge as the primary focus of ethics in anesthesiology.

Stephen H. Jackson, M.D.
Chair, ASA Committee on Ethics

INTRODUCTION

This *Syllabus* contains a presentation discussing implementation of a bioethics curriculum and four modules for teaching discrete aspects of informed consent.

“Implementation of an Ethics Curriculum: Getting Started” describes Gail Van Norman’s experiences at the University of Washington Department of Anesthesiology. This article provides a blueprint for designing a consummate bioethics program for anesthesiology residents.

The first module, “Introduction to Informed Consent,” provides a broad overview that can serve as a basis for understanding the succeeding three modules. The second module, “Who Speaks for the Patient,” focuses on assessing patient competence and the use of proxy decision-makers. The third and fourth modules, “Special Issues in the Care of Children” and “Informed Consent for Jehovah’s Witnesses,” center on the special challenges of informed consent for these two populations of patients.

Each module contains the following elements:

Summary review: A discussion of the pertinent issues designed for use as both a background source for instructors and a handout for residents.

Annotated bibliography: A guide for readers to selected references. Highly suggested references are bolded.

Cases: Bioethics education is best accomplished by a mixture of didactic education and case conferences. To facilitate case-based teaching, each author offers case presentations (formatted to facilitate reproduction) that have proven didactic success. Each case also includes instructor’s notes that may be used to guide the discussion. We anticipate that the examples provided will encourage faculty to develop their own teaching cases.

Special teaching method: Residents tend to find nontraditional instructional methodology both practical and stimulating. Each module therefore includes a nontraditional vehicle for teaching bioethics.

The *Syllabus* is designed to be used creatively and flexibly according to the specific demands of your department. For example, presentation of a module can begin with a didactic lecture, with future sessions centering on case conferences and special teaching methods to clarify key points. Another option would be to distribute the summary review and to focus the teaching session on the case conferences. Departments may also choose to teach a specific module to CA-1s, another to CA-2s, etc.

The *Syllabus on Ethics* and certain references are available on the **Wood Library-Museum of Anesthesiology Web site at <http://www.asahq.org/wlm/>**. References that are not on the Web site are available by request from the Wood Library-Museum of Anesthesiology.

We, the contributors to the syllabus, stand willingly available as a resource for teaching faculty seeking advice and assistance in developing a bioethics curriculum.

David B. Waisel, M.D.
Editor

INTRODUCTION TO END-OF-LIFE CARE

The 1998 syllabus concentrated on informed consent as a fundamental issue in bioethics that is relevant to the practice of anesthesiology. The 1999 supplement to the Syllabus focuses on end-of-life issues as they impact on patient management.

“Hospice Care: Live All the Days of Your Life” is an interview with Perry G. Fine, M.D. Dr. Fine is an anesthesiologist, a pain management specialist, a member of the ASA Committee on Ethics and the medical director of VistaCare hospice. He gives us insight into the use of hospice and the roles anesthesiologists may play in hospice patients’ therapy.

Module E, “Perioperative DNR Orders to Refuse Resuscitation,” discusses the theoretical and practical aspects of do-not-resuscitate (DNR) orders in the O.R. It reviews why patients are permitted to refuse therapy and different mechanisms for documenting perioperative orders.

Module F, “Medical Futility,” focuses on recognizing, defining and managing care that may be futile. It squarely addresses the double-edge sword of our increasing ability to apply life-sustaining therapy, and facilitates the reader’s understanding and ability to consider this often murky issue.

Module G, “Redefining Death: Ethical, Legal and Medical Implications of Brain Death Determination in Anesthesia Practice” discusses the confluence of events that brought about the concept of brain death. It explains how the determination of brain death is made and its implications, particularly for organ transplantation.

The following books have been published recently and are worth adding to your bioethics library.

Caplan AL. *Due Consideration: Controversy in the Age of Medical Miracles*. New York: John Wiley & Sons, Inc.; 1997.

Caplan AL. *Am I My Brother’s Keeper? The Ethical Frontiers of Biomedicine*. Bloomington, IN: Indiana University Press; 1998.

Jonsen AR. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. 4th ed. New York: McGraw-Hill; 1997.

Jonsen AR. *The Birth of Bioethics*. New York: Oxford University Press; 1998.

Jonsen AR, Veatch RM, Walters LB. *Source Book in Bioethics: A Documentary History*. Washington, DC: Georgetown University Press; 1998.

La Puma J. *Managed Care Ethics: Essays on the Impact of Managed Care on Traditional Medical Ethics*. New York: Hatherleigh Press; 1998.

The Syllabus is designed to be used creatively and flexibly according to the specific demands of your department. The Syllabus on Ethics is available on the Wood Library-Museum of Anesthesiology Web site at <<http://www.asahq.org/wlm/>>.

We, of course, are ready and willing to be available as a faculty and department resource.

David B. Waisel, M.D.

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Starting a Bioethics Library

We are often asked what books or journals should be in a bioethics library for residents. This short list contains what we advise to be readily accessible for anesthesiology faculty and residents. Additional materials are available from the Wood Library-Museum of Anesthesiology.

Bioethics Textbooks

Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 4th ed. New York: Oxford University Press; 1994.

Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. 3rd ed. New York: McGraw-Hill; 1992.

Medical-Legal Textbooks

Sanbar SS, Gibofsky A, Firestone MH, LeBlang TR. *Legal Medicine*. 3rd ed. St. Louis: Mosby-Year Book Inc; 1995.

Journals

Many journals have articles pertaining to bioethics, most notably *The New England Journal of Medicine* and *Annals of Internal Medicine*. The two journals listed below, however, are the most practical and widely read journals of bioethics and should be available to residents.

The Hastings Center Report

The Journal of Clinical Ethics

Ethical Guidelines of Medical Organizations

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; 1997:401-403.

Council on Ethical and Judicial Affairs, American Medical Association. *Code of Medical Ethics: Current Opinions With Annotations*. Chicago: American Medical Association; 1997.

Notable Reviews

Ethical issues in anesthesia. In: Lake CL, Rice LJ, Sperry, RJ. eds. *Advances in Anesthesia*. Vol. 14. St. Louis, MO: Mosby-Year Book Inc; 1996:227-260.

IMPLEMENTATION OF AN ETHICS CURRICULUM: GETTING STARTED

THE DOCTOR-PATIENT RELATIONSHIP, regardless of the specialty, goes beyond the practice of technological skills, and is inter-woven with moral values involving respect and trust, rights and duties, truthfulness, confidentiality, integrity and fairness.¹ The practice of medicine is suffused with moral value — the act of “doing good” — and the education of practitioners of medical arts therefore requires more than the development of technical skills. Medical education is, and should be, intimately entwined with the moral development of its graduates. Education in the ethics of medical practice is integral to the creation of a “physician,” as versus the training of a technician. In support of this concept, in 1996, the Accreditation Council for Graduate Medical Education mandated ethics education as a part of every residency curriculum.²

Building a curriculum program that encompasses medical ethics is an exciting, if not challenging, task. The broad goals of ethics education as they apply to the clinical practice of anesthesiology present opportunities for creative academic faculty in search of a “niche” in a truly “leading edge” area of residency education and medical education research.

How an ethics curriculum is implemented depends on each department’s environment, receptivity and needs as well as the goals of ethics education. How ethics should be taught, and who should teach it, flow from the educational ends we wish to meet.

I. What Should Be the Goals of Ethics Education in Residency?

While it is agreed that ethics should be a part of any residency curriculum,³⁻¹¹ the goals of teaching ethics are not entirely settled. The reasons for the recent groundswell of interest in the ethical dimensions of medicine are complex and not entirely obvious. The idea that technological advances in medicine have led to an increase in the number and complexity of ethical problems in medicine may be more perception than fact, since

even such “modern” ethical issues in medicine as abortion and euthanasia have foundations in distant historical debate.¹² The social readiness in the United States in the 1950s and 1960s to question authority, together with perceptions that medicine has become driven by technology and technical values, may have set the stage for the re-examination of the moral values in medicine.¹³ Recognition that caring for patients involves more than addressing the technical aspects of disease may have lead to a search for answers in ethical terms. In the words of L.R. Kass, “... if healing the sick is always the heart of the physician’s business, and if, as I suspect, the essential features of the healing relation between the physician and the ill have not been, indeed cannot be, altered by technological advance or societal change, then medicine must remain (at its core) what it always has been — a very special profession...”¹⁴

Ethics education has been promoted on an assumption that certain moral behavior is expected and desirable among all physicians, both in their collegial interactions as well as their treatment of patients. Furthermore, ethics education has been promoted on the assumption that certain undesirable practices and personal traits have evolved in the medical environment, which a consciously directed moral education can correct.¹⁵ Promoters of formal clinical ethics education therefore assume that past ills and future mistakes in medical practice will be remedied, and that education in ethics will promote moral behavior.^{4,5,6,7,16} Detractors point out that “evil” can and has occurred, even in the face of appropriate education, and that there is little evidence that the moral development of physicians is changed through education.⁷ Proving that education changes behavior, however, is difficult for even more traditional areas of medical education. It is unclear, for example, that education in biochemistry has any affect on the decisions, behavior or competency of physicians. Yet biochemistry is considered a basic aspect of medical education.

Discussion of moral development and moral character as a vital part of becoming a physician creates a sense of queasiness among many doctors, who may be nervous that anyone can become the victim of moral finger-pointing, and who believe that in ethics there are, or should be, “no right answers.” Physicians skewered on the horns of a moral dilemma in practice, however, suffer acutely themselves, and are helped little by the pronouncement that “there is no right answer.” Clinicians desire solutions to moral problems involving patient care, just as they seek viable treatments for physical diseases and symptoms.

Should ethics education be a way of directing and fostering moral development of physicians or should it provide tools for “solving” certain types of clinical ethical problems or both?^{15,17} We can teach clinical problem analysis and potential “short-term” solutions to certain types of problems, but appropriate moral development of physicians might build a health care environment in which ethical problems, because they are seldom dilemmas in the true sense, become less and less frequent.

At the University of Washington Department of Anesthesiology, we have a three-year curriculum program devoted to the teaching of clinical ethics in anesthesia practice. Four faculty members are primarily interested in the presentation of ethical issues and curriculum development, and the program is now three years old. While the structure is basically the same from year to year, our view of the program remains fluid, and our ethics curriculum is still evolving. It is helpful, however, to look at one program’s goals and approach in ethics education and how we have tried to meet those goals.

II. Teaching Ethics in Multiple Formats

In our program, we believe that individual students may learn best in different formats, and so we have three forums in which clinical ethical problem solving is discussed: a case-based lecture series dealing with basic ethical issues in anesthesia practice, a regular presentation of ethical issues at our departmental morbidity and mortality conference, and a yearly evening ethics forum involving members of the community as well as experts from other medical departments.

Case-Based Lectures in Clinical Ethical Problem-Solving. Our program began with the simple goal of presenting common ethical problems encountered in anesthesia practice to our residents in order to familiarize them with one approach to resolving ethical dilemmas. We used a method of clinical-ethical case analysis described by Jonsen,¹⁸ in which a case is presented with four questions to answer:

- 1) What are the medical indications for the procedure?
- 2) What are the quality of life features of the case? That is, what will the patient’s quality of life be with and without the procedure?
- 3) What are the patient preferences?
- 4) What contextual features contribute to the case? That is, are there familial, financial or legal pressures to act? What about schedule conflicts, just distribution of scarce resources, political pressures?

Each case is discussed, and the answers to each of these four questions are developed by the residents, who are then asked to formulate a “resolution” to the problem and discuss how their resolution addresses the various ethical principles that may be in conflict.

Question #1, for example, represents the ethical principles of beneficence (doing good) and nonmaleficence (avoiding harm) from the physician’s perspective. An answer to question #1 must include a discussion of the medical alternatives available to the patient and their respective benefits and harms. Question #2 represents the principles of beneficence and non-maleficence again, but from the perspective of the patient. Question #3 represents the ethical

principle of respect for patient autonomy. In question #3, residents must consider features that may affect the patient's self-determination, such as whether the patient is competent and whether they are making a voluntary decision. Question #4 represents issues of justice. Are the physicians or patients being subjected to unfair pressure? Are resources being allocated justly?

Residents have two lecture hours per year devoted to medical ethics teaching in the first two years of residency and a two-hour seminar in the senior year. Each lecture begins with an illustrative case, which is "analyzed" as the lecture develops, and then didactic material is presented. Sample case development can be found beginning on page B-9.

The first year's lectures are devoted to basic and common problems in anesthesia practice like informed consent issues and do-not-resuscitate orders in the operating room. In the second year, somewhat more complex issues such as proxy decision-making are explored. In the third year, a two-hour seminar is devoted to a medical ethics topic of broader implications, usually utilizing a topic in the news that year. Topics have included understanding definitions of brain death, ethical issues in organ trans-plantation and rationing health care.

Morbidity and Mortality Conference. Our department has a weekly conference discussing interesting or illustrative cases from recent schedules at each of our department hospitals. Three or four times a year, a collection of cases involving ethical issues is used as the conference focus. In this way, the general faculty are involved in the education process regarding clinical ethical dilemmas. The case format described above is used to initiate discussion.

Annual Evening Ethics Forum. Our residency program includes monthly evening "specials" for residents, in which dinner is provided and a two- to three-hour program is presented on a variety of topics, ranging from management of the difficult airway to substance abuse. One "special" per year is devoted to ethical issues in medicine and anesthesia practice. In this forum, a panel of experts is convened to have a moderated round-table discussion about two medical cases involving ethical issues. We try to utilize both

community experts and visiting professors. A typical panel consists of an anesthesiologist, an ethicist, an attorney, a theologian, a media representative and a second medical expert representing the specialty involved in the case. Each panelist is given the case scenarios to be discussed in advance, together with a list of questions to consider that might be addressed by the case moderator during the evening. The panelists are also given "bare bones" medical facts for the case, and some relevant references and articles of interest from both the medical and lay literature are presented. Since the issues of focus are ethical and not medical, medical features of the case are de-emphasized in the discussion.

Each case is moderated by a faculty member familiar with the ethical features which we wish to use as teaching points. A tentative case "development" is composed and rehearsed in advance by the moderator, who then presents the scenario to the panel and asks each panelist in turn to respond to various issues in the case.

The result is a "real-time case," with reactions from experts who might in real life function in an advisory capacity to the physicians involved. Our aim is to provide residents with a broader perspective on medical ethical issues; one which included the perspectives of other medical specialties, nonphysician ethicists, legal experts and spiritual or theological experts. Preparation for the evening is intense, but the results have received praise from the residents and panelists alike. It's also fun.

We found, as many other clinical educators have, that case-based discussions appear to elicit the most interest and participation from both faculty and residents.^{15,17,19-25} This is likely due to its similarity to other aspects of residency education, in which the diagnosis and treatment of disease is learned by "doing cases" and discussing anecdotal scenarios. The use of real cases emphasizes the relevance of recognizing and developing an approach to ethical problems for use in everyday practice. While we sometimes use cases from sources other than the University, we feel that the best discussions are generated if the residents admit to difficult situations they themselves have experienced and how they handled them.

Promotion of these discussions requires that we emphasize and guard against any negative repercussions to residents who bring problems to light. Cases that are brought to us privately by residents are often used for group and departmental case discussions. In all cases, the residents involved are forewarned, and case details are changed to “protect the innocent.”

Case discussion also require an atmosphere of “sympathetic listening.” We find that tough ethical dilemmas, like tough medical decisions, are often painful and elicit dramatic emotions in the participants. It is not uncommon for residents or faculty discussing difficult dilemmas to exhibit guilt, anger, frustration and sorrow.

III. Experience Expands the Goals of Ethics Teaching

As we have gained some experience in clinical ethics education, our goals have broadened from that of simple case discussion. We now have at least five goals in ethics education.

Goal 1: We hypothesize that residents have trouble recognizing ethical problems as such, and tend to view them as issues of authority and “turf.” One goal of ethics education should be to help residents and faculty appropriately identify true ethical conflicts and distinguish them from other types of conflicts. We want residents to recognize that not all conflicts are ethical conflicts and that not all ethical conflicts can be reduced to issues of authority and territory.

Examples of issues we have seen include:

“The patient won’t do what I want them to.” Residents may be distracted from practicing respect for patient autonomy by the affront of having the patient question their “authority.”

“The surgeon is telling me what to do with my patient.” Rather than explore whether in fact the surgeon might be correct in what they want to do, the resident is caught up in a “turf war” and is prevented from focusing on patient care by an argument with another physician regarding propriety over the patient.

“I don’t agree with my attending about what should be done.” Residents may recognize an

ethical conflict, but feel prevented from exploring the dilemma out of fear of reprisals from an authority to which they are subordinate. While recognition of authority is important in medical education, residents should be encouraged to appropriately speak up when faced with ethical conflicts, to follow the principle of “*primum non tacere*,” (first, do not be silent) as discussed by Dwyer.¹⁹

“A colleague is behaving in an unethical/obnoxious/inappropriate manner.” Residents may react to each type of behavior similarly, despite the fact that they represent different conflicts which require different responses. Disrespectful behavior from a colleague does not equate with unethical care of a patient.

Goal 2: Identification of ethical problems is only the beginning in developing an approach to clinical ethical problems. In analyzing real cases using a simple format, we hope to develop habits that will help a resident approach ethical problems in a constructive manner.

By having a formal approach to ethical problems we ensure that:

- a) All aspects of a problem are considered.
- b) Conflicting features of the case are identified.
- c) The true nature of the conflict can be recognized, whether it is ethical, emotional, authoritative or otherwise in nature.
- d) An appropriate approach to the identified conflict can be formulated.

Goal 3: We want to expose residents to the ethical conflicts they are likely to see in practice. By anticipating some of the common ethical problems in anesthesiology, residents can develop an approach prior to encountering difficulty, much the same as we ask residents to have a defined approach to the difficulty airway.

Issues we want residents to consider are:

- a) Do-not-resuscitate orders in the operating room
- b) Informed consent
- c) Proxy consent for medical care
- d) Brain death (ethical issues and diagnosis)
- e) Organ procurement/ transplantation issues
- f) Physician aid-in-dying and euthanasia

Goal 4: In addition to ethical issues common to anesthesia practice, we believe that anesthesia residents have an obligation as medical practitioners and, as knowledgeable members of society, to have an awareness of broader ethical issues facing medicine.

Issues that we examine include:

- a) Managed care
- b) Economic credentialing
- c) Allocation of scarce resources
- d) Professionalism and contractual issues of employment
- e) Research and publication ethics

Goal 5: We believe that language is an essential part of education.²⁶ Language contributes to the solution of problems through precise and respectful communication during conflicts. Language also shapes the way we think and how we act. Finally, appropriate use of language may prevent problems and can facilitate problem-solving.

The development of good language skills involves four key aspects: knowledge, respect, practice and example. We try to promote the development of language as a tool in residency in the following ways:

- a) We discourage faculty and residents from using disrespectful language in any communication involving patients and colleagues.
- b) We encourage the use of precise language and appropriate medical and ethical terminology in both written and oral communication.
- c) We encourage residents to present cases at departmental conferences as a way of developing comfort with public communication.

IV. Ethics Faculty

As in any educational program, the goals of ethics education direct the program development. While formal ethics education for faculty who teach ethics is ideal, more often a program starts with the simple belief on the part of one or more faculty members that the teaching goal is important enough to gain their interest and attention. Many physicians teaching clinical ethics started on the strength of their interest in the topic and problems and have relied on self-education. For faculty members interested in ethics education and in teaching ethics, several courses are offered in the United States each year that can help educators get started. A list of basic texts is also recommended in the *Syllabus* (page iii), and **members of the American Society of Anesthesiologists Committee on Ethics are willingly available as resources for educators.**

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INTRODUCTION TO INFORMED CONSENT

THE LAST 40 YEARS HAVE BROUGHT ABOUT an increased respect for the rights of the individual. One way medicine has acknowledged this movement has been in the growth and development of informed consent. Obtaining **assent**, the agreement of a patient to have a procedure, has changed to obtaining **consent**, the autonomous, informed authorization by a patient to have a procedure. This was put in specific relief by three court cases: *Salgo*, *Natanson* and *Canterbury*. Residents should be familiar with these cases as they are the legal articulations of the goals of informed consent.

In 1957, *Salgo* brought forth the requirement of informed consent. Salgo became paraplegic following translumbar aortography. He had not been informed of the risks of the procedure. The court introduced the concept of informed consent by requiring the physician to explain the risks, benefits and alternatives of the procedure to the patient.

In 1960, *Natanson* began to define what information should be told to the patient to fulfill the requirement of informed consent. Natanson had severe radiation burns following the use of cobalt radiotherapy, a new technology. Although some disclosure had taken place, the court held that the disclosure had been inadequate. This case introduced the **professional practice standard**, which requires disclosure to the extent that other physicians in the community would make under similar circumstances.

In 1972, *Canterbury* refined what should be disclosed. Canterbury became quadriplegic following a laminectomy. He sued, claiming he should have been informed about the low but finite likelihood of such a significant risk. Although the surgeons did fulfill the professional practice standard, the court held that the disclosure was insufficient, and promulgated the **reasonable person standard**, which requires a physician to disclose the information that the hypothetical reasonable patient would consider important to make a decision.

What Is Informed Consent? The obligation to respect a patient's right to self-determination is commonly referred to as the principle of respect for autonomy. In anesthesiology, this principle is honored by the process of the patient and the anesthesiologist deciding on a plan and the patient's authorization of the anesthesiologist to perform that plan. The process of obtaining informed consent is often considered in two senses: the legal sense and the ethical sense.

The legal sense of informed consent requires the fulfilling of a process as defined by the local institution. This often takes the form of writing a note in the chart or having a patient sign a document. Anesthesiologists should be aware that completing the institutional requirements does not necessarily achieve the goals of informed consent. Patients may, for example, sign forms they do not understand. The institutional requirement, however, does provide a useful reminder to the provider to obtain informed consent, and its completion is evidence that some discussion about risks has taken place.

Mechanically fulfilling the legal sense of informed consent, however, rarely satisfies the ethical requirements incumbent upon a physician. A physician shows respect for a patient's right to self-determination by nurturing the patient's ability to achieve as much autonomy as possible in decision-making. To abrogate this expression of autonomy is to treat the patient as less than a person. To achieve the ethical sense of informed consent, then, the anesthesiologist must seek to maximize the ability of the patient to make substantially autonomous decisions. By steadfastly pursuing this goal, the anesthesiologist is not only more likely to fulfill the ethical requirements of informed consent but also to decrease liability exposure. Beauchamp and Childress have divided the process of informed consent into elements that provide a pathway toward achieving the ethical spirit of informed consent.

Process of Informed Consent

Threshold Elements

Competence and Decision-making Capacity
Voluntariness

Informational Elements

Disclosure
Recommendation
Understanding

Consent Elements

Decision
Autonomous authorization

Threshold Elements

Competence and Decision-making Capacity.

The term competent means that a patient is legally capable of consenting to a medical procedure. Every adult patient is assumed to be competent to consent to medical procedures, unless ruled otherwise by a judge. Decision-making capacity, on the other hand, refers to the ability of a person to make a specific decision at a specific time. A patient's capacity to make decisions may vary.

Anesthesiologists encounter patients with limited decision-making capacity in at least three fundamental situations (see **Who Speaks for the Patient**, page B-1, and **Special Issues in the Care of Children**, page C-1).

1. The patient without legal decision-making authority, such as a minor or a legally incompetent patient. Anesthesiologists should encourage these patients to make decisions and participate in their care as much as possible. For example, an 8-year-old may be able to choose whether to have an intravenous or inhalation induction but not whether to have the operation.

2. The patient whose decision-making capacity is temporarily altered as from preoperative sedation or pain medication. Recognize, too, that the level of impairment varies depending on the medication, the tolerance of the patient to the medication and the decision to be made. Indeed, some patients have improved decision-making capacity when pain is decreased (consider at which time the parturient receiving a labor epidural may be most capable of making an informed decision).

3. The patient who appears to have a preexisting impairment in decision-making capacity.

Anesthesiologists have an obligation to consider a patient's decision-making capacity and are encouraged to seek help when needed in making this determination. Evidence of adequate decision-making capacity includes the ability to understand the situation, to comprehend the relevant information and to express a preference based on rational, internally consistent reasoning. For example, it may be rational for patients to refuse a spinal because they are frightened of a needle being inserted in their back. Even if their anesthesiologists believe a regional anesthetic would be of lesser risk than a general anesthetic, patients may choose the general anesthetic because they value certain attributes (no needle in the back, being "totally out") more than they value minimizing risk. Physician disagreement with a patient's choice does not necessarily constitute inadequate decision-making capacity. Patients are allowed to make what anesthesiologists perceive to be poor decisions. Anesthesiologists, however, do not necessarily have to provide care if they believe the patient's choice is inappropriate or likely to result in harm (see **informed refusal**, page A-4).

Voluntariness. Physicians should only perform procedures on patients who are acting of their own accord. This issue comes into play most prominently when determining what to do with a patients who may have limited decision-making capacity (see **Who Speaks for the Patient**, page B-1). Anesthesiologists should also recognize that they may hinder the ability of a patient to act voluntarily if information is presented to a patient in an inappropriate way. For example, an anesthesiologist should not try to influence the patient's choice by presenting misleading information or by "playing down" certain risks. Censoring the information provided does not permit a patient to make a voluntary decision.

Informational Elements

Disclosure. Most localities use either the professional practice standard or the reasonable person standard to determine the information that needs to be disclosed. A third standard, the subjective person standard, defines perhaps the ideal disclosure but is difficult to use as a legal standard.

1. Professional practice standard. The extent of disclosure is dictated by the practices of the local physician community. The difficulty with this standard is that this level of disclosure may be found to be insufficient to fulfill both ethical and legal requirements. Further, having physicians determine what should be disclosed ignores the fundamental desire to have the patient be at the center of decision-making.

2. Reasonable person standard. Disclosure should be to the extent that would satisfy the hypothetical reasonable person. The difficulty with this standard is that it is unclear what the reasonable patient may want. For example, younger patients may prefer more information than older patients. Gender and other demographic data are not necessarily predictive of what a patient may desire for disclosure. Moreover, it does not require the caregiver to individualize the informed consent process.

3. Subjective person standard. The disclosure is tailored to the particular patient's wants and needs. However, determining to what extent a patient wants disclosure can be problematic. This is also difficult to use as a legal standard because part of determining liability for insufficient informed consent is causality, or the requirement that the patient would have chosen a different option with knowledge of the additional information. If a court were to employ a subjective person standard, patients could always claim they would have made a different decision.

A problem with all three standards is that they do not articulate exactly what a patient should be told. One solution is to mention risks that cause a temporary complication 10 percent of the time and a more permanent complication 0.5 percent of the time, and then to ask the patient if they want to know about less common and more severe risks. This allows the patient to retain some control of the informed consent process. Anesthesiologists should routinely include in disclosures the specific risks and benefits of each anesthetic option, the complications of instrumentation of the airway, the risks and benefits of invasive monitoring, the presence and use of a fallback plan, and the basis for the anesthesiologist's recommendation. For example, a recommendation might be widely accepted

and based on high-quality multicenter studies, or it might be controversial and based on personal opinion. Anesthesiologists should also inform the patient whether an individual or an anesthesia care team will be providing anesthesia services, and, if the latter, the names and roles of the team members.

The most common theory of suit relating to informed consent is negligence. Negligence means that the anesthesiologist did not provide sufficient disclosure to permit a patient to make an informed decision.

Materiality and **causality** are the legal requirements used to ascertain if the information given was sufficient. Materiality determines whether the information met the local standard of care, which is usually either the professional practice standard or the reasonable person standard. Causality determines whether the additional information would have affected the patient's decision. Because patients can always say they would have made a different choice, most courts determine causality by deciding if the hypothetical reasonable person would have used that additional information to choose differently. The court can, however, consider factors specific to the patient and situation. For example, a patient must have time to consider and ask questions about the information. Disclosing risks as the patient is wheeled into the operating room is unlikely to be considered adequate.

Recommendation. Some have taken the idea of respect for autonomy out of context and mistakenly believed that the anesthesiologist must present the options without offering an opinion. This is wrong. Anesthesiologists are, in fact, obligated to offer an opinion as to which options are preferable and the advantages and disadvantages of each option. By explaining the underpinnings of their opinions, anesthesiologists allow the patient not only to receive the benefit of their expertise but also to understand the reason for the recommendation. Patients can then decide for themselves which benefits best fit their priorities.

When making a recommendation, anesthesiologists must be careful to do so in an ethically appropriate manner. The use of **persuasion**, the act of presenting information to the patient to

buttress a recommendation, is appropriate and indeed required. **Manipulation**, however, which can be defined as inappropriately causing a certain behavior, is ethically unacceptable. For example, an anesthesiologist may manipulate a patient by not offering general anesthesia for an operation because of a desire to minimize operating room time or a desire to gain experience with regional anesthesia. This is inappropriate. **Coercion**, the act of threatening a patient with a plausible punishment so the patient will act in a certain way, is clearly prohibited.

Understanding. Patients need to understand the risks and benefits of the proposed procedures, the recommendation made and why that recommendation was made. It is difficult to determine if a patient fully understands the informed consent discussion, and, indeed, many patients may not. For instance, in one study, 27 percent of postoperative surgical patients did not know which organ had been operated upon, and 44 percent did not know the nature of the procedure (Byrne and others, 1988). Only 55 percent of cancer patients could list one of the major complications for chemotherapy within one day of signing the consent forms (Cassileth and others, 1980). Preprinted risk-specific consent forms do not necessarily help retention of risks (Clark and others, 1991). Decision-makers have even signed consent forms that they acknowledge they do not understand (Waisel and Truog, 1995).

This information should not cause the anesthesiologist to abandon the informed consent process. Instead, this information should spur the anesthesiologist 1) to focus on important information without cluttering the discussion with lists of risks and 2) to attempt to thoroughly educate patients according to their individual needs. By doing this, anesthesiologists may more adequately achieve the goal of substantial self-determination.

Consent Elements

Decision. Following the above process, the patient needs to decide on an anesthetic technique. A patient may decide that none of the techniques offered by the anesthesiologist is acceptable or may decide that he or she prefers a technique that the anesthesiologist does not consider acceptable.

This brings forth the concept of **informed refusal** and whether an anesthesiologist must do whatever a patient wants. For example, consider a patient who is eight-hours postpartum and wishes to have general anesthesia for her tubal ligation. She hears about the risks and benefits for regional anesthesia, appears to understand them and chooses, as is her right, general anesthesia over regional anesthesia. Is the anesthesiologist obligated, then, to do the case?

The answer, for the most part, is no. In nonemergent situations, anesthesiologists are not ethically obligated to provide care that they believe is inappropriate. It would behoove the anesthesiologist to discuss his or her concerns with the patient, so as to help the patient understand the risks she would be taking. Indeed, in situations requiring informed refusal, the anesthesiologist should give additional information about the ramifications of the patient's choice. In the example cited above, this woman should be educated about a greater likelihood of difficulties with airway management and an increased risk of aspiration before accepting her preference for general anesthesia. Her reasons for preferring general anesthesia should be ascertained to see if they are based on fact or if the goals she prefers can be achieved in another way. For example, she may be frightened of a spinal headache because she incorrectly thinks that it always follows a spinal and does not resolve for a month. If she understood that spinal headaches occur less frequently, resolve more quickly and even are treatable, she may then choose a spinal anesthetic for her tubal ligation.

Autonomous authorization. The informed consent process concludes with the patient intentionally authorizing the anesthesiologist to perform a specific procedure. This authorization is the expression of the patient's self-determination and therefore is the basis of informed consent.

Some mistakenly hold that the elements of informed consent can never be fully achieved: no patient can ever be fully autonomous, fully informed or fully free from pressure. This incorrect thinking arises from an unrealistic belief that informed consent must be total. Anesthesiologists should disregard this impos-

sible standard and prioritize the goal of achieving a substantial level of informed consent.

Other Issues

Same-day surgery and the preoperative evaluation clinic. Changes over the past few years have made the process of an anesthesiologist obtaining informed consent from a patient more problematic. One significant example is the growth of same-day surgery and the preoperative evaluation clinic. The anesthesiologist who performs the preoperative evaluation and obtains informed consent may not be the anesthesiologist providing anesthesia. A patient may not meet the anesthesiologist or undergo an informed consent discussion until minutes before the surgery, and a rushed atmosphere may render the process meaningless. Anesthesiologists need to be aware of these problems and take organizational, institutional and personal steps to decrease their impact on the informed consent process.

Emergency situations. The requirements for obtaining informed consent in emergency situations are less strict. Informed consent for emergency care is based on the assumption that patients want life-sustaining treatment. Anesthesiologists should provide as much information as is practical. In emergencies, anesthesiologists are for the most part expected to provide care for a patient whom they otherwise might have refused care on an elective basis.

Ethics consultation services. The process of obtaining informed consent can put the anesthesiologist in the difficult situation of recognizing that there is an ethical dilemma that he or she is unable to resolve. Institutional ethics committees and their consultation services provide experience and expertise in helping to resolve such dilemmas.

Summary. Anesthesiologists *get* informed consent; they do not *give* informed consent. By viewing informed consent through this prism, the anesthesiologist will remember that the locus of decision-making lies with the patient, and the process of obtaining informed consent is best driven by the desire to fully satisfy the patient's needs.

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Case 1

A Standard Preoperative Discussion

You are asked to provide a preoperative anesthetic evaluation for a 32-year-old man who is scheduled to have arthroscopy of the knee. He is otherwise healthy. The procedure can be performed under local anesthesia with sedation, regional anesthesia or general anesthesia.

- 1) How do you greet the patient? Do you have to tell him you are a resident?
- 2) The first thing the patient says is “I want to go to sleep for this, Doc.” Can you restrict your discussion of anesthetic options to general anesthesia?
- 3) What do you need to tell him about each technique? How do you determine what you need to tell the patient? Give specific examples of a disclosure that meets reasonable person standards for local anesthesia with sedation, regional anesthesia and general anesthesia.
- 4) If a resident wants to do an epidural (for experience), can he or she talk the patient into it? What is the difference among persuasion, manipulation and coercion?
- 5) What do you need to write down? Why? Does documenting the informed consent discussion give legal protection?
- 6) How should the interview conclude?

Case 1, Instructor's Notes

1) Patients have a right to know to whom they are talking. An introduction should not only include a name, but also the physician's service, level (e.g., resident, attending), role, and if that person will be doing the anesthesia.

2) It is not necessarily in the patient's best interest for the anesthesiologist to readily acquiesce to a possibly uninformed request. An integral part of informed consent is that the patient make a knowledgeable decision. The patient may be requesting general anesthesia because of a lack of information. For example, the orthopedic surgeon may have told the patient that general anesthesia is better. Or, this patient may have had a relative who had a bad experience with regional anesthesia. It is worth probing these experiences and explaining to the patient why this situation may be different.

3) Anesthesiologists need to forthrightly offer the advantages and disadvantages of each technique. Some patients may be more frightened of a needlestick in the back than they would of some operative discomfort, and so they may prefer a local. Others may want no pain at all. What is important is to interact with the patient so you can help him determine the best technique for himself.

4) The resident can certainly mention the advantages of the epidural (as long as the disadvantages are also presented), but the resident should in no way misrepresent these advantages and disadvantages to manipulate the patient into accepting epidural anesthesia. Patients and their caregivers may not share the same values. As such, the patient should be the one to decide which values should predominate.

5) There are several purposes for institutional requirements for informed consent:

a) It is a reminder to caregivers of the necessity to obtain informed consent (anesthesiologists should think in terms of "getting" informed consent rather than "giving" informed consent; the former puts the focus on the patient, the latter on the physician).

b) It documents that a discussion did take place and that there was an exchange of information.

c) It may prompt patients to ask questions, especially if they read a written document.

6) The interview should conclude with the patient authorizing the anesthesiologist to perform a specific anesthetic. Residents should understand that the absence of an objection is not equivalent to an authorization. Even non-verbal patients can signify authorization with hand or head motions.

Case 2

Informed Refusal: General Anesthesia for a Cataract?

A 68-year-old woman with severe chronic obstructive pulmonary disease wishes to have general anesthesia for cataract surgery. As her anesthesiologist, you feel that local anesthesia with sedation poses less risk than general anesthesia. She can lie flat comfortably for the time needed for this procedure.

- 1) Are you obligated to present the other options?
- 2) How would you present the risks of general anesthesia without manipulating her (i.e., scaring her) into accepting local anesthesia with sedation? Can you “push” the patient into accepting local anesthesia with sedation?
- 3) If the patient continues to prefer general anesthesia, must you provide it for her? Is it coercive to tell her that she may need to return on a different day for a different anesthesiologist if she desires general anesthesia?
- 4) May you give her intravenous sedation so she “calms down” and is more willing to accept local anesthesia with sedation?

Case 2, Instructor's Notes

1) Yes, you are obligated to present the other anesthetic options. In fact, part of the concept of informed refusal is the idea that a patient should have substantial knowledge about a technique before rejecting it. Therefore, it is appropriate and necessary for the anesthesiologist to educate the patient about the risks and benefits of both general anesthesia and local anesthesia with sedation; otherwise, she would not be making an informed choice. Persuasion is a justifiable technique for educating patients. Coercion is not. Properly informing this woman about options may help her consider a technique previously rejected out of misinformation. Indeed, the anesthesiologist should try to determine why the patient prefers general anesthesia and specifically address her fears while reassuring her about the safety and comfort of local anesthesia with sedation. The patient may still prefer general anesthesia for her cataract operation after the anesthesiologist has attempted to make her fully informed. This is the concept of informed refusal.

2) This is indeed a difficult question. Frightening a patient into accepting local anesthesia with sedation is neither ethically nor medically appropriate. On the other hand, the anesthesiologist has an obligation to forthrightly inform the patient. The anesthesiologist must then, in a calm manner, inform the patient factually why local anesthesia may be safer than general anesthesia. For example, the anesthesiologist could say, "I am not saying that general anesthesia is unsafe. In my opinion, however, it does give you a higher likelihood of having postoperative trouble. With your COPD, I am concerned that you might have some difficulty with your breathing after I remove the breathing tube from you. So, obviously, if I can avoid putting a breathing tube in you, I think you could avoid having complications related to a breathing tube, such as...."

3) In nonemergent circumstances, physicians are not obligated to provide care that they feel is not in their patients' best interest. This fundamentally arises from the ethical tenet "First, do no harm." But, clinicians should be reticent to make this claim and should only do so in the truest of circumstances. This right to refuse to provide care is ripe for abuse because physicians can easily use this virtuous claim as a pretense not to provide care.

4) This brings forth a distinction between the appropriate use of sedation to calm an anxious-but-willing patient and the inappropriate use of sedation to manipulate a patient's decision-making. If she desired local anesthesia with sedation, but she requests to be "fortified" with sedation, that is appropriate. Part of anesthetic care is providing anxiolysis. But sedating a competent patient in order to reverse a previous decision is wholly unethical.

Case 3

Your Informed Consent Process

Each department may have unique difficulties in the process of obtaining informed consent. Residents should evaluate their system and propose methods of improvement.

- 1) What system problems are currently present? How do these problems affect patient care and the obtaining of informed consent?
- 2) What are potential solutions?
- 3) What is production pressure? What are sources of production pressure? Does your current system reflect the impact of production pressure?
- 4) How can production pressure affect the ability and desire to enact potential solutions?

Case 3, Instructor's Notes

1) Problems may include:

- a) In the preoperative anesthetic clinic, the person obtaining informed consent does not administer the anesthetic.
 - no opportunity to develop relationship
 - inability to finalize anesthetic plans until the day of surgery
 - patient confusion over who is caregiver
- b) Obtaining informed consent the day of surgery may limit the value of the discussion.
 - no opportunity for the patient to think about anesthetic options
 - no opportunity to minimize anxiety about anesthesia
 - the requirement to obtain informed consent from a patient who may be anxious about the surgery and therefore distracted
 - pressure to rush the informed consent process to minimize delays in the operating room schedule
 - limited value of informed consent discussion (e.g., patient has already made all arrangements and the informed consent discussion has become a formality)

2) Potential solutions may include:

- a) The anesthesiologist can have a telephone discussion with the patient the night before surgery.
- b) Preoperative discussions and other care can be better coordinated for the more complex patients.

3 & 4) Production pressure is “the internal or external pressure on the anesthetist to keep the operating room schedule moving along...” (Gaba, Fish and Howard, 1994). Production pressures may cause anesthesiologists to deliberately “cut corners” or to make unintentional errors out of haste. Internal pressures include the desires to avoid delaying surgery, avoid litigation, get along with surgeons and work when fatigued. External pressures include exhortations from surgeons to proceed with cases instead of canceling them, hasten anesthetic procedures and alter usual techniques. Anesthesiologists may feel pressure from administrators

to reduce turnover time and limit the use of expensive drugs. External pressure may also come from colleagues, consultants and the patients and their families (Gaba, Howard and Jump, 1994).

“No one sets out to create a system that poses undue risks ... [n]onetheless, in the absence of frequent overt negative outcomes, safety concerns may be eroded by the other increasing pressures. We are concerned that to appear competitive, to attract patients or to negotiate agreements with surgeons and managed care organizations, both hospitals and anesthesiologists may be tempted to make excessive claims of productivity, cost efficiency and safety that cannot be met realistically. In an era of progressively greater constraints on costs of care and growing intensity of competition, there will be increased pressure to increase production at the expense of safety.” (Gaba, Howard and Jump, 1994)

Special Teaching Technique

Role-playing

Residents may better understand the informed consent process by role-playing specific problems. The resident assigned as the patient is given the scenario, and the resident assigned as the physician is given a bullet (e.g., 40-year-old male for anterior cruciate reconstruction) and conducts a preoperative interview. The other residents critique the interview at its conclusion. Another option is to have all the residents pair off in groups of four, with two residents role-playing and two residents offering suggestions back and forth.

Scenarios:

1) A healthy but belligerent 40-year-old who will be having an anterior cruciate reconstruction tells you, "I'll talk to you now, but I want an attending to do my anesthesia." You are in a teaching institution and attendings rarely if ever directly administer anesthesia care. (Consider the differences in this case if the hospital were a small community hospital or a large VA hospital, or if the surgery were more complex or even life-threatening.)

2) You are called to the emergency room to preoperatively evaluate a 90-year-old woman with acute peripheral vascular occlusion. The surgeon says she will lose her leg if they do not operate immediately. She has decided she doesn't want the procedure. However, all her family members do want her to get the procedure and have told the surgeon to proceed. The surgeon has agreed to proceed. (A third and fourth student can play a family member and surgeon, respectively.)

3) A 55-year-old ASA III for suprarenal aortic aneurysm repair does not want to hear about the anesthesia. He repeats over and over, "Do what you need to do." When you bring up an epidural for postoperative pain relief, he says, "Look, I don't care. I'd really rather watch the football game," and he turns to the television.

4) A 35-year-old woman presents for laparoscopy for infertility. She has been waiting a long time for this procedure, and it took quite a bit of juggling to make all the proper arrangements. Unfortunately, she has come down with a severe cold, including wheezing on auscultation of the lungs and a productive cough with yellow sputum. She tells you she wants to go through with the procedure "no matter what." (Consider changing the case by giving the patient a more or less severe upper respiratory infection or by varying how long the patient must wait until being able to reschedule the procedure.)

WHO SPEAKS FOR THE PATIENT?

Ethical Principles in Assessing Patient Competence and Appropriate Use of Proxy Decision-Makers in the Practice of Anesthesiology

WHY DO WE NEED PROXY DECISION-MAKING? Respect for patient autonomy requires that competent adults be allowed to determine what happens to them. In the 1960s and 1970s, concern arose that increasingly expensive and invasive medical therapies might not be accomplishing ends consistent with the personal goals and values of the patients they served. Issues of medical futility were raised with regard to certain interventions such as cardiopulmonary resuscitation, which in many medical settings had been proven essentially futile, as well as other interventions such as chemotherapy, which were perceived in some circumstances to be cruel.

Active patient participation in decisions about their medical care is paramount because of the ethical principle of respect for patient autonomy as well as the legal requirement for informed consent. When patients are unable to participate fully in the informed consent process, ethical principles and legal precedents have established that their wishes can be carried out through the actions of proxy decision-makers.

The case of Joseph Saikewicz. Joseph was a 67-year-old institutionalized man with an estimated IQ of 10 and a mental age of about two and a half years. He communicated with gestures and grunts and responded only to gestures or physical contact. He appeared disoriented in unfamiliar physical surroundings and did not appear aware of common dangers. In 1976, he was diagnosed as having acute myelogenous leukemia. In about 30 percent to 50 percent of cases of this type of leukemia, chemotherapy brought about a temporary remission, usually lasting two to 13 months. Results were poorer for those over age 60. Belchertown State School petitioned the court to appoint a guardian to make the decisions about his care and treatment. The court-appointed guardian found that Joseph's disease was incurable, that chemotherapy had significant adverse effects and discomfort, and

that the patient could not understand the treatment or its resulting pain. It was concluded that not treating Joseph "would be in his best interests." The Supreme Court of Massachusetts upheld the decision. Joseph died five months after diagnosis (Beauchamp and Childress, 1994).

The matter of Karen Ann Quinlan. In April, 1975, the then 22-year-old Karen was brought to the hospital in a coma of unexplained etiology and from which she never recovered. After several months, her parents requested that she be removed from mechanical ventilation. They did this after consultation with their church and with church support in the assertion that the ventilator constituted extraordinary support, and that to return her to her "natural state," even if it resulted in death, was morally correct. The hospital refused.

By any criteria, Karen was not brain-dead, and disconnecting her from the ventilator violated the medical ethics edict to "do no harm." The Quinlans petitioned the Superior Court of New Jersey for Karen's father to be appointed guardian for the express purpose of removing her from the ventilator. The petition was refused, and the Quinlans appealed to the State Supreme Court. The court returned a verdict in March 1976 in favor of the Quinlans. The doctors, however, refused to disconnect her from the ventilator, and after two months, Karen was weaned from the ventilator and transferred to another facility. She survived another nine years.

Paul Armstrong, attorney for the Quinlan family, based his arguments in the decision of the U.S. Supreme Court in 1965 in *Griswold v. Connecticut* (guaranteeing the right of access to contraception) and *Roe v. Wade*. Evidence was presented that the Quinlans were merely trying to carry out the actions Karen would have wanted but was no longer able to express. The doctors argued that courts have no business interfering with physicians' medical judgments.

The court decision included several interesting points. While doctors argued that medical values and judgment should be determinative, the court asserted that “judges should not be prevented from deciding matters clearly justiciable, nor preclude a re-examination by the Court as to underlying *human* values and rights.”

To the argument that judges lacked the expertise to overrule a professional decision based on prevailing medical practice and standards, the court asserted, in essence, that what doctors said in court and what they did in practice were two different things. The court questioned whether there was, indeed, an internal consistency to the decisions of doctors. The court pointed out that there was a “widening ambiguity” to the actions of physicians in not providing advanced life support or resuscitation to the hopelessly ill. The court accused doctors of using “judicious neglect” by writing “in pencil on a patient’s chart the foreboding initials DNR.” While doctors distinguished between sins of omission and sins of commission, the court found that “the thread of logic in such distinctions may be elusive to the nonmedical mind,” because the end was the same — the patient died.

Finally, the court accused doctors of being unwilling in Karen Ann Quinlan’s case to do what they did as a matter of course in other cases *because of fear of malpractice suits or criminal prosecution*. Doctors, in other words, were accused of acting out of self-interest and not in the interests of their patients. The court took as its duty to “find a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection.”

Assumptions Behind Proxy Decision-making. Historically, proxy decision-making was based on three assumptions:

- 1) That the incompetent patient’s right to refuse medical care may be exercised through a proxy decision-maker.
- 2) That, knowing the patient’s wishes, the proxy will make the decision that the incompetent patient would make if competent. The proxy decision-maker would “don the mantle,” of the patient (so-called substituted judgment).

- 3) That, in the absence of proxy decision-makers, doctors might act less out of interest for the patient than out of self-interest to avoid litigation.

The proxy decision-maker often would be a family member who would be best acquainted with the patient’s values and views of medical care and the entire life “context” of the patient. Further, the family has a unique attachment to the patient, and the family is more likely to “treat the patient as a person, rather than a symbol of a cause.” (Emanuel and Emanuel, 1992)

Objections to Proxy Decision-making.

- 1) In the absence of specific directions, the proxy decision is at best an approximation of the patient’s wishes.
- 2) The interpretation of the proxy decision-maker is subject to the biases, values and psychological agendas of the person making the decision.
- 3) Incompetent patients can be both emotional and financial burdens, and proxy decision-makers may have a potential conflict of interest that can distort their beliefs and testimony about what the patient would have wanted.
- 4) Making life or death decision for someone is psychologically stressful; surveys show that people are more hesitant to terminate care for relatives than for themselves.

Research on proxy decision-making shows that proxies and patients infrequently discuss issues and values surrounding the use and withdrawal of life-sustaining technologies. Moreover, the majority of patients say they have not discussed their preferences regarding cardiopulmonary resuscitation with a family member or physician (TABLE 1).

TABLE 1: Percents of Patients Having Prior Discussions With Families and Doctors About Life-Sustaining Interventions

Discussed with Family	Discussed with Doctors	Number of Subjects
16%	7%	70 ^a
45%	11%	75 ^b
55%	6%	152 ^c
NA	23%	119 ^d

Research indicates that family members are unreliable at assessing a patient's quality of life. Epstein found "highly significant" discrepancies between patients and proxies in the assessment of the patients' emotional health and satisfaction (Epstein and others, 1989). Finally, studies have shown that proxies cannot accurately predict patients' preferences for life-sustaining interventions (TABLE 2).

TABLE 2: Agreement Between Patient and Proxy About the Use of CPR

Patients' Medical Condition	Percent Agreement	Kappa Statistic	Number of Pairs
Currently healthy	88%	0.30	57 ^a
Dementia	68%	0.27	57 ^a
Currently healthy	90%	0.35	90 ^d
Incapacitating stroke	53%	0.08	90 ^d

Legend: a. Seckler and others, 1991; b. Gamble and others, 1991; c. Lo and others, 1985; d. Uhlmann and others, 1988.

Mechanisms for Proxy Decision-making.

1) Living will (advance directive): A competent patient's statement of his or her wishes for end-

of-life care, executed in front of qualified witnesses.

2) Durable power of attorney: A mechanism for the competent patient to designate a proxy decision-maker should the patient become incompetent. This is designed to follow the principle of substituted judgment.

3) Legal hierarchy: Most states have a hierarchy through which a legal surrogate is assigned if one has not been designated by the patient. In Washington state, for example, the hierarchy in descending order is as follows:

- Legal Guardian
- Recipient of Durable Power of Attorney
- Spouse
- Adult Children (provided that their decision is unanimous)
- Parents
- Siblings (provided that their decision is unanimous)

***We strongly suggest
that you become familiar with the law
in the state in which you practice.***

Medical Decisions Which a Surrogate May NOT Make. The laws vary from state to state, but certain therapies may **NOT** be agreed to by any surrogate and can only be carried out under court order if the patient is incompetent to consent. In Washington state, for example, psychotherapy and electroconvulsive therapy cannot be consented to by a surrogate. In Massachusetts, sterilization of a minor or mentally handicapped person requires a court order and cannot be carried out with parental consent alone.

Don't Forget the Role of the Anesthesiologist! Courts have found anesthesiologists liable for harm that comes to the patient while under anesthesia. Anesthesiologists have been held responsible if unwanted medical therapies are performed on the unconscious patient.

When Is a Patient Unable to Make Decisions About Therapy?

1) The patient is unconscious and will not regain consciousness before a medical decision must be made. Decisions involving patient competency should be weighed against the urgency of the treatment under consideration.

2) The patient is conscious but legally incompetent. If the patient is suspected to be incompetent but has not been so declared by a judge, the anesthesiologist needs to seek appropriate help to make such a determination.

3) The patient is conscious but immature. The patient may be either too young or too immature to formulate and express preferences, to understand implications of therapy and disease or to place decisions in perspective (see **Special Issues in the Care of Children**, page C-1).

Assessing Patient Competence. Situations in which patients are actually adjudged to be unable to make medical decisions for themselves are very limited, but situations in which doctors have serious concerns about the abilities of patients to make decisions are a common occurrence. Anesthesiologists are called upon to assess the capabilities of their patients to make medical decisions under suboptimal circumstances: the preoperative anesthetic assessment of a patient often takes place only moments before surgery or in a noisy and hectic environment (such as in the active throes of labor) with the physician and patient coming together as virtual, if not actual, strangers. The preoperative interaction may be further handicapped by the anxieties of the patient and physician, by the effects of preoperative medications and by impediments to communications such as language differences or physical impairments of communication. The situation may be further compounded by the urgent need for surgery. In the setting of the intensive care unit, actions such as the withdrawal of ventilator support — or even the termination of nutritional support — can lead us to ask basic questions about the moral and ethical foundations of what we do as well as about who can and should make such soul-wrenching decisions on behalf of patients who can no longer decide or express their decisions for themselves.

When questions arise about a patient's ability to make medical decisions, what can the anesthesiologist do to clarify whether the patient can act as his or her own decision-maker or whether a surrogate decision-maker should provide informed consent?

A patient can be competent to do certain tasks but not others. Different tasks require different

competencies. A patient who may be confused about what day of the week it is, for example, may nevertheless possess the skills needed to consent to medical care.

In general, tests of competency to consent to care require that the patient be able to understand the nature of the condition requiring treatment, the proposed treatment, the likely risks and benefits of the treatment, available alternative therapies and the necessity that a decision be made. The patient is not held to a level of understanding approaching expertise but should be able to understand to the degree that it affects their quality of life. Decisions made by patients in opposition to established medical advice do **NOT** constitute proof of incompetence! Decisions made in the face of unusual belief systems, if consistent, do **NOT** constitute proof of mental illness!

Mr. A, a 60-year-old man with severe peripheral vascular disease, presents for placement of a jejunostomy feeding tube because of inability to eat following a below-the-knee amputation. He has had multiple cerebrovascular accidents with right hemiparesis and expressive aphasia. Because of difficulty swallowing, he has problems with chronic aspiration and has been hospitalized multiple times for treatment of pneumonia. During the current hospital admission, he has refused medications and has "given up" trying to eat. He indicates with difficulty that he "only wants to die." He refuses to discuss anesthesia, beyond saying that he does not want surgery and wants to die. Is he competent to refuse therapy?

In studies of hospitalized patients referred to psychiatric consultation for independent evaluations of competency to give informed consent or to refuse medical therapy, patients like Mr. A were far more likely to be referred for evaluation of competence because of refusal to accept medical therapy than because of other evidence of impaired mental capacity. Refusal of therapy or diagnostic procedures or threats to leave against medical advice constituted up to 70 percent of such referrals (Weinstock and others, 1984). Yet, of patients refusing therapy who were formally evaluated, only about half were found to be incompetent. Patients were more likely to be found incompetent if they were try-

ing to terminate care against medical advice or carried the diagnosis of organic brain syndrome or chronic alcohol abuse. Patients with psychiatric diagnoses such as depression or schizophrenia, or patients who were refusing only some part of medical therapy or diagnostic procedures were unlikely to be found incompetent to make medical decisions.

Patients who agreed to therapy represented a smaller percentage of referrals for competency evaluations (17 percent versus 26 percent) than patients who refused treatment, and they were more likely, if evaluated, to be judged competent (57 percent versus 100 percent) (see **Competence** in annotated bibliography).

While this finding may reflect an actual association of consent for care with competence, the authors speculated that refusal of therapy is merely more likely to trigger suspicion by physicians that patients are incompetent, *reflecting a bias against patients who refuse medical care*. Such suspicion could represent a reflection of anger or frustration on the part of physicians struggling to care for difficult patients and also raises concerns that physicians judge the competency of patients to make decisions based on their perception of the quality of the decisions the patients make.

There are two problems with this approach. First, any judgment about the quality of patient decision-making interjects the physician's biases, personal values and perceptions about quality of life above those of the patient, effectively usurping patient autonomy. Second, such judgments entail a false assumption that all competent decisions are necessarily "good" decisions. Respect for patient autonomy requires a difficult surrender to the precept that competent patients, once informed, have a right to make their own decisions, even if they are "bad" decisions. If physicians are allowed to intervene whenever they disagree with a patient's choice, doctors will once again assume a paternal role with their patients, one that has been consistently rejected in favor of the moral as well as legal rights of patients to behave independently and determine for themselves what will be done to them.

In summary, evaluation of the need for a proxy decision-maker in a conscious patient rests in determining if the patient is able to receive and understand information necessary to make a decision about medical care. Psychiatric evaluation may be helpful when it is not obvious that the patient has the necessary skills. The patient's decision itself, whether it is to proceed with or to forego medical care, should not be the determining factor in referring a patient for psychiatric evaluation or in a finding of incompetence.

Patients with mental impairments are likely to be competent to make medical decisions, whether the impairment is dementia, mental illness or mental retardation. Characteristics associated with incompetence include chronic alcohol abuse and diagnosis of organic brain syndrome. Psychiatric diagnoses are unlikely to be associated with an inability to give informed consent or informed refusal. Finally, consent to medical care should not be taken as evidence of competence to make medical decisions in a patient who is otherwise obviously impaired.

Assessing Surrogate Competence. "Health care professionals remain moral agents, with a responsibility to safeguard the patient's interests and preferences (where known) by monitoring the quality of surrogate decision-making" (Beauchamp and Childress, 1994). Family conflicts of interest that threaten a patient's previous wishes, as well as proxy incompetence, inadequate information or emotional instability, all may disqualify even a close family member from acting as a surrogate decision-maker.

When Might Competence Be Questionable in a Conscious Patient?

Can laboring women give informed consent?

Arguments have been given that laboring women are not competent to make decisions because pain obscures their ability to hear and understand the risks and benefits of procedures. Courts have used cooperation for epidural placement in the face of pain as an indicator of the ability to set aside physical discomfort to accomplish a goal and as an implied acceptance of the procedure and risks. While it has been shown in multiple studies and settings that many patients, including laboring women, have little memory of the informed consent process, this

lack of memory to the obtaining of consent has not generally been an accepted argument that consent was not obtained. Proxy decision-makers are appropriate only when laboring women show other signs of not being competent to make decisions, such as a past history of mental incompetence, severe mental illness, obvious organic brain syndromes such as encephalopathy associated with pregnancy-induced hypertension, or unconsciousness.

Is the premedicated patient incompetent?

Premedicated patients are not automatically incompetent. A patient who is in pain, for example, may be more able to listen to a risk discussion once the pain is treated. The patient may actually *regain competency* as a result of medication. Patient competence is judged by the nature and quality of the discussion that occurs, irrespective of whether or not the patient has been given medication.

Withholding pain medication from a patient who is in acute distress for the purpose of obtaining consent is not only potentially cruel but also may coerce the patient to consent to unwanted care in order to get relief of pain. To quote Stanley Rosenbaum, Professor of Anesthesiology, Medicine and Surgery at Yale University, "Any will can be broken if you torture it long enough." Coercion "entirely compromises autonomy." (Beauchamp and Childress, 1994) Informed consent obtained under such circumstances may be suspect, both from the issues of competency and voluntariness.

Competence should be at least questioned in a somnolent patient or one who is obviously hallucinating.

Are mentally ill patients incompetent to consent?

Mentally ill patients are not incompetent to make many decisions, unless extremely incapacitated. Depression, unless incapacitating or leading to hallucinations, does not constitute incompetence. Even schizophrenia and other severe mental disorders do not automatically disqualify a patient from making a competent decision. When patients' decisions differ from those of their physicians, it is important not to make the assumption of incompetence. However, professional consultation may be needed to

separate issues of patient competency from eccentricity.

Are mentally retarded patients incompetent?

Competence is highly individual and depends less on absolute IQ than on relative maturity. A patient can have a low IQ, yet still be able to understand and express preferences for medical care.

What about demented patients? Competence can wax and wane. Patients can suffer from dementia that impairs memory, for example, but not understanding.

What about the patient with difficulties communicating?

It is important to sort out whether patients suffer from problems with understanding and reasoning or are merely impaired in their ability to express preferences. Patients who are not fluent in the language of the doctor, or are deaf or suffer from various forms of expressive aphasia are not, therefore, incompetent, even though they may have difficulty expressing themselves. Interpreters, written information and speech and rehabilitation specialists may be of help in particular circumstances. Family members and friends may have a great deal of experience in working with the patient's particular communication problem and are an important resource.

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Case 1

Refusing Care

Mr. A, a 60-year-old man with severe peripheral vascular disease, presents for placement of a jejunostomy feeding tube because of inability to eat following a below-the-knee amputation. As a result of multiple cerebrovascular accidents, he has a right hemiparesis and an expressive aphasia. Because of difficulty swallowing, he has problems with chronic aspiration and has been hospitalized multiple times for treatment of pneumonia. During the current hospital admission, he has refused medications and has “given up” trying to eat. He indicates with difficulty that he “only wants to die.” He refuses to discuss anesthesia, beyond saying that he does not want surgery and wants to die. Is he competent to refuse therapy?

1) Use a systematic approach to evaluate and discuss the clinical ethical problems presented in this case.

- a) What are the medical indications, risks, benefits and alternatives to the placement of a jejunostomy tube to provide nutrition?
- b) What are the quality of life expectations from the alternative choices?
- c) What are the patient’s preferences?
- d) Are there any contextual features that should be considered?

2) What features distinguish competent from incompetent patients? What are resources available to an anesthesiologist to aid in the evaluation of patient competency?

*This case is also designed to illustrate the four questions approach of analyzing an ethical dilemma discussed in **Implementation of an Ethics Curriculum: Getting Started**, page 1.*

Case 1, Instructor's Notes

I. The Four Questions

In order to discuss the issues in a clinical ethical problem, whether it be in the setting of a learning discussion or in the clinical setting in which the problem must actually be solved, it is important to be able to outline the features of the case in an organized and coherent fashion. Just as clinical progress notes often follow a common format, so should ethical case discussion. In clinical progress notes, we might organize our communication of the issues along a "SOAP" format: **S**ubjective (what the patient tells us), **O**bjective (what we observe in terms of behavior and physical exam), **A**ssessment (how we interpret the subjective and objective information that we have gathered) and **P**lan (what we intend to do). Jonsen has proposed a method of expressing the features of a clinical ethics case into four categories that will help us to organize and evaluate the problem (Jonsen, 1990). The four categories correspond roughly to the major principles in biomedical ethics: beneficence (the principle of doing good), nonmaleficence (the principle of avoiding harm), respect for patient autonomy (the principle that competent people can decide for themselves what will be done to them) and justice (the principle that people should be treated fairly with regard to what resources are owed to them). The four categories proposed by Jonsen can be expressed in the form of **four questions** each student should answer about the case under discussion:

1. What are the *medical indications*, risks and benefits, and alternatives of the treatment being proposed? (Illustrating the principles of beneficence and nonmaleficence from the medical point of view.)
2. What are the *quality of life* expectations from the alternative choices? (Illustrating the principles of beneficence and nonmaleficence from the point of view of the patient's values.)
3. What are the *patient's preferences*? (Illustrating the principle of respect for patient autonomy.)
4. Are there any *contextual features* that should be considered? (Illustrating consideration of the principles of justice.)

Question 1) Medical indications. The medical indications for the proposed procedure are to provide nutrition for the patient, in whom inability to eat combined with complications of attempts at oral nutrition have lead to a search for alternative methods of alimentation. Alternative methods of dealing with the nutritional issues include:

- 1) continued attempts at oral nutrition
- 2) placement of a feeding tube into the jejunum by oral or nasal route
- 3) gastrostomy
- 4) jejunostomy
- 5) hyperalimentation via central venous access

Each has advantages and disadvantages. Continued attempts to use the oral route of nutrition had failed and had the disadvantage of predisposing to the complication of aspiration in this patient. Oral feeding involves "hard work" on the part of the patient, which may be exhausting and discouraging, contributing to depression and the patient's desire to "give up." Feeding tubes by oral or nasal routes have some physical discomfort associated with them and may carry the complication of nasal erosion. In addition, they are visible, and as such may present unacceptable characteristics to patients. Gastrostomy or jejunostomy (with or without feeding tubes) have the disadvantage of being invasive, requiring a surgical procedure with potential complications of anesthesia and surgery, however unlikely they might be. But alimentation is simplified, utilizes the patient's GI tract for nutrition and may be more aesthetic to the patient than a nasogastric tube. Hyperalimentation requires central venous access, with potential complications, and more specialized care in the use of nutritional materials. In addition, nutritional supplies are expensive.

Question 2) Quality of life. Some aspects of the patient's quality of life may improve with better nutritional access. Better access may decrease the number of episodes of aspiration and subsequent hospitalizations for I.V. antibiotics. Better nutrition may provide more energy, ability to fight infection and ability to respond to physical therapy. The patient may feel less depressed and hopeless. Improved nutrition is almost certain to

improve this patient's sense of physical well-being and to promote improved survival. Failure to provide adequate nutrition is likely to contribute to the patient's inability to fight infection, lack of energy, listlessness and depression.

Prolongation of this patient's life may or may not be a net benefit to the patient, depending on how he views his potential "best case scenario." It is possible that this patient's functional level is so poor that he sees prolongation of his life as unwanted further suffering.

Question 3) Patient preferences. The patient states that he does not want surgery and wants to die. The right of a competent adult to make such a decision is supported by both ethical principles respecting autonomy and legal precedents stating that "every person of adult years and sound mind has the right to determine what shall be done to them." (Schoendorff v. New York Hospital)

When considering patient statements of their preferences, we have an obligation to patients to facilitate and support their ability to make independent and unencumbered decisions. Is this patient's ability to decide affected by correctable encumbrances? One example of an encumbrance is inadequate information: has the patient had a reasonable opportunity to hear the advantages and disadvantages to the proposed treatment? One study showed that doctors were far less likely to try to discuss end-of-life decisions directly with the patient if the patient was felt to suffer from mental impairment (Uhlmann and others, 1988). Many patients with mild forms of mental impairment are perfectly capable of participating in medical decisions.

Another potential encumbrance for this patient is a physical impairment in the ability to express himself. Patients with expressive aphasia often suffer from some receptive aphasia as well. Are there ways in which we can better determine whether the patient is being given an adequate opportunity to understand and then express his wishes? Is the patient suffering from dementia or other organic brain problems that might call into question his competence to make decisions? Finally, is the patient depressed, and if so, is depression preventing him from making an un-

encumbered decision? The mere presence of depression itself does **NOT** imply incompetence.

What other resources can we use to evaluate the ability of this patient to make decisions? We can ask experts, such as rehabilitation specialists, to help us evaluate the patient's ability to understand options and express decisions. Psychiatric evaluation may help clarify the extent of depression and whether or not it impairs decision-making. Family and friends may be able to tell us if the decision to forego care is consistent with past decisions and whether it is in general agreement with the philosophical context of the patient's life. A primary care doctor may be able to tell us if he or she has had discussions in the past with the patient about care and what the patient's approach has been. A review of past medical records may reveal a previous expression of the patient's wishes regarding medical care and support toward the end of life. In short, many resources exist to help us determine if the patient's decision appears autonomous and consistent with past decisions.

Question 4) Contextual features. Contextual features can include any features that might influence the "flavor" of the case.

Legal aspects of such a case may influence a physician's decision. As the court suspected in the case of Karen Ann Quinlan, doctors do in fact base some decisions on fear of litigation and self-interest. It is important to note that self-interest is not an ethical principle and cannot be used to ethically justify an act.

Are medical resources being used fairly? Should expensive care be allotted to a patient who does not wish to live under these conditions?

Are family members exerting influence? Family members may, out of a sense of guilt or helplessness, exert pressure to ignore a patient's wishes to be allowed to die. Alternatively, family members may suffer from conscious or unconscious motivations to support a death-wish.

Are the physicians and other caregivers subject to subconscious motives? Physicians who are overly reluctant to accept a patient's decision may be imposing their own values and anxieties

on the patient, including fear of professional failure. Physicians who are overly anxious to accept the patient's decision without determining that it is unencumbered may be responding to suffering that they themselves experience in caring for an ungrateful patient.

Do financial considerations have undue weight in the patient's decision? If the patient is afraid of impoverishing family resources, they may be pressured to relinquish medical options.

Many kinds of "outside" influences may appropriately or inappropriately affect the way in which we respond to a patient's wishes.

II. Case Development

Once the initial outline of the case has been carried out, we can now "develop" the case to include specific educational points. Using the syllabus as a resource for answers, a model case development might include the following questions:

Is Mr. A competent to refuse therapy?

- 1) Are there features of the case presentation that suggest problems with Mr. A's competency?
- 2) What evidence in the case presentation do you have to support his competency?
- 3) What are the features of "competency?"
- 4) What does Mr. A's refusal of medical care indicate about his competency?
- 5) Suppose, instead of multiple cerebrovascular accidents, Mr. A suffered from schizophrenia? Is he more or less likely to be found competent by an expert consultant?

Mr. A's wife appears tearful and confused about the medical issues. She is unwilling to sign a consent form for the surgery, saying that she does not want to go "against" her husband's wishes. His daughter, on the other hand, insists that surgery proceed and, at the request of the surgeon, has signed a consent form. The surgeon reports to you that he or she has obtained a valid consent for the procedure and demands that you proceed.

- 1) Is the daughter's consent legally valid?
- 2) What is the legal order of surrogacy in your state?
- 3) What is the likelihood that Mrs. A has had a direct discussion of these care issues with Mr. A?

You decide not to proceed until the issues are clarified, and you request a competency evaluation for the patient. The consultant returns the opinion that the patient is probably not competent, based on the presence of severe impairment from organic brain disease and both receptive and expressive aphasia. The daughter insists that surgery proceed, and the wife still refuses to sign the consent. Both present conflicting perspectives on "what the patient would want." The surgeon wonders why you are holding up the surgery, since you now know the patient is likely incompetent and the surgeon has a signed consent from a surrogate. What should you do?

It is not uncommon for family members to be in conflict with one another about what should be done in an incompetent patient's medical care. Resources to remember include family counseling, the hospital ethics advisory committee and even the court system, which may go so far as to appoint a guardian ad litem to determine the patient's best interests.

The rest of the story...

This case represents a real scenario from clinical practice. The case was halted until a competency evaluation could take place. In fact, problems with communication proved to be the major obstruction to discussion with the patient. With patience and some help from rehabilitation specialists, the patient ultimately agreed to have surgery. His depression has improved.

Case 2

A Change of Surgical Plans

Mrs. C, a 28-year-old Chinese woman who immigrated to the United States at age 25, presents for laparotomy and lysis of adhesions for intermittent pelvic pain. She is otherwise healthy. During preoperative discussion, her language skills appear more than adequate to understand the procedure, risks and potential benefits. Her husband has accompanied her to the hospital, but did not come to the surgery holding area. Her surgeon is native Chinese and is known to take care of many members of the local Asian community. He is being assisted in the surgery by another gynecologist.

During laparotomy, one severely adhered fallopian tube is damaged during attempts to remove the adhesions and is removed. The other fallopian tube appears severely scarred from previous infection. In addition, the patient is found to have several large uterine fibroids. The gynecologist announces his intention to proceed with hysterectomy, on the assumption that the fibroids are the cause of the patient's pain and that she is likely infertile anyway.

You inform the surgeon that he does not have consent for hysterectomy and that you object to proceeding, since it does not represent an emergency at this time. You would like the patient to give informed consent. Failing to convince you that his patients "are Chinese and will abide by his best decision, since culturally they rely on their doctors to choose," he then scrubs out, announcing his intention to procure the husband's consent.

Should you accept a surrogate consent for this procedure?

- 1) Use a systematic approach to evaluate and discuss the clinical ethical problems presented in this case.
 - a) What are the medical indications, risks, benefits and alternatives to laparotomy for diagnosis and relief of chronic pelvic pain? What are the medical indications, risks, benefits and alternatives to hysterectomy?
 - b) What are the quality of life expectations from the alternative choices?
 - c) What are the patient's preferences?
 - d) Are there any contextual features that should be considered?
- 2) What is the appropriate use of surrogate consent?
- 3) Under what circumstances is it inappropriate?
- 4) What are the anesthesiologist's obligations in acting on behalf of the unconscious patient?

Case 2, Instructor's Notes

I. The Four Questions

Question 1) Medical indications. Medical indications for the original surgery include diagnosis and relief of chronic pelvic pain. Alternative therapies include no therapy (there is no indication that any life or health-threatening process is in play), conservative antibiotic and/or hormonal therapy, with attendant risks of drug reactions, side effects and expense, and other surgical approaches such as laparoscopy with similar risks and benefits to mini-laparotomy.

Medical indications for hysterectomy are for relief of pelvic pain. But the risks-to-benefits ratio is different than that of simple lysis of adhesions. Hysterectomy will result in infertility for this patient, who may not have been informed of this potential result. While severe fallopian tube scarring makes traditional conception unlikely in this woman, she still has options, which include in vitro fertilization, and could still potentially bear children if her uterus is not removed. Alternatives to hysterectomy include hormonal therapy or myomectomy with preservation of the uterus.

Question 2) Quality of Life. Relief of pelvic pain may have far-reaching effects in the patient's life. We don't know, for example, what effect chronic pelvic pain has had in her marriage: chronic illness, sexual dysfunction and/or infertility may have resulted and may, in turn, be magnified by cultural expectations. Her ability to work inside or outside the home may be impaired, and her perception of her quality of life may be poor. Relief of pain may play an important role in her family life as well as in her own physical comfort.

Question 3) Patient Preferences. We know that the patient has agreed to surgery for the diagnosis and relief of pain. What we do not know is whether she would be willing to give up the possibility of having children if she knew the alternatives to hysterectomy

Question 4) Contextual Features. Strong cultural bias permeates this case, but in ways that are hard to assess without the patient's input. The gynecologist's assertion that he can speak for the patient may reflect true cultural norms,

but without talking to the patient, we cannot be sure. The husband may also traditionally be able to speak for his wife, but without having the patient's input, we would be guessing. Fertility is important in many Asian cultures, but might not override the choices of specific couples.

Legal precedents suggest that the patient should be informed about the procedure and asked for her consent, unless the emergent nature of the intervention precludes such a discussion. The patient faces no such emergency, but would face the inconvenience of another surgery and the potential complications of a second procedure and anesthetic.

There are strong influences against interrupting the flow of patient care in the operating room environment, which include inconveniencing operating room personnel, the surgeon, the anesthesiologist and the patient. Marked pressure is likely to be exerted to proceed if the surgeon deems it "necessary" to proceed at this time.

II. Case Development

At the heart of this case is the question, "Should you accept a surrogate consent for this procedure?"

When do you need surrogate consent? When medical therapy is needed and the patient is unable to give consent, surrogate consent can be sought. Patients are unable to give consent when they are too immature (as in the case of many minor children), when they are incompetent or when they are unconscious. But is surrogate consent always appropriate?

Instead of uterine fibroids, the surgeon discovers a large, walled-off abscess in the pelvic gutter, which originates from a large rectal perforation. Resection of this part of the rectum will require a colostomy. The surgeon consults a colorectal colleague, who agrees that the surgery is needed and that rupture of the abscess could result in widespread pelvic and abdominal contamination, infection and, potentially, death. The consultant strongly recommends proceeding with emergent surgery at this

time. Is surrogate consent appropriate in this case? While surrogate consent can be sought for unconscious patients, the appropriateness of obtaining surrogate consent for the purpose of medical therapy depends on several factors. How urgent is the need for treatment? How likely is it that the patient can regain consciousness or competency in time to both give consent and benefit from the proposed procedure? Obviously, the more elective the procedure, the more time can and should be allowed to permit patients to decide for themselves.

The ethical principle at stake is respect for patient autonomy. Surrogate consent is at best an approximation of the patient's wishes and, at worst, an expression of the wishes of the surrogate and not of the patient. Studies show that surrogates often do not know what patients would want, and their judgments correlate poorly with those of patients. Since surrogate consent is imperfect, we should try whenever possible to obtain the patient's consent directly.

In the case of the patient with uterine fibroids, postponing definitive surgery until the patient can hear about the risks and benefits is not likely to reduce the benefit she would receive from hysterectomy if she decided to proceed. In the case of the patient with a potentially life-threatening abscess, postponement of treatment may lead to the patient's death. In the interest of benefiting the patient medically while still respecting her autonomy, it seems appropriate to ask for surrogate consent in the latter case, but not in the former.

The surgeon returns after a discussion with the husband, in which the husband has consented for hysterectomy. Should you proceed? Ethical principles behind obtaining consent demand that we support the patient's ability to be informed and to decide what will be done to them. Surrogate consent is no different in principle and is an appropriate substitute for the patient's consent only when the principle of respect for patient autonomy cannot be carried out in a safe manner without it. Since informed consent can be obtained from this patient if we allow her the time to regain consciousness, principles for respect for her autonomy require us to do our best to facilitate her return to consciousness.

Despite your objection, the surgeon leaves to scrub in order to proceed with hysterectomy. Is there anything you should do? Anesthesiologists have been held legally liable for injuries done to patients while under general anesthesia. In legal principles, the anesthesiologist is responsible for removing from the patient the ability to protect themselves and, therefore, assumes responsibility to protect the patient from unwanted intrusions. Ethically, anesthesiologists have the same obligations that all physicians carry: to see that the competent patient's wishes about his or her care are carried out.

In a practical vein, it is useful to be aware of the resources present in the operating room when medical, ethical or legal disputes arise. You can request that the surgery be stopped and not aided by nursing staff, until nursing and medical administrators, an ethics advisory committee or hospital legal counsel can be consulted.

The rest of the story...

This case is taken from actual practice. The gynecologist left the room to obtain consent, at which point the first assistant expressed his own reluctance to proceed under these circumstances and gratitude to the anesthesiologist for objecting. The husband refused to give consent, and surgery was halted. The patient stated on the following day that she wanted the surgery to relieve pain "so that she could bear children." She stated unequivocally that she would have brought suit if the surgeon had performed a hysterectomy.

Special Teaching Method

Expanded Use of Case Scenarios

Case-based learning discussions are effective tools for using “real-life” scenarios to illustrate specific teaching points. The use of real cases emphasizes to residents and faculty the reality that ethical problems are common in clinical practice and are virtually certain to arise in the course of “normal” anesthesia care. While faculty and residents become familiar with the “four questions” case discussion format and the flow of case-based learning, the use of a single case illustration is simple and provides “linear” flow that is easy to understand. A single case limits participation to some degree, however, and participation is key to inspiring interest in residents and faculty about the approach and solution to ethical problems.

In addition, an important goal of case-based teaching should be the development of oral presentation skills among residents: clear, concise, knowledgeable and respectful communication can be an important determinant in whether a difficult ethical problem is approached in a constructive or confrontational manner. As Shafer (1995) so aptly pointed out, language and metaphor do not just reflect our understanding of anesthesia practice, they shape the way we think about it. Constructive and compassionate language skills can help to shape compassionate and constructive practices.

One highly interactive way to use case-based discussions is to find related scenarios that illustrate different points set forth in the learning goals for the discussion. Instead of one case, each of several cases is developed by a separate resident “assigned group,” and then presented orally to the entire lecture group for discussion.

An example learning session is described in **When Should I Listen to the Patient?** (see B-17), which is based on true case scenarios.

When Should I Listen to the Patient?

Is a surrogate decision-maker always appropriate in urgent medical situations?

Goals for Residents:

- 1) To utilize a systematic approach to the evaluation and discussion of clinical ethical problems by outlining the four major aspects of each case.
 - a) medical indications
 - b) quality of life
 - c) patient preferences
 - d) contextual features
- 2) To communicate clearly and concisely the issues in each case, together with an assessment and a proposed course of action for each scenario.
- 3) To review ethical principles supporting the use of surrogate decision-makers and the appropriate circumstances in which they should be used.
- 4) To learn which features may help in deciding whether a patient is competent to consent to or to refuse medical care in an urgent situation.
 - a) review the features of competence
 - b) summarize resources available to suggest whether a patient can make certain medical decisions
 - c) develop a list of resources that may be of help in determining competence in urgent clinical situations

The Lecture Plan:

In this lesson, four case scenarios with similar features will be used to illustrate points relevant to the teaching goals set forth in the case. Case preparation ahead of time is necessary, and teaching materials are distributed at least one week in advance to the residents.

The resident group is divided into four “teams,” each of which will be responsible for the development of a case to be presented on the lecture day. Each resident is provided with the following materials:

- 1) The names of the residents on their “team.”
- 2) Their own case scenario only (four case scenarios are included below for the teacher).
- 3) The teaching goals of the session.
- 4) A letter of expectations for each resident (see B-18).
- 5) The references used in case development should be supplied so that the resident will spend time working on case development and not on trips to the library.

On lecture day, each resident group presents its findings on the case they were assigned (try to keep each case presentation to 10 minutes). The remaining portion of the lecture time is spent in general discussion of features that distinguish the cases and a summary of the teaching goals.

Note: This type of teaching session requires a tight schedule!

The short cases are designed so that half the page (the Short Case side) can be photocopied and distributed initially and the whole page can be distributed later if desired. Following all four short cases is one page (B-23) with instructor’s notes.

Sample Letter

Expectations for Residents

Our discussion of clinical ethical topics on Wednesday will concern the use of surrogate consent for procedures. We will be discussing several recent cases in which questions arose about a patient's refusal of anesthesia services in an urgent medical situation. For the purpose of discussion, you are being asked to work with several other residents to discuss (briefly) one of these cases. All of the materials you need are included in this packet.

On Wednesday, your resident "team" will be asked to present the enclosed case to the rest of the group. Each member of your team should take responsibility for a brief (1-2 minute) presentation of the group's findings in one or more of the following categories:

- 1) What are the medical indications and risks for the intubation?
- 2) What are the quality of life issues in the case?
- 3) What are the patient's preferences, including evidence that supports or questions the patient's ability to make the decision?
- 4) Is there a surrogate decision-maker involved? If so, who is it, and is that person an appropriate person to make the decision? What "outside influences" may affect their ability to decide?
- 5) If there is no surrogate, should there be one? If so, who would be appropriate and why?
- 6) What are the contextual features of the case not covered in the above questions?
- 7) You are the anesthesiologist in the scenario! What would you do? Why?

Short Case 1

You are the on-call anesthesia resident in a large teaching hospital. You are called at 3 a.m. for a “stat” intubation in the ICU. When you arrive, you find an 80-year-old woman, sitting bolt upright in bed, in obvious respiratory distress. Vital signs are stable, respiratory rate is 40. The patient suffers from inoperable esophageal carcinoma that has eroded into the trachea. Her respiratory distress has been increasing throughout the night, and in the past hour, her oxygenation has been worsening. The medicine resident insists that you intubate the patient immediately. When you approach the bedside and start to explain to the patient what you are about to do, she tells you that she has cancer and does not want to be intubated. The medicine resident points to the patient’s most recent arterial blood gas, with a PaO_2 of 53 on 75% FIO_2 , and a PaCO_2 of 72, and states that the patient has “carbon dioxide narcosis, hypoxemia, and is incompetent to make this decision.” The resident demands that you intubate the patient. Is the patient incompetent? What would you do?

The rest of the story...

Despite growing demands from the medicine resident to intubate the patient, the anesthesia resident reviewed the chart and discovered the rest of the blood gas. Questioning the medicine resident’s assessment of the patient’s decompensation, particularly in light of the patient’s clarity of communication despite her distress, the anesthesia resident contacted his own attending, who in turn contacted the intensive care attending most familiar with the case (in this case, not the on-call attending). The medicine attending revealed that, while no decision had been reached, the patient had, indeed, expressed doubts in the past about desiring intubation. The patient had no family with which to discuss the issues. After communicating again with the patient, intubation was avoided, comfort measures instituted to relieve respiratory distress, and the patient died approximately 12 hours later.

Short Case 2

You are called to the emergency room to intubate a somnolent patient with respiratory decompensation. On arrival, you find a 42-year-old woman who suffers from severe pulmonary fibrosis and pulmonary hypertension. She is somnolent, with arterial blood gases that show pH 7.28, PaCO₂ 72, PaO₂ 49 and HCO₃ 26. When you approach the bedside and tell her that you are there to “place a breathing tube,” she says one word between breaths: “No.” The ER doctor requests that you intubate her over her objection, and he hardly needs to point out the blood gas, the patient’s mental status and her obvious physical distress, since your inclination is to proceed with intubation. But should you? Can you quickly produce any other information to support your inclination?

The rest of the story...

This patient was well-known to the medical center, if not to this particular ER doctor. The anesthesia resident inquired about the patient’s family, to discover that the patient’s husband was en route and expected in the next half hour. The chart had not been reviewed, largely because it consisted of four volumes and was more than eight inches thick, but a quick look at the chart revealed that while there was no previous advance directive, the pulmonologist had documented a recent discussion in clinic about the issues of intubation, in which the patient expressed doubts about wanting intubation. The blood gas indicated acute respiratory decompensation, and the patient’s mental status raised questions about her competence. A call was put out to the patient’s primary pulmonologist, and the anesthesia resident, with the support of his attending, reassured the patient, who was by now nearly unconscious, and began assisted mask ventilation in the hope that the patient’s doctor would call. Preparations were under way to intubate, when the patient’s husband arrived and stated unequivocally that the patient had decided to refuse intubation after her discussion with the pulmonologist earlier. He refused surrogate consent for intubation. Comfort measures were instituted, and the patient was transferred to a hospital bed. The pulmonologist was reached and confirmed the husband’s assertions. The patient died two hours later without regaining consciousness.

Short Case 3

You are called to the emergency room to intubate an 80-year-old woman with known COPD who has just been brought in by ambulance. She is unconscious, her respiratory rate is 40, and she appears cyanotic. ABGs on 100% mask reveal pH 7.21, PaCO₂ 75, PaO₂ 45, and HCO₃ 26. She has been hospitalized multiple times. On her last hospitalization two weeks ago, a “do-not-resuscitate” order was entered into the patient’s record at the insistence of both her and her husband. The husband is en route.

The rest of the story...

In this case, the acuteness of the clinical situation overwhelmed both the anesthesia resident and attending, who asked the advanced ethics question, “Why not intubate in the emergent situation because the patient can always be extubated later if appropriate?” In this acute emergent situation, neither the resident nor attending could think of an ethically compelling reason not to intubate. While this is not an “incorrect” decision, they were about to discover the “downside” of this approach when the husband arrived. He was beside himself when he discovered that his wife had been intubated. He did not understand the doctors’ decision, since information in the chart made it clear what the patient’s wishes were. He perceived the intubation as cruel and invasive, and disrespectful to his wife’s wishes to die a death with “dignity.” It was extremely painful for him to now be faced with the responsibility of telling his wife’s caregivers to “take the tube out,” and he ultimately expressed feelings of guilt and a sense of direct responsibility for her death. The endotracheal tube was removed in the ER, and she died 30 minutes later.

Short Case 4

An 84-year-old woman with a long-standing history of COPD presents to the ER with severe respiratory distress. ABGs on 100% face mask shows pH 7.25, PaCO₂ 68, PaO₂ 49, and HCO₃ 28. The patient is awake and appears alert, but distressed. When you explain that you are going to intubate her, she insists that she does not want to be intubated but refuses to give a reason. Review of her chart fails to disclose any prior DNR or do-not-intubate order, and she has been intubated before. There is no advance directive. She has no family. What should you do?

The rest of the story...

In this case, the patient was expressing a wish inconsistent with past medical experience with her. There is evidence that her respiratory decompensation was acute, and elevated PaCO₂ might be impairing her judgment. While patients can certainly “change their minds” about medical care, the best evidence we have in an acute situation like this is past behavior. While no one in the ER was familiar with the patient, her pulmonologist was available and had a long-standing relationship with the patient. Her pulmonologist expressed puzzlement about the patient’s refusal and came to the ER to see the patient. The patient expressed immediate relief upon seeing a familiar face. When her doctor suggested that “a breathing tube might help,” the patient readily agreed to intubation. She was suffering from acute pneumonia, and after intubation and IV antibiotics, she was extubated and ultimately discharged home.

Short Cases, Instructor's Notes

Short Case 1

In this case, other ABG values included a pH of 7.32, and HCO₃ of 36. Is this an “acute” decompensation, as presented? Is the patient likely to be suffering from carbon dioxide “narcosis?” Does the patient’s interaction suggest “narcosis?” Does she understand the implications of her situation and decision? Does an on-call medicine resident necessarily have the best information about this patient? To whom can you turn to get “better information?” Is there someone we should be rousing from sleep who is more familiar with the patient? Is there any evidence in the chart that this patient has previously expressed the desire not to be intubated? Or to not undertake any other means to prolong life?

Short Case 2

Who is behaving as the patient’s surrogate in this case? Can you think of a more appropriate surrogate than the doctor? Where is the patient’s family? What is the patient’s history? She has known severe pulmonary disease and is not a candidate for lung transplant. Is it possible that intubation as an intervention has been discussed before? Do we know if she has an advance directive? Does the chart indicate a past desire not to be intubated? Can you think of anyone else who might help us here?

Short Case 3

What issues should induce us to proceed with intubation in this patient? Who, or what, is acting as the patient’s surrogate in this case? Is the surrogate appropriate?

Advanced ethics question: Why not intubate in the emergent situation, since you can always extubate later if it turns out to be the wrong decision?

Short Case 4

What evidence do we have that this patient’s decision-making capacity might be impaired? How can we clarify whether she is competent? Is the evidence to suggest that her refusal today is inconsistent with past behavior? Is there anyone else we can call upon for more information?

INFORMED CONSENT: SPECIAL ISSUES IN THE CARE OF CHILDREN

DISCUSSIONS ON INFORMED CONSENT always begin by pointing out the sea of change that has occurred over the past 40 years in medical decision-making. Earlier generations of physicians made decisions for patients based upon the physicians' perception of the patients' best interests, often with little involvement from the patients themselves. Physicians did not regard this behavior as unethical; indeed, they felt that it would be unethical to place too much of the burden of decision-making upon the patient and family. Consistent with this approach, patients and families were also often "protected" from the harsh realities of unfavorable diagnoses and prognoses.

One of the defining features of the 1960s, however, was a rebellion from authority and a renewed emphasis upon the rights and freedoms of the individual. From the civil rights movement to student protests to consumer activism, citizens demanded greater involvement and control in decisions that affected them. The patient-physician relationship was not immune from this revolution, and the pursuit of patient autonomy became a defining issue for the bioethics movement.

Philosophically, the foundations for this new approach to the patient-physician relationship could be found in liberal political theory, and its emphasis upon individual rights and freedoms. From the classical works of John Stuart Mill and Immanuel Kant, through the more modern philosophy of John Rawls, priority is given to supporting the autonomy of individuals. This philosophical stance has been reflected in the law. Beginning with the Salgo case in 1957 and progressing through Canterbury in 1972 (see **Introduction to Informed Consent**), the courts have steadily moved away from allowing physicians the right to decide for their patients and toward the view that the locus of decision-making authority must reside with the patient.

There is a long history in pediatrics of new technologies and ideas being developed in the world of adult medicine and then filtering down

to the care of younger patients. This has been true not only in the realm of medicine, but also in the area of ethics. And, just as we have learned that some medications or treatments do not work as well in children as they do in adults, so have we learned that some ethical principles do not work as well in pediatrics as in the rest of medicine. Such is the case with informed consent.

In retrospect, this should not be surprising, since the entire theory of informed consent is based upon the concept of patient autonomy. As the term is used in the philosophical sense, autonomous action requires a very high level of functioning. According to the standards of Kant, for example, many otherwise typical adults would have difficulty qualifying for the label of "autonomous." If this is a high standard for adults, then it is insurmountable for most children. In other words, the very foundations of informed consent are based upon standards that are simply inapplicable in most of pediatrics.

Of course, the same problem is also common among adult patients, since many of them are too ill to participate in their own decision-making to any meaningful extent. Nevertheless, the concept of autonomy can still be applied in these cases, since it is only necessary to determine what the patient *would have wanted* if only he or she were capable of autonomous functioning. In other words, in these circumstances, the task is to find a surrogate decision-maker who knows the patient well and who can use the principle of **substituted judgment** to make the decision that the patient would have made if he or she were competent. In this way, the foundational reliance upon the principle of autonomy is maintained.

Unfortunately, this philosophical maneuver is generally not available to pediatricians, since young children have never attained a degree of function that would qualify them as autonomous. It is therefore impossible to say what decision they would make if they were autonomous, since they have never achieved that

state or condition. Any discussion of substituted judgment in this situation is a purely fictional activity based only in fantasy. In other words, the attempt to develop a theory of informed consent in pediatrics that is based upon the principles developed for competent adults has been a complete failure and has probably done more to confuse the issues rather than to clarify them.

Best Interests Standard. In an attempt to bridge this theoretical gulf, judges and ethicists have turned to the concept of **best interests** to guide decision-making for children and other individuals who have never achieved an autonomous state. This standard is explicitly *not* based upon a respect for the child's autonomy, but is rather an *objective* standard designed to aim at what is best for the child overall. Since it is an objective standard, the decisions that are chosen for a child on this basis should be independent of the decision-maker. In other words, this standard presupposes that there is a single "best" decision for the child and that this decision should be the same regardless of whether it is the parents, the caregivers or the state empowered with making the decision.

Of course, in actual practice, it is never this easy. In any interesting case, it is usually quite difficult to determine what is in the child's best interests, and reasonable people will disagree. We are therefore left with the practical problem of deciding how decisions should be made for children. And the answer, of course, not only with medical decisions but with decisions in virtually every facet of life, is to give the parents authority over decision-making for their children.

It is important to realize, however, that this is not the case because we believe that parents "own" their children. Whereas adults may have the absolute right to forego necessary repairs on their automobiles, they do not have the right to forego necessary care for their children. Again, decision-making for children is based upon the child's best interests, and parents have been chosen as the decision-makers in most cases for the practical reasons that 1) *someone* has to be designated to determine what is in the child's best interests, and 2) there is no reason to think (in most cases) that anyone is *better* qualified than the child's parents.

As an aside, some have argued that the choice of parents as decision-makers for their children is not as arbitrary as implied here. For example, we know that children are likely to adopt at least some of the values and beliefs of their parents as they grow into adults. This implies that the decisions made by the child's parents are, perhaps, likely to be the same decisions that the child would have made if the child were old enough to have formed his or her own values and beliefs. In addition, some argue that parents should be given more weight than others in decision-making because they must bear the consequences of the decisions. For example, if a decision is made to discontinue life-support on a child when the prognosis is poor, the parents are the ones who must live with the grief and perhaps guilt of that decision. On the other hand, if the decision is made to continue with life-support and the child survives, the parents are the ones who may need to assume responsibility for caring for a multiply handicapped child. For both of these reasons, therefore, some have argued that the priority given to parents in decision-making is more than just a choice of convenience.

Nevertheless, the fundamental responsibility of parents is to make choices for their children based upon their perception of the child's best interest. For the reasons outlined, we defer to the parents' determination of the child's best interest, unless it falls outside of a range that society deems to be "reasonable." We can think of the acceptable range of treatment choices as falling along a continuum, with a lower bound defined by unacceptable *undertreatment* of the child, and an upper bound defined by unacceptable *overtreatment* of the child.

A Case of Undertreatment: Baby Doe. How is the acceptable range of choices defined and determined? Not surprisingly, the answer to this is complex and is best illustrated by examples. Perhaps the best case study illustrating undertreatment is the 1982 case of Baby Doe. Baby Doe was born in Bloomington, Indiana, with Down Syndrome and a tracheoesophageal fistula. Based upon their assessment of the child's future, the parents elected not to proceed with surgery, and the baby died of dehydration. At that time, a clear consensus did not exist about the permissible spectrum of treatment for children with Down Syndrome. As the case became public, however, a consensus developed that nontreatment of children with Down Syndrome on the basis of their disability was outside the range of acceptable options. This conclusion was legally and politically enforced through enactment of the so-called Baby Doe Law, more formally known as the 1984 Amendments to the Child Abuse Prevention and Treatment Act. As a result of these ethical, legal and political discussions, children with Down Syndrome now receive treatment for correctable surgical conditions, regardless of the views of the parents.

A Case of Overtreatment: Baby L. The other end of the spectrum has proven even more difficult to define. A well-known example of presumed overtreatment occurred at Children's Hospital in Boston in 1987, and has come to be known as the case of Baby L. This involved a 2-year-old girl with severe birth asphyxia and a history of repeated aspiration pneumonias and cardiorespiratory arrests. Her neurological functioning was at the level of a newborn. During an admission for treatment of yet another aspiration pneumonia, her condition deteriorated and she developed the need for mechanical ventilation. In light of her clinical condition, the director of the intensive care unit felt that this potential escalation of care would be inappropriate and refused authorization to admit her to the ICU. Baby L's mother, on the other hand, insisted that her child's life be sustained by any means available. As discussion of the case moved from the hospital's ethics committee to the courts, a physician at another institution was located who was willing to provide care in accordance with the mother's wishes, and the child was transferred to a different facility.

Since this case, there have been several others where physicians have tried to refuse to provide care they believed to be futile but which was demanded by parents. With rare exception, courts have not been sympathetic to this assessment by physicians, and in most cases the child has continued to be treated against the judgment of the clinicians.

The problem of overtreatment has continued to be a serious and unresolved issue. In response to this problem, a number of hospitals have developed "futility" policies. At least two states have adopted legislation regarding futile care, several medical societies have written guidelines on futility, and the American Medical Association has appointed a task force to address the issue of futile and inappropriate treatment. A better understanding of the "upper bound" of the spectrum of acceptable choices by parent decision-makers must therefore await the outcome of these efforts to define "overtreatment."

Determining Best Interests. In the meantime, what guidelines should be used, by parents or others, in attempting to determine a child's best interest? An excellent framework for deliberating about this issue was outlined by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in their 1983 publication titled, *Deciding to Forego Life-extending Treatment*. They proposed five considerations by which to assess a child's best interests:

1) The amount of suffering and the potential for relief

- 2) The severity of dysfunction and the potential for restoration of function
- 3) The expected duration of life
- 4) The potential for personal satisfaction and enjoyment of life
- 5) The possibility of developing a capacity for self-determination

In addition, in an adaptation of work produced by that Commission, ethicist Christine Mitchell has proposed a table for evaluating the different assessments of parents and caregivers regarding a child's best interests (see TABLE).

TABLE: Resolving Conflicts Between Surrogates and Clinicians

<i>MEDICAL OPINION</i>	<i>SURROGATE EVALUATION</i>		
	"Worth a Try"	"Don't Know"	"Not Worth It"
Standard Treatment	Treat	Treat	Do Not Treat/ Optional Review
Uncertainty	Trial of Treatment	Trial of Treatment	No Treatment
Highly Unlikely to Work	Trial or Transfer	Permissive No Treatment with Review	No Treatment
No Medical Benefit	Treatment and Review/ No Treatment and Review	No Treatment	No Treatment
Won't Work	No Treatment and Review	No Treatment	No Treatment

To summarize up to this point, the task of determining a child's best interests is generally the responsibility of the child's parents, unless their assessment falls outside of a range held acceptable by society (as expressed through legislation and the courts). Therefore, while the process of obtaining "informed consent" from parents for treatment of their children is superficially very similar to the process of obtaining informed consent from an autonomous adult, the rationale behind the process is radically different. For this reason, the Committee on Bioethics of the American Academy of Pediatrics (1995) recently wrote:

"We now realize that the doctrine of "informed consent" has only limited *direct* application in pediatrics. Only **patients** who have appropriate decisional capacity and legal empowerment can give **informed consent** to medical care. In all other situations, parents or other surrogates provide **informed permission** for diagnosis and treatment of children with the **assent** of the child whenever appropriate."(emphasis in original)

Reconciling Law and Ethics: Competence and Decision-Making Capacity. In addition to the problems outlined above, informed consent in pediatrics is also complicated by differences between the requirements of law and the principles of ethics. As noted above, informed consent (in the legal sense) can only be given by someone who is competent (in the legal sense). In other words, informed consent is legally valid only for patients who have reached the age of legal majority (either 18 or 21 years, depending upon the jurisdiction).

For this reason, the President's Commission (referred to above) pointed out a very important distinction between *competence* and *decision-making capacity*. Competence, the Commission noted, is a legal term. Only a judge can decide that an individual is incompetent. With regard to medical decision-making, however, the question that matters most is not whether the patient is legally competent, but whether the patient has decision-making capacity. Furthermore, whereas competence is an "all or none" phenomena,

decision-making capacity exists on a spectrum. This spectrum is defined by two dimensions, or axes. On one axis is the developmental maturity of the patient; on the other is the consequences of the decision. On this theory, a 10-year-old may have sufficient decisional capacity to decide whether to undergo cosmetic surgery, whereas the child would not have sufficient capacity to decide whether to undergo a potentially life-saving appendectomy. Therefore, the preferences of the 10-year-old child should be given great weight in the former situation and little weight in the latter. While one could argue, from an ethical perspective, that some 20-year-olds do not have sufficient decisional capacity to refuse potentially life-saving therapy, anyone over the age of majority must be presumed to have decisional capacity unless there is very strong evidence to the contrary.

Emancipated minor status. Reconciliation of the legal requirements of informed consent with the ethical requirement to respect decisional capacity is often difficult. From a legal perspective, two approaches have been adopted in the law to bring these two into closer agreement. First, all states recognize some form of emancipated minor status. An emancipated minor has the same rights in making health care decisions as an individual who has reached the age of majority. Three categories of emancipation are recognized: 1) court-ordered emancipation (e.g., teenagers living apart from their parents who petition the court to be treated as though they have reached legal majority); 2) statutorily defined emancipation (e.g., married minors or minors who are parents); or 3) medical emancipation (e.g., minors seeking treatment for a specific medical condition such as a sexually transmitted disease).

Mature minor doctrine. The other approach, utilized in some jurisdictions, is the mature minor doctrine. This is more limited in scope than emancipation statutes and recognizes that, in many instances, minors may have sufficient maturity to make important decisions for themselves. Rather than affecting the global status of the individual, mature minor statutes are generally invoked for empowering minors to make particular decisions.

Assent for Pediatric Patients. The American Academy of Pediatrics has been even more progressive than the law in emphasizing the importance of involving children in decision-making to the fullest extent of their capacity. As noted previously, the Academy's Committee on Bioethics (1995) has promoted much more extensive use of the concept of *assent*. The Committee noted that assent should include at least the following elements

- 1) Helping the patient achieve a developmentally appropriate awareness of the nature of his or her condition.
- 2) Telling the patient what he or she can expect with tests and treatment(s).
- 3) Making a clinical assessment of the patient's understanding of the situation and the factors influencing how he or she is responding (including whether there is inappropriate pressure to accept testing or therapy).
- 4) Soliciting an expression of the patient's willingness to accept the proposed care. Regarding this final point, "... no one should solicit a patient's views without intending to weigh them seriously. In situations in which the patient will have to receive medical care despite his or her objection, the patient should be told that fact and should not be deceived."

The Committee noted that, as they develop, children "should become the primary guardians of personal health and the primary partners in medical decision-making, assuming responsibility from their parents." In emphasizing the importance of this being an interactive process, the Committee made clear that it was not recommending the development of new bureaucratic mechanisms, such as the use of "assent forms." Nevertheless, the Committee's endorsement of the concepts of parental permission and assent suggest changes in our approach to decision-making for children that are nothing short of radical.

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Case 1

The Child of a Jehovah's Witness

A 7-year-old presents for resection of an abdominal tumor. The neoplasm is quite vascular, and extensive blood loss is anticipated. In the preoperative waiting area, the child's parents notify you that they are Jehovah's Witnesses and that they will not give permission for their child to receive blood or blood products.

- 1) What should you discuss with the family?
- 2) Would the situation be different if the patient were 17 years old? Why?
- 3) Should a court order for blood administration be obtained preoperatively? How would you accomplish this in your hospital?
- 4) What should be included in the documentation for informed consent for the anesthetic and surgery?

Case 1, Instructor's Notes

This is a “bread and butter” case for the pediatric anesthesiologist, and everyone who practices in the field should be very clear about how to handle cases like this. Unfortunately, many anesthesiologists have been taught that Jehovah's Witnesses have the right to refuse blood transfusions, without learning the exceptions to this rule. While it is true that virtually any competent adult has the right to refuse even life-saving medical treatments, there are some exceptions. For example, some judges have ordered the mothers of small children to be transfused against their will, on the view that the mother does not have the right to abandon her children by refusing a life-saving treatment. In addition, legally incompetent minors are also excluded from the general rule, on the grounds that the refusal of blood by the parents is not congruent with the child's best interests.

As discussed above, however, there are inconsistencies between the law and ethics of informed consent. While the law holds that any unemancipated minor is legally incompetent, ethics would focus primarily upon the decisional capacity of the child. If, for example, the patient were a mature 17-year-old who was deeply committed to the beliefs of his/her religion, then the ethically “right” approach would be to honor the patient's refusal. This would be acceptable from a legal perspective, however, only if a judge made an exception based upon the mature minor doctrine.

At a practical level, how should the anesthesiologist proceed? The following is an outline of the process at the Children's Hospital in Boston (the correct procedure at other hospitals may vary, depending upon the opinions of the hospital's administration and legal counsel). When caring for any non-emancipated minor, the anesthesiologist needs to inform the patient's parents that, in the event that blood or blood products would be life-saving, a court order will be sought to administer these agents. This communication must be clearly documented in the chart. Since giving permission for the administration of blood products is contrary to the tenets of their faith, it is not necessary for the parents to give written consent for the administration of blood products. Nevertheless, they

should understand that a court order will be sought if they decide to proceed with surgery and the administration of blood products becomes potentially life-saving.

If more than minimal blood loss is anticipated, should a court order for blood administration be obtained prospectively? The answer to this depends upon the local circumstances. In many cases, hospital legal counsel will have a relationship with the local judiciary such that a court order can be obtained very quickly. In this case, especially when the need for a life-saving transfusion is relatively unlikely, it is probably not necessary to obtain a prospective order. On the other hand, if there is a chance that the judge involved will not be familiar with the case law surrounding Jehovah's Witness patients, then waiting until the blood is needed could be a mistake. In any case, based upon the strong legal precedent for giving blood in these situations, no child should be allowed to die because of parental refusal to consent for the administration of blood products.

Against this background, however, anesthesiologists should make every effort to administer an anesthetic in accord with the parents' religious beliefs. This means that the anesthesiologist should be skilled in all of the techniques that are currently available to minimize the need for transfusions, including hemodilution, cell-saver technology and even hormonal therapy to stimulate the production of red blood cells. Jehovah's Witnesses vary in exactly which techniques they will accept (for example, there is controversy within the membership over whether cell saver techniques or the administration of albumin is acceptable), so the anesthesiologist should explore with the family the exact requirements of their beliefs. Again, however, while making all reasonable accommodation to avoid the need for a transfusion, no child of Jehovah's Witness parents should die for lack of transfused blood without the physicians seeking a court order to administer the blood against the parents' wishes.

Case 2

A Teenager Refuses Care

A 16-year-old presents to the preoperative waiting area for spinal fusion surgery. She is healthy except for progressive idiopathic scoliosis. Her parents have taken her to see an orthopedic surgeon, who recommended and scheduled surgery. While awaiting surgery over the past several weeks, she has become quite anxious. Her parents have repeatedly insisted, however, that she undergo this operation in order to prevent the cosmetic and physiologic abnormalities that will develop unless progression is halted. In the preoperative waiting area, she is visibly upset. She refuses to allow insertion of an intravenous catheter, and she refuses to leave the waiting area and enter the operating room. When you ask her why she is refusing the surgery, she bases her decision upon a fear of needles and the thought of “being cut.” At this time, you believe that the only way to induce anesthesia would be to forcibly hold her down and administer an IM or IV sedative like ketamine.

- 1) How should you proceed? What options do you have?
- 2) Should she be forcibly subdued?
- 3) Is it relevant that she is refusing surgery because she is afraid of needles and of “being cut?” What if she were refusing surgery out of a fear of death or intraoperative awareness?
- 4) What principles influence how you should proceed?

Case 2, Instructor's Notes

This is a difficult case, and there are few right answers. The only definite recommendation is that this adolescent should not be forcibly subdued, either physically or with sedatives, at this time. The case is not urgent, and the surgery should be deferred. This will allow time to involve other consultants (adolescent medicine specialists, psychiatrists, etc.) and to formulate a plan for the future.

Hopefully, this young woman can be persuaded to undergo the procedure willingly. If her reluctance is based primarily upon acute anxiety in the preoperative holding area, then she may benefit from a sedative like oral diazepam before coming to the hospital on her next visit. If the care team can be convinced that she is definitely committed to undergoing the surgery but is simply unable to control her emotions in the immediate preoperative period, then it may be possible to make a contract with her so that she understands that she will be forcibly restrained and sedated on the next occasion if she is unable to control herself. In this way, her more fundamental request (to undergo surgery) will be honored, even though her immediate request (to leave the hospital) will be overridden.

A more difficult question will arise if she persists in her refusal of surgery. This refusal is even further complicated by the "immature" reasons given for her refusal (fear of needles and of "being cut"). To see the matter more clearly, if she were five years younger, there would be little question about the appropriateness of proceeding against her will, while if she were 25 years older, overriding her refusal could be legal grounds for a charge of battery against the physicians. This is, therefore, a difficult decision that should be made only after extensive involvement from her primary and consulting physicians as well as her parents. The ultimate question is whether the benefits of the spinal surgery are sufficiently large and sufficiently probable to offset the potentially substantial harm of forcing her into surgery against her will. As noted in the text above, everyone involved should clearly understand that the choice is not "the parents' decision." The relevant question concerns what decision is in her best interest. While the parents can

provide very helpful information toward answering this question, their views are certainly not determinative.

Case 3

The Privacy of Teenagers

Recently, a 16-year-old young woman underwent elective surgery in your hospital. Several days later, she experienced a miscarriage. The Chief of Staff of the hospital demanded that the anesthesia department adopt a policy requiring all females of childbearing age to have a pregnancy test prior to any anesthetic or surgery.

- 1) What kind of policy would you create?
- 2) How would it be implemented?
- 3) What problems would you anticipate?

Case 3, Instructor's Notes

Anesthetic agents may pose risks to pregnant woman. As described in the case, many hospitals therefore require a pregnancy test on any woman of childbearing age who needs anesthesia and surgery. From the discussions above, it should be apparent that policies of this type may create difficult dilemmas in the pediatric population.

The problems arise if the adolescent female does not want her parents to know that she is pregnant. In addition, in many states, adolescents have the legal right to keep this information private from their parents. When there is a policy to routinely do a urine test for pregnancy on all women of childbearing age, the anesthesiologist can be placed in an ethical and legal bind.

For example, if a pregnancy test is routinely sent on all adolescent females, then the result will be important to the decision about whether or not to go ahead with surgery. If the anesthesiologist believes the case should be postponed, and if the adolescent refuses to allow her parents to know the results of the pregnancy test, then the anesthesiologist may be in the awkward position of telling the patient's parents that the case is canceled without being able to tell them why.

Fortunately, this difficult conundrum is almost always avoidable by immediately involving pediatricians, gynecologists and social workers with expertise in adolescent issues, since they will usually convince the adolescent that the best course of action is for the patient to inform her parents of the test results and to work together in dealing with the pregnancy. Nevertheless, there is still the possibility that the adolescent will refuse to disclose this information to her parents.

Finally, an approach used by some institutions is to notify the adolescent before the day of surgery that routine pregnancy testing will be done preoperatively and that this information will be used to determine whether or not to proceed with elective surgery. This prenotification will allow adolescents who suspect they may be pregnant and who want to keep this information private the opportunity to deal with the situation in other ways, and not be unexpectedly confronted with the information on the day of surgery.

Special Teaching Method

In most teaching hospitals, anesthesiologists interact primarily with a child's parents in obtaining consent for anesthesia. According to the principles discussed here, however, anesthesiologists should involve children in decision-making to the fullest extent of their capacity.

As an exercise, anesthesia residents should make a conscious effort for a week to "push the envelope" of involving children in the discussions about anesthesia and the process of informed consent. While it is certainly important for the anesthesiologist to remain appropriate and not to overstep the bounds of reasonable expectations by the child and the family, this exercise will almost certainly reveal that children are generally much more capable of participating in these discussions than we typically realize.

After a week or so, the trainees should get together again and discuss their experiences with consciously testing the limits of pediatric involvement in decision-making. Hopefully, the insights gained from this experiential exercise will lead to long-term changes in understanding and behavior.

INFORMED CONSENT FOR JEHOVAH'S WITNESSES

IMAGINE YOURSELF AS AN ANESTHESIOLOGIST on the old time TV show "Password," and the phrase that appeared on your screen was Jehovah's Witness. There can be little doubt what the response in this word association game would be: refuses blood transfusion. While practicing anesthesiologists are well aware that members of the Jehovah's Witness faith routinely refuse blood transfusion in the perioperative setting, it behooves us to have a clear understanding of not only this religious sect's beliefs, but also the legal, ethical and medical implications of entering into the care of a Jehovah's Witness. In this regard, a number of important issues need to be addressed so that a practicing anesthesiologist can be knowledgeable in obtaining proper informed consent for the Jehovah's Witness in the perioperative period.

The Origin of the Religious Beliefs of Jehovah's Witnesses. It is imperative to recognize that the Jehovah's Witness religion is a fundamentalist Christian sect whose orthodoxy believes that eternal salvation is forfeited upon receiving a blood transfusion. The official church opinion appeared in the Watchtower in 1945 and was based on numerous biblical passages in both the Old and New Testaments describing the so-called "blood sin." It is important to emphasize that to Jehovah's Witnesses, the sanctity of blood is central to their faith and must be acknowledged and respected by anesthesiologists who are providing care.

Reviewing some of these biblical passages may help provide insight into this religious sect. Biblical references show not only that a Jehovah's Witness should not "take" blood, but also that the punishment is "being cut off from his people" (the loss of eternal life).

Every moving thing that liveth shall be meat for you; even as the green herb have I given you all things. But flesh with the life thereof, which is the blood thereof, shall ye not eat. (Genesis 9:3, 4)

Moreover, ye shall eat no manner of blood, whether it be of fowl or of beast

in any of your dwellings. Whatsoever soul it be that eatest any manner of blood, even that should shall be cut off from his people. (Leviticus 7:26, 27)

Indeed, to the Jehovah's Witness, the Bible states that transfusion is prohibited even in emergency situations. This passage refers to starving soldiers who have eaten forbidden food.

Behold the people sin against the Lord, in that they eat with the blood. (I Samuel 14:33)

Once a foundation for religious understanding has been laid, other topics related to transfusion can be considered. This includes component therapy, hormonal therapy, autologous blood transfusion, intraoperative blood conservation techniques and organ transplantation. Obtaining copies of the Watchtower and their numerous publications regarding the sanctity of blood is helpful and can provide further insight into the patient's religion.

Legal Considerations. At this time, all law regarding the care of the Jehovah's Witness is case rather than statutory law, and therefore each state may have different rulings about the care of these patients. It may be important, therefore, to review those particular cases for the state in which the anesthesiologist practices. Different cases may be reviewed within the context of the law and include the competent adult with no dependents undergoing an elective procedure, the competent adult with no dependents in the emergency situation, the competent adult with dependents, the incompetent patient in the emergency setting, the pregnant patient and minors in both the emergency and elective situations. As a gross generalization, competent, nonpregnant adults who are not sole providers may refuse blood products. On the other hand, the courts have had a tendency to intervene in favor of transfusions for patients who are parturients, minors, sole providers and other adults who are in emergency situations and unable to communicate or have not provided an advance directive. This is based in part on the idea that refusing life-sustaining treatment requires clear enunciation. As part of the

informed consent process, it is important to review the advance medical directive/release that is often provided by the Jehovah's Witness to the anesthesiologist. (See Appendix).

Ethical Considerations. The principle of respect for autonomy holds that patients have a right to follow a "self-chosen plan." Physicians have an obligation to support that right. In this situation, the patient's right would be to determine whether to receive transfusions. On the other hand, particularly when a minor is involved, physicians have an obligation to respect the principle of beneficence or the requirement to promote that which is good. This principle can be interpreted as requiring the physician to give life-sustaining blood. Finally, the state has a paternalistic interest in preventing "suicide" and in ensuring that minors have an adult to care for them. This comes to the forefront with situations involving parturients, sole caregivers and minors.

It is obvious from a review of the legal cases cited that the principles of either respect for autonomy or beneficence enter into every case decision. The reader should determine what his or her state's rights and interests are in regard to the care of the Jehovah's Witness patient and how they balance with the individual patient's rights.

Providing Care. It is important to take into account the personal, moral and ethical beliefs of the anesthesiologist who is caring for the Jehovah's Witness patient. While the concept may be a difficult one for the novice to grasp, by entering into a covenant with a Jehovah's Witness patient, the anesthesiologist accepts the patient's belief that receiving a transfusion will prevent him or her from achieving eternal salvation. *In the eyes of Jehovah's Witnesses, physicians who allow them to die rather than receive blood transfusions practice the principle of beneficence and, in so doing, pay the ultimate respect to their religion. Each anesthesiologist needs to consider whether the constraints imposed by the Jehovah's Witness patient is acceptable to his or her ethical, moral and personal standards.* If an anesthesiologist can not agree to a patient's desires, the anesthesiologist has both the right and obligation to withdraw from that patient's care. The anesthesiologist

should then attempt to find a substitute caregiver.

Medical Alternatives to Blood Transfusions. While the discussion centers on informed consent for the Jehovah's Witness patient, this cannot be properly entertained without a clear understanding of the medical alternatives to transfusion. As in any religion it should be pointed out that there are reform and orthodox viewpoints and, therefore, each patient may make individual choices that differ from others of their same religion. The TABLE below outlines techniques and therapies that can be offered in the perioperative period to either conserve or prevent blood loss.

TABLE. Perioperative Techniques and Therapies Acceptable to Jehovah's Witnesses

TECHNIQUE / THERAPY
Hypotensive anesthesia
Crystalloid solution
Induced hypothermia
Synthetic colloid solutions
Continuous arterial blood gas monitoring
Dextran
In-line blood reservoirs
Desmopressin
Microchemistry blood analysis
Iron
Extracorporeal circulation* (nonblood-primed)
Perfluorocarbons
Cell-saver systems
Erythropoietin*
Hemodilution*
Human albumin*

**Potentially unacceptable to many Jehovah's Witnesses and therefore best discussed with the individual patient.*

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Case, Part 1

A Jehovah's Witness "Needs" Blood

A 52-year-old female presents for a same-day admission abdominal hysterectomy. She has been followed for a number of years by her gynecologist who recognizes that she is a Jehovah's Witness. Her past medical history is only pertinent for anemia attributed to her uterine leiomyomas for which she has been referred to an internist for preoperative iron supplementation. As an outpatient, her hemoglobin levels range between 10-10.5 g/dl. A dictated preoperative history and physical by the gynecologist is present on the chart that documents the patient's religion as a Jehovah's Witness. On the day of admission, however, neither the patient nor the gynecologist inform the anesthesiologist performing the preoperative history and physical of the patient's religious beliefs. The hospital consent form does not discuss the possible need for intraoperative transfusion. The anesthesiologist directly involved in her case is also unaware of her prior verbal refusal of blood transfusion. During the course of the general anesthetic, she loses 1500 cc of blood acutely. Despite normal hemodynamics, the surgeon requests the patient receive 2 units of packed red blood cells. The anesthesiologist agrees to transfuse. The remainder of the case proceeds without further complications. On postoperative day one, the patient and her husband are astonished and dismayed at the revelation that she has been transfused. An eventual malpractice lawsuit is filed.

- 1) What is your understanding of the Jehovah's Witness' objection to blood transfusion?
- 2) Is there a consensus of legal opinion regarding the rights of this competent patient?
- 3) Are there situations in which the patient's rights are outweighed by the rights or interests of others (e.g., the physicians, hospital or state)? If so, how would these pertain to this case?
- 4) Who is ultimately responsible for directing intraoperative transfusion: the surgeon or the anesthesiologist? What if the surgeon was to convey to the anesthesiologist the patient's religious objection but still insisted on the transfusion?
- 5) Who then is responsible for obtaining consent for transfusion?
- 6) If a patient does not sign a written consent, are the patient's religious objections considered null and void?
- 7) If the patient were a known Jehovah's Witness, what course should the anesthesiologist take in caring for this patient in the preoperative setting?
- 8) Is the anesthesiologist obliged to deliver care in this case? What about in an emergency case?
- 9) What were the medical alternatives to transfusion in this case?

Case, Part 1, Instructor's Notes

1) The objection to blood transfusions is based on the biblical interpretation that accepting a blood transfusion will cause them to forfeit eternal salvation. How does the fact that this objection arises from religious beliefs affect its weight?

2) Care of the Jehovah's Witness is based on case law rather than statutory law. While the courts have some responsibility to consider previous case law, distinctions in cases may cause different legal outcomes.

3) Situations in which the patient's rights conflict and may be outweighed by the rights and interests of others center on situations in which a third party is affected. These include parturients, sole providers and minors.

4 & 5) This is a complex issue that includes other substantive concerns such as patient-anesthesiologist relationship and the role of the consultant. Neither provider necessarily has overriding decision-making authority. Once the anesthesiologist obtains informed consent from the patient and agrees not to give a transfusion, the anesthesiologist is honor-bound to fulfill that promise. If the anesthesiologist first hears about the patient's religious beliefs during the anesthetic, he or she must try to ascertain if there is a viable written directive from that patient. In the absence of that directive and direct conversation with the patient, the anesthesiologist should probably transfuse. Of course, the anesthesiologist would have been better off to have ascertained the patient's preferences about transfusion therapy before the operation. Participants of this case discussion should consider which cases anesthesiologists should obtain informed consent for blood transfusion and what information should be provided.

6) A signed consent is desirable because it can clearly define the patient's preferences and provide support in discussions with other caregivers if the patient is unable to communicate (e.g., under general anesthesia). A signed consent also provides legal support. Lack of a signed consent, however, does not make the patient's transfusion preferences null and void.

An anesthesiologist can base refusal of therapy on a thorough discussion with the patient (although documentation of the discussion is preferred, even without the patient's signature).

7) The anesthesiologist should clarify and agree to the patient's preferences, ensure that the surgeon was aware of and amenable to the patient's desires and use perioperative alternatives to blood transfusions.

8) An anesthesiologist is not obligated to provide care in the nonemergent situation, but he or she should make attempts to find alternate care. In emergency cases, the anesthesiologist should provide care until arrangements for a replacement can be made.

9) See the TABLE (page D-2) and the article by Benson KT. *Anesth Analg*. 1989; 69:647-656.

Case, Part 2

A Question of Law

During the evidentiary proceedings, the surgeon and patient admit during deposition that neither had informed the anesthesiologist of the patient's religious beliefs, and a written refusal of transfusion form was never signed. Nonetheless, the anesthesiologist is named in the lawsuit and is also cited for having transfused the patient despite normal heart rate and blood pressure.

- 1) Is lack of knowledge regarding this patient's religious objection to transfusion, despite a pre-operative written surgical history recognizing her as a Jehovah's Witness, sufficient evidence of the anesthesiologist's innocence?
- 2) Should the relative lack of medical need for transfusion be allowed into evidence as part of the malpractice proceeding?
- 3) Are there grounds for filing battery charges against the physicians involved?

Case, Part 2, Instructor's Notes

1-4) These are questions for an individual court to decide, and as noted, these matters are based on case law so there are no definable statutes upon which to base this discussion. Whether an anesthesiologist needs to discuss blood transfusions with a patient preoperatively depends in part on the likelihood of the patient needing a transfusion. Perhaps the anesthesiologist should have broached the issue preoperatively as part of sound medical care; however, whether this conversation is required as "standard of care" remains debatable.

If the anesthesiologist were truly unaware of the patient's objection to blood transfusion, then he or she would not be held accountable for administering blood, as no clear-cut verbal or written directive was provided. In the event that a directive to withhold blood transfusion was specified, then the anesthesiologist was obligated not to transfuse. However, in this situation, one has to consider whether the transfusion was medically indicated. If the transfusion was not medically indicated, then the anesthesiologist may be held liable for not practicing the standard of care for blood transfusion in any patient.

The fact that the patient is a Jehovah's Witness may or may not be relevant in any ensuing damages awarded. Legally, however, the plaintiff's attorney would have to show that damages occurred due to the transfusion.

Special Teaching Method

Mock Trial

A mock trial may be an educational and entertaining way to examine the complexity and reasoning of the case law for Jehovah's Witnesses. It is quite possible that original decisions may be overturned by the mock appellate court.

Suggested situations and cases:

- 1) The competent adult who has no dependents and is in an emergency situation

In re Estate of Brooks, 205 N.E., 2d. 435, (1965). The court ruled that transfusing without the patient's consent was in violation of her constitutional rights.

John F. Kennedy Memorial Hospital v. Heston, 279 A.2d 670, (1971). The court ruled in favor of the state's interest to sustain life.

- 2) The competent adult who has dependents and is in an emergency situation

In re President and Directors of Georgetown College, Inc., 331 F.2d 1000 D.C.cir., (1964). The court authorized transfusions to the mother of a 7-month-old child.

Holmes v. Silver Cross Hospital of Joliet, Illinois, 340 F.Supp. 125, (1972). The court ruled that the patient's civil rights were violated when the patient (a father of one) was transfused with blood following a motor vehicle accident.

- 3) The pregnant adult

In the matter of the Application of Jamaica Hospital, 491 N.Y.2d. 898, (1985). The court appointed a conservator to be able to transfuse a pregnant Jehovah's Witness in case she hemorrhaged from her esophageal varices.

- 4) The minor patient

Sampson v. Taylor, 29 N.Y.2d. 900 (1972). The court ruled to permit transfusions for a 15-year-old boy's elective operation to repair significant facial disfigurement secondary to neurofibromatosis.

In re E.G., 58 U.S.L.W. 2321, (1989). The court ruled that a 17-year-old patient was a "mature minor" and therefore capable of refusing transfusions as part of the therapy to achieve remission of leukemia.

APPENDIX I

ADVANCE MEDICAL DIRECTIVE/RELEASE

I, _____, make this advance directive as a formal statement of my wishes. These instructions reflect my resolute decision.

I direct that no blood transfusions (whole blood, red cells, white cells, platelets, or blood plasma) be given to me under any circumstances, even if physicians deem such necessary to preserve my life or health. I will accept nonblood volume expanders (such as dextran, saline or Ringer's solution, or hetastarch) and other nonblood management.

This legal directive is an exercise of my right to accept or to refuse medical treatment in accord with my deeply held values and convictions. I am one of Jehovah's Witnesses, and I make this directive out of obedience to commands in the Bible, such as: "Keep abstaining ... from blood." (Acts 15:28, 29). This is, and has been, my unwavering religious stand for _____ years. I am _____ years old.

I also know that there are various dangers associated with blood transfusions. So I have decided to avoid such dangers and, instead, to accept whatever risks may seem to be involved in my choice of alternative nonblood management.

I release physicians, anesthesiologists, and hospitals and their personnel from liability for any damages that might be caused by my refusal of blood, despite their otherwise competent care.

I authorize the person(s) named on the reverse to see that my instructions set forth in this directive are upheld and to answer any questions about my absolute refusal of blood.

Signature _____

Date _____

Address _____

Telephone _____

Witness _____

Witness _____

HOSPICE CARE: LIVE ALL THE DAYS OF YOUR LIFE

— AN INTERVIEW WITH PERRY G. FINE, M.D.

WE SAT DOWN WITH PERRY G. FINE, M.D., TO discuss hospice. An anesthesiologist, Dr. Fine is the medical director for VistaCare Hospice, the second largest hospice care company in the United States. VistaCare cares for more than 2,000 patients in more than 15 states. **Hospice is the skillful application of care by an interdisciplinary team of caregivers to bring the patient and family through the dying process.** Hospice professionals focus on reducing pain and symptoms by providing medical, emotional, psychological and spiritual care to the patient, and assisting the family in coping with their impending loss and their grief afterward. Hospice care is palliative rather than curative, with an emphasis on pain and symptom control, so that a person may live the last days of life fully, with dignity and comfort, at home or in a home-like setting.

* * * * *

What is the goal of hospice?

To optimize the time remaining. That's it, it is that simple. Everything we do is toward that goal. Hospice's values are neither to postpone nor hasten death, which is, in a way, antithetical to the conventional medicine view of "we will make you better." In fact, in some senses, hospice is a backlash against the overemphasis of curative care in conventional medicine.

"Optimizing the time remaining" is obviously a personal thing, but for the most part, it centers on reconnecting patients with the sense of life. The desire to stay alive comes from the relationships we form. People lose this powerful desire when they are isolated, alone. **People choose to die out of despair.** Hospice reconnects them to the sense of life by creating an environment for relationships. By aggressively managing comfort issues, the patient is more able to focus on engagement. Hospice provides a place for the relationship to occur and helps the patients and loved ones achieve these relationships. Hospice workers are specially trained to help patients manage issues like guilt over the life they lead ... or didn't lead.

How does hospice work?

Hospice works by the team approach. It includes nurses, social workers, pastoral care, licensed vocational nurses and volunteers, all of whom are trained in psychosocial issues and the value of understanding other people's values. Volunteers may be old or young, rich or poor, with the common characteristic that they are people who care. Of particular interest to anesthesiologists is the role of the medical director. The medical director oversees all aspects of patient care. He or she must have an interest and expertise in palliative medicine and a philosophy of care consistent with hospice. About 50 percent are internists or family practice doctors, and 20-30 percent are oncologists and neurologists. Very few are anesthesiologists, which is unfortunate, because anesthesiologists are ideally suited to being hospice directors.

The philosophy of choosing care in hospice is simple: Will this intervention improve the quality of the patient's life? **Will it provide comfort?** Medical directors need to use common sense in management. We don't order a lab test unless we need that information to decide about an intervention that provides comfort. As you can guess, we order very few labs. We also use therapies differently. For example, if a patient feels fatigued, we will use a trial of red blood cell transfusion, without even checking the hemoglobin. The benefit-burden ratio changes — the patient has little to lose and a lot to gain. If the quality of life improves, go with it.

"The current patient care delivery system is deficient in regard to the care of the terminally ill. Expertise in pain management is often not available to patients, and comprehensive and enduring care is the exception. We are concerned about providing overly aggressive, unwarranted care, while care that is optimally suited to the dying person's needs is often not available in our health care system or is not covered by insurance."

American Medical Association, 1996

HOSPICE FACTS*

The Hospice Patient

- Approximately 450,000 patients were served by hospice in the U.S. in 1996
- 60 percent suffered from cancer; 10 percent suffered from cardiovascular disease or pulmonary disease and Alzheimer's disease; 4 percent of the patients had AIDS
- 67 percent were 65 years of age or older; 32 percent were adults under 65; and 1 percent were 17 or younger children
- 52 percent of patients were male, 48 percent female

The Hospice Caregiver

- Approximately 70,000 people from all walks of life volunteer with hospice programs, providing more than 5 million hours of direct care and services annually.
- Hospice programs employ more than 25,000 paid professionals, made up of physicians, nurses, social workers, administrators, home health aides, therapists, clergy and bereavement specialists.
- There are approximately 3,200 operational or planned hospice programs in all 50 states, the District of Columbia and Puerto Rico. In the 1990s, annual growth of new hospices has averaged around 8 percent. In the past five years, growth has averaged nearly 17 percent.

The Remuneration

- It was not until 1996 that the Health Care Financing Administration (HCFA) approved a diagnostic code for palliative care.
- Only 3 percent of the Medicare entitlement for hospice services is utilized.

1996 Information

*Source: National Hospice Organization

How do you manage pain?

Don't put the cart ahead of the horse. Before you can effectively treat pain, you have to get the patient to trust you, to tell you about their pain, discomfort and fear.

Ask about pain and discomfort *early, regularly* and *systematically*. Use a protocolized recurrent assessment of pain, depression and anxiety, and a wide-ranging use of therapies such as biofeedback, hypnosis, stimulants and consultant availability.

Believe the patient and family in their reports of pain and what relieves it. By the time the patient gets to hospice, they have usually received suboptimal pain control. Make them believe that you care about their comfort needs and that you can treat it, and that the patient can complain to you and that you believe them.

Choose pain control options appropriate for the patient, family and setting. Provide comfort care and treat nonpain symptoms. Major symptoms such as depression, anxiety, pruritus are, for the most part, undertreated. Chronic pain can lead to depression and the desire to commit suicide.

Deliver interventions in a timely, logical and coordinated fashion. Do not underdose. Dose by the clock and around the clock for continuous pain problems. Look for and treat breakthrough pain. Regular doses limit reoccurrence of pain and the need to use pain as a signal for medication. Patients receiving this type of treatment are more able to maintain a therapeutic drug level in the body, and they do not have to worry about "bothering" the caregiver to get them medications.

Empower patients and their families. Enable them to control their course to the greatest extent possible. Always respond immediately. If you don't, patients will not feel safe in your ability or willingness to treat pain rapidly and aggressively. Emphasize that pain is not necessary. Patients tend to think that pain is inevitable, so they are too easily satisfied with their care and do not seek better pain control.

Why is pain undertreated?

Pain is undertreated because:

- Patients, families and caregivers are afraid of side effects.
- Individuals are intimidated by the health care system leading them to be passive or timid.
- Complaining or certain types of treatment may conflict with cultural norms and beliefs.
- It is believed by patients, families and caregivers that the pain is inevitable or untreatable.
- Physicians are either not good or not aggressive at treating pain. In the landmark Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), close to half of the patients had treatable pain that was out of control in the days before death.
- Pain is purely subjective. Some people may express great emotion regardless of physical basis of pain, while others may appear comfortable even with a significant pain-inducing experience. Caregivers must be instructed to assess and believe a patient's pain complaint.

Pain is the fifth vital sign.

The two most common types of pain are **persistent (or continuous) pain** and **breakthrough pain**. Persistent pain lasts around the clock and is best treated with long-acting analgesics. There are three types of breakthrough pain. **Incident breakthrough pain** is event-related (e.g., movement, weight-bearing, toileting). These pains should be treated prophylactically prior to the activity whenever possible. **Spontaneous breakthrough pain** just happens. It is usually of a neuropathic etiology and unrelated to any provoking activity or event. Spontaneous pain should be treated by available doses of quick-acting, short-lived analgesics and use of so-called adjunct drugs (tricyclic antidepressants, antiepileptics, local anesthetics, corticosteroids, etc.) in order to prevent or reduce the frequency or intensity of neuropathic pain. The third type of breakthrough pain is **end-of-dose failure**. End-of-dose failure results from an overly long dosing interval leading to declining blood levels of analgesic. The solution is to shorten the dose interval or increase the dose if tolerated.

As a general rule, one-third of patients are oversedated, one-third get the right amount of pain medication, and one-third are significantly undertreated.

What are comfort care issues?

The foremost emotional is *fear* — fear of pain, delirium, loss of control and being a burden on others. Patients complain of fatigue and a weariness of life. We find that when we reconnect people with life, this weariness fades. Depression is common. At least 25 percent of terminally ill patients with depression respond to treatment with antidepressants or stimulants. Physical symptoms include side effects of opioids such as pruritus, nausea and constipation. Dyspnea, skin breakdown, edema and many other somatic problems frequently accompany advance disease. Virtually all of these are treatable one way or another if we adequately assess them and apply the knowledge available in the palliative medicine literature.

What are the big problems in end-of-life care?

The first is **errors of commission and omission**. The most common *error of commission* is persisting with inappropriate “curative” therapy, and therefore, patients enter hospice care too late. We apply “curative” interventions that have no beneficial outcome, and we fail to fulfill the spirit of informed consent for this from patients or their proxies. I suspect that if the decision-makers really knew that there were no benefits to be derived from these procedures, they would never consent to them. We don't know how to put on the brakes. We can leave people brutalized. We need to go back to basics: Why do patients want things done? What do people hope for? Do they really understand the consequences of interventions? Do they really understand the alternatives? Do we? Do they fear being abandoned by us if they don't do our bidding?

The most common *error of omission* is inadequate pain management and application of comfort measures. We have the knowledge and ability to reduce problems, but we have an in-

sufficient system to implement and solve them. Our systems of care are not devised to elaborate and respect patient preferences.

The second is **systems problems**. We have problems with regulatory issues, institutional barriers, myths ... it still amazes me that people fear opioids in the hospice population. State regulatory boards scare people because they focus on illicit use rather than the much larger public health problem of medical undertreatment of pain. Let me digress. Why do we fear opioid addiction? We fear the undesirable behaviors associated with the addiction — criminal behavior, sociopathy and so forth. These issues are not relevant in the population who we are called to serve: the very ill, the vulnerable, the dying.

Another *systems problem* is that even though many insurance companies, Medicare and Medicaid offer hospice coverage, this care path has not been accessed by even a small percentage of those eligible. On the other hand, many of the comfort measures needed to optimize the time remaining — spiritual and emotional counseling for the patient and family, treatment of pain and other distressing symptoms, as well as respite for caregivers — are not covered by insurance, especially for patients living in the home or a long-term care facility.

The third is **absence of education**. *Education* supplies the knowledge, skills and attitudes necessary for patient care. These are close to nonexistent in end-of-life care. It is not a formal element in most medical educations, and it is not taught at the bedside. End-of-life care should be the educational equivalent to prenatal care. In response to this problem, the AMA has set up a program to teach about end-of-life care in medical school, but it will be a while before we see its effects.

The fourth is **insufficient research**. We have a puny knowledge base. Evidence-based medicine in end-of-life care is inadequate. In addition to the physical problems, we need to look at social and spiritual symptoms. We need to help people make decisions by determining and providing them the information necessary to make decisions.

What are the benefits and burdens of specific interventions like tube feedings, intravenous fluids, sedation and pain-relieving procedures? This will help people determine “Is it worth it?”

How can we afford this?

A conservative estimate is that 10-12 percent of health care costs are spent on taking care of people in their last six months of life. Currently, much of this “care” is unwarranted and overly burdensome. Palliative care medical services would not be a money loser; in fact, it may even be a money saver. Although we need to be mindful of costs, saving money is not our primary goal. Dying patients who receive formal palliative care medicine services, rather than exclusive curative care, live significantly longer and have a much better quality of remaining life. Additionally, the family members and caregivers are much more satisfied with this model of terminal health care.

How did you get involved in this?

I have actually been involved in hospice since 1986. A community hospice program was looking for medical direction and other physicians had lots of excuses — no time, no knowledge, no interest. The hospice persisted, and I relented. At that time, I found that the hospice clinicians were underskilled in medical management with, for example, poor case presentations and inadequate use of the standard constructs of medicine. I was similarly challenged in so far as the teaching of hospice care in medicine was wholly inadequate — and, all too often, it still is.

Part of the reason I decided to do this was my previous experience of working as an orderly in a skilled nursing facility. That really helped me appreciate human suffering during the last phase of life. In fact, in a way, it influenced my desire to go to medical school, to better be able to help people in pain.

As it was, the hospice I was working with was having trouble. Basically, we were not making substantial inroads; our resources were too limited to affect more than a small handful of patients — and even more scarce to do outcomes research. The only people we were affecting were

HOSPICE

other hospice organizations: we were competing with each other for the same small number of referrals from a few enlightened physicians.

A colleague suggested that I talk to a businessperson he knew in Phoenix who was interested in improving end-of-life care. Like a lot of people who become interested in this issue, he had his own story of a brother who had died young, with a fairly bad dying experience. He helped convince me that hospice needed to act as a business: good financial management, more effective penetration into the community at large and improved referral patterns. We started studying the situation, doing due diligence, and we found that society was spending a lot of money to do a horrible job at end-of-life care. No one was getting anything even approximating equal value for their money. So, this businessman was looking for people who were willing to take on hospice as a business project to improve quality, evaluate outcomes and manage costs in a highly responsible manner.

He needed a national medical director. We decided to define quality care through constructive research. We needed to develop a sophisticated clinical and administrative information system in order to evaluate what we were doing clinically and figure out how to do it better. We wanted to create guidelines for care, aggressively market through public and professional education and harness the creative energies of physicians and researchers at the national and local levels.

Well, I eased into it. I wasn't suspicious, I was concerned. Patient care was my priority, and I was not yet a convert to the idea that this was the way to go. Obviously now, I am, because people who want to do good but are not solvent are reduced to being beggars, to depending on others to help them do good. And no matter how right they may be, control is in someone else's hands.

What do you do as medical director?

I continue in my role as Professor in the Department of Anesthesiology at the University of Utah where I continue to practice medicine in the pain management center. I commit most of my time to "spreading the word" through public and pro-

fessional educational activities. I have a central role in maintaining our priorities — ensuring the highest quality of clinical care throughout our extensive network of programs around the country. Evidence-based medicine is an imperative and so I am actively involved in our outcomes program, both in daily care and in clinical research.

Why does an anesthesiologist need to know about hospice?

First, that it is *available*. Knowledge of the availability of hospice and what it is will help your patients and your ability to be a consultant in pain management for patients near the end of life. Second, you need to know that you can provide a significant service to hospices. Anesthesiologists offer pain management, technical therapeutic interventions, applied pharmacotherapy and the concept of titration. Anesthesiologists can positively influence care of the dying. Hospice fills an extremely important human need. Anesthesiologists as physicians with unique skills have an obligation to utilize their expertise where there is so much need.

How can anesthesiologists get involved in hospice? Do they need any special training?

The first step is to call your local hospice, ask to sit in on interdisciplinary team conferences, make some home visits and become involved. Study available resources. Join the American Academy of Hospice and Palliative Medicine. Someday in the near future, palliative medicine will be a recognized medical specialty in the United States as it currently is in most British Commonwealth countries. Until that time, you must rely on your own initiative and networking abilities.

What is the challenge for hospice now? The first challenge is to become credible in the eyes of medicine. Credibility comes with science: outcomes studies, cost-effectiveness studies, alliances, seamless care, network alliances. Hospice needs to be involved in evidence-based medicine, methodology and data collection. It must establish and monitor quality indicators.

With credibility comes remuneration. For better or worse, money plays a large role in our society. This brings the need for financial ac-

countability. Companies will demand contracts whereby hospices will be financially accountable. It is critical to know exactly what your costs are — by patient care day, by diagnosis, by component of care.

The second challenge is to make caregivers recognize the difficulty of being a patient in chronic pain or suffering. Sick people depend on the prerogatives of others to get things like pain medications. It is very hard to understand how frightening this dependency is. It is far easier to ignore it than to embrace it.

Why can't hospice and physician-assisted suicide (PAS) coexist? Why can't there be a continuum of high quality accessible hospice, and when pain management and sufficient comfort care cannot be achieved, then the ability to help the patient die?

First of all, PAS is completely antithetical to the idea of hospice. We do not postpone or hasten death. We connect people to people. Second, PAS makes it too easy not to improve end-of-life care because PAS makes an all too easy escape-hatch. It is a great excuse not to provide the best palliative care possible. Third, legislatively approving PAS at this time is wrong. We have not committed enough time, thought, consideration and research to understand the dying experience and if and when PAS may be appropriate, if ever.

With this in mind, pain should be treated as aggressively as necessary. Work hard to understand your patients goals and values. It is important to note that pain management and the issue of PAS or hastened death have become inappropriately intertwined. There is absolutely no data that shows that titrated analgesia hastens death; there is growing evidence to the contrary.

Lastly, it is interesting to observe that the spectre of PAS in Oregon has really focused that state's attention on end-of-life care, greatly increasing referral to hospice.

Final comments?

Good palliative care is a basic human right. The U.S. Supreme Court has recently arrived at this same conclusion. It is encouraging to see

high and respected medical bodies such as the AMA and the Institute of Medicine identifying this as a priority.

In 1997, the Institute of Medicine published *Approaching Death: Improving Care at the End of Life*. Recommendation #1 is a good summary of the paper.

RECOMMENDATION 1: People with advanced, potentially fatal illnesses and those close to them should be able to expect and receive reliable, skillful and supportive care.

Educating people about care at the end of life is a critical responsibility of physicians, hospitals, hospices, support groups, public programs and the media. Most patients and families need information not only about diagnosis and prognosis but also about what support and what outcomes they should reasonably be able to expect. They should, for example, not be allowed to believe that pain is inevitable or that supportive care is incompatible with continuing efforts to diagnose and treat. They should learn — before their last few days of life — that supportive services are available from hospices and elsewhere in the community and that those involved in their care will help arrange such services. Patient and family expectations and understanding will be aided by advance care planning that considers needs and goals, identifies appropriate surrogate decision-makers and avoids narrow preoccupation with written directives. To these ends, health care organizations and other relevant parties should adopt policies regarding information, education and assistance related to end-of-life decisions and services. For those who seek to build public understanding of dying as a part of life and to generate public demand for better supportive services, one model can be found in the perspectives, spirit and strategies that have guided efforts to promote effective prenatal care and develop mother-oriented and family-oriented arrangements for childbirth.

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Foley KM. Competent care for the dying instead of physician-assisted suicide. *N Engl J Med*. 1997; 336:54-57.

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Jacox A, Carr DB, Payne R, et al. Management of Cancer Pain. Clinical Practice Guideline No. 9. AHCPR Publication No. 94-0592. Rockville, MD: Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, Public Health Service; 1994.

Cancer Pain Relief and Palliative Care: Report of the WHO Expert Committee. Geneva, Switzerland: World Health Organization; 1990.

The **Journal of Pain and Symptom Management** offers an Ethics Rounds series, "which will explore the broad range of ethical issues encountered in palliative care." This series started in the February 1998 issue and is an excellent source for case studies and continuing education.

HOSPICE

INTERNET RESOURCES

Dying Well: Ira Byock's Web page:
<<http://www.dyingwell.com>>

American Academy of Hospice and Palliative
Medicine: <<http://www.aahpm.org>>

Elder Information and Assistance:
<<http://www.elderinfo.com>>

Institute of Medicine:
<<http://www.nas.edu/iom>>

National Hospice Organization:
<<http://www.nho.org>>

NPR: The End of Life; Exploring Death in
America: <<http://www.npr.org>>

Project on Death in America Soros Foundation:
<<http://www.soros.org/death.html>>

Toolkit of Instruments to Measure End of Life
Care: <<http://www.toolkit.htm>>

HOSPICE

Special Teaching Method

Contact a local hospice and ask them to teach you about hospice care. Invite the medical director to visit with you, and offer to accompany him or her on rounds. Establish a hospice rotation.

PERIOPERATIVE DNR ORDERS TO LIMIT RESUSCITATION

DO-NOT-RESUSCITATE (DNR)* ORDERS ARE AN excellent example of the concept of a *dilemma*. On one hand is the traditional desire of physicians to preserve life. On the other hand, there are the ethical obligations to respect patient autonomy, to recognize that people have different values and to acknowledge that death is not the ultimate evil.

History of DNR Orders. Since the incorporation of cardiopulmonary resuscitation into practice in the 1960s, medicine in general has made the assumption that a patient would always prefer to be resuscitated.

Recognizing this as a potential problem, the American Medical Association in 1974 endorsed a policy that said in part, “the purpose of cardiopulmonary resuscitation is the prevention of sudden unexpected death. Cardiopulmonary resuscitation is not indicated in cases of terminal irreversible illness where death is not unexpected.”¹ Two years later, the approach to do-not-resuscitate policies from Boston’s Beth Israel Hospital and Massachusetts General Hospital were published in *The New England Journal of Medicine*.^{2,3} These policies acknowledged the need to protect patients’ rights to limit the use of modern-day technology during terminal illness.

Following their initial development, DNR orders underwent many adaptations, addressing recognized and perceived deficits such as documentation, communication, determining whether patients with DNR orders had a right to intensive care therapy, and how to satisfactorily limit resuscitation for the patient who is brought to the emergency room. Still, DNR was not accepted as an option in the operating room until the early 1990s.

Driven by groundbreaking articles in 1991, the American Society of Anesthesiologists and the American College of Surgeons published statements in 1993 and 1994 advocating the re-evaluation— instead of the mandatory revocation — of a surgical patient’s DNR order.⁴⁻⁷ These views reflected the well-rooted belief that the right of patients to define the type of care they receive is at the core of our current understanding and practice of medical ethics and that these principles are valid and are to be honored unless otherwise trumped.

This, of course, did not solve the whole problem. Today’s questions about perioperative DNR orders center on finding the best way to enact them. While it is tempting to disregard clinicians who wish to revoke DNR orders as paternalistic and old-fashioned, their objections are, for the most part, based on procedural concerns such as being unable to satisfy the patient’s desire to have limited care appropriately and correctly applied, and not on a fundamental disagreement with the patient’s right to self-determination. Not to consider these legitimate reservations will limit the appropriate and fullest use of perioperative DNR orders.

Good Reasons to Prefer Clear Revocation of the DNR Order. One set of reasons centers on the uncertainty of what is considered to be resuscitation in the operating room. Anesthesia and surgery routinely involve many acts that are considered to be resuscitation on the ward, such as supplemental oxygen delivery, intubation, intravenous and arterial access, and the use of cardiovascular drugs to treat arrhythmias and minor hemodynamic changes. By establishing a clear reference, such as revoking the DNR order, the difficult question of determining “what is resuscitation” can be avoided. Caregivers then do not have to worry if a certain intervention is considered to be resuscitative, and they do not have to worry about limiting anesthetic or surgical interventions. Perhaps more importantly, they do not need to worry about having their hands tied if an easily fixable event occurs.

* Some institutions use the acronym DNAR: Do not attempt resuscitation.

Outcomes from witnessed arrests are much better than from those that are unwitnessed, especially when the cause of the arrest is iatrogenic. As such, the chance of quality survival after an arrest in the operating room is higher than after an arrest elsewhere.

Other reasons to provide full resuscitation in the operating room may be less legitimate. Caregivers may feel responsible for the death or consider death a failure. They may believe that a death while under anesthetic care might be harmful in terms of reputation.

Anesthesiologists may also have unfounded legal concerns. Deaths can be categorized as expected or unexpected; an expected death is not considered to involve physician negligence. Others may believe that it is better to “err on the side of life” when making these decisions. Again, this shows a misperception that any form of life is always more valuable than death to the individual patient.

Arguments for Retaining DNR Status. Do-not-resuscitate orders are predicated on the idea that patients may forgo certain procedures and their possible benefits because they choose not to undertake the associated burdens. The burdens may be related to either the resuscitation attempt itself or to the decrement in functional or cognitive capacity that would likely follow, even from a successful attempt at resuscitation. This individualized weighing of the benefit-to-burden ratios of resuscitative procedures is as valid in the operating room as on the ward.

Obtaining the Perioperative DNR Order. Resuscitation should be discussed and defined in light of the surgical procedures, the anesthetic options and the patient’s goals. Understanding a patient’s specific fears, such as long-term suffering in the ICU or being an emotional or economic burden on their family, helps the patient, anesthesiologist and other caregivers articulate their concerns and plan appropriate resuscitation measures. The patient’s expectations from discussions with other caregivers should also be reviewed. Anesthesiologists are then prepared to clarify and document the de-

sired resuscitation status in the operating room by using one of two broadly overlapping approaches, the procedure-directed approach or the goal-directed approach.

Patients’ Desires. Clemency and Thompson performed in-depth interviews with 18 terminally ill patients about resuscitative orders in the perioperative period.⁸ Of the 18 patients, five were men with AIDS and two were men with cancer, six were women with cancer and five were women with other diseases. The average age of the men was 37 years and the average age of the women was 67 years.

The patients were first asked why they desired to limit resuscitation in nonoperative situations. Patients initiated DNR orders out of a desire to limit the physical, emotional and financial costs to themselves and their families, and out of a desire not to live a life without quality.

Patients were then asked if they would have surgery, and if they would, what they would like done with their DNR orders. Fifteen of the 18 would agree to surgery that enhances quality of life or decreases pain unrelated to disease. Three of the 18 would not agree to surgery, believing that the interventions brought too much burden for too little benefit.

Some patients were more willing to undergo certain types of surgeries. Patients favored procedures that would relieve discomfort, enhance the quality of their lives or treat an isolated and remediable problem (e.g., a broken leg).

Patients differed on how they wanted their DNR order interpreted for the perioperative period. However, nearly all wanted to have input as to how their DNR orders should be interpreted and as to whether physicians should use the patients’ goals alone or lists of specific interventions.

Some wanted to suspend DNR orders:

“ [The] operating room ... is hallowed ground ... something special ... I want the doctor to do the best he can.”

PERIOPERATIVE DNR ORDERS

Some wanted a procedure-directed order:

“My biggest fear ... is that some doctors could choose ... who is going to live and who is going to die...”

“I’d like to spell it out to them ... I would want everything to be discussed.”

Some wanted a goal-directed order:

“If [the doctor] ... would just talk to me and my family ... I would let him decide what would be appropriate after he knew what my idea was behind the order.”

A good perioperative DNR policy offers different methods of documentation. Here are several ways to obtain and document DNR in the O.R.

Procedure-Directed Orders. The procedure-directed approach replicates successful mechanisms used to document DNR orders on the ward. A checklist of specific interventions is presented, and the decision-makers choose which interventions may be used. Anesthesiologists can advise their patients based on the benefit and burden of each intervention as well as the likelihood of that intervention allowing the patient to achieve desired goals. Interventions frequently on such lists include tracheal intubation or other airway management, postoperative ventilation, chest compressions, defibrillation, vasoactive drugs and invasive monitoring. The strength of procedure-based orders is that they are unambiguous and clearly define which procedures are desired. This important feature is necessary for ward medicine, where a patient may have multiple caregivers throughout their stay. Procedure-based orders, however, do not allow for clinical subtleties that may be difficult to precisely document and define.

Goal-Directed Orders.⁹ The goal-directed approach permits patients to guide therapy by prioritizing outcomes rather than procedures. After defining desirable outcomes, decision-makers empower the caregivers to use clinical judgment to determine how specific interventions will affect achieving the goals. Predictions

about the success of interventions that are made by the anesthesiologist at the time of the resuscitation are likely to be more accurate than predictions made preoperatively, when the quality and nature of the problems are not known. Therapy may be guided by goals rather than specific procedures because patients in the operating room are cared for by specific, knowledgeable physicians for a defined period of time. Ideally, these physicians would have the necessary discussions with the decision-makers in order to understand and properly implement the desired approach. It is helpful to define a goal-directed approach on three axes: the burden the patient is willing to accept, the benefit the patient wants, and the likelihood of success. For example, one patient may wish to undertake a significant burden of resuscitation if the likelihood of leaving the hospital is high but not if it is low. Another patient may choose to accept only minor burdens in the form of pain and suffering and only if the likelihood of returning to his/her preoperative function is very high.

The strength of the goal-directed approach is that physicians should rarely feel that their hands are tied: they would not need to discontinue resuscitation based on a technicality that may not be consistent with the patient’s desires. The problem, of course, is that the goal-directed approach is not as clear cut as a procedure-directed approach. The goal-directed approach arose from the idea that since patients think in terms of outcomes, it may be more natural and effective to communicate about goals rather than procedures.

Comparing Procedure-Directed and Goal-Directed Orders (Table 1). Both goal-directed and procedure-directed approaches require the anesthesiologist to make predictions about the outcome of resuscitation. But since the goal-directed approach allows the prediction to be made at the time of resuscitation, it is likely to be more accurate. Goal-based agreements are more practical in the operating room than on the ward because they can be established with specific physicians for a finite period of time.

In practice, both methods may be used to facilitate discussion before completing documenta-

Table 1: Comparison of goal-directed and procedure-directed DNR orders

Goal-Directed	Procedure-Directed
Short-term care — hours	Long-term care — days to months
Operating rooms	Wards
Intimate knowledge of patient	General knowledge of patient
A few specified caregivers	Many unspecified caregivers
Flexible response	Defined response
Narrative or Checklist	Checklist

Sample DNR Consent Form

Goal-directed and procedure-directed options may be combined into one form. The sample form lists four options: the first is full resuscitation; the second is a procedure-directed order; the third is a goal-directed order, which seems to have the most common applicability; and the fourth is a goal-directed order that the patient and caregivers can tailor.

Option 1 — Full Resuscitation

The patient desires that full resuscitative measures be employed during anesthesia and surgery and in the postanesthesia care unit, regardless of the clinical situation

Option 2 — Limited Resuscitation: Procedure-Directed

During anesthesia and surgery, the patient refuses the following specific resuscitative interventions:

A checklist or summary statement listing desired procedures should appear here.

Option 3 — Limited Resuscitation: Goal-Directed #1

The patient desires resuscitative efforts during surgery and in the postanesthesia care unit only if the adverse events are believed to be both *temporary* and *reversible*, in the clinical judgment of the attending anesthesiologists and surgeons.

Option 4 — Limited Resuscitation: Goal-Directed #2

The patient desires resuscitative efforts during surgery and in the postanesthesia care unit only if, in the clinical judgments of the attending anesthesiologists and surgeons, such resuscitative procedures will support the following goals and values of the patient:

A summary statement of the patient's goals and values should follow this list of options.

tion in accordance with institutional policies. An important part of the re-evaluation is determining postoperative plans. A patient may want therapy continued for a limited time before withdrawing it. This expresses the patient's belief that a burden (a few days of ventilatory support) may be worth a benefit (extubation of the trachea), but at some point, the increasing burden may not be worth the decreasing likelihood of the benefit. Indeed, it is well-accepted that withholding and withdrawing life-sustaining treatments are ethically equivalent actions and that the considerations in making the decisions should be the same. Physicians may feel starting a treatment binds them to a responsibility for continuing that treatment. Withdrawing such treatment may make these clinicians feel they are breaching expectations or that they have personally failed in their duties to the patient. Clarification of both personal and professional goals and expectations at the outset may help avoid these ethically troubling thoughts. Legally, a physician should be no more concerned about stopping an ineffective treatment than not starting one. In fact, withholding a therapy may require a higher degree of certainty about its probable failure or lack of desirability than that which withdrawing a therapy requires after demonstration that it has not achieved its goals. As such, the ethical considerations involved in a decision to withdraw mechanical ventilation should be the same as those involved in a decision to withhold it.

Resolving Conflicts. Patients and anesthesiologists should be aware of the need for a negotiated and universal agreement. Discussions should include other pertinent caregivers such as surgeons, intensivists and primary care physicians and nurses; preferably, all members of the team must at least be willing to abide by the agreement. This provides greater patient satisfaction and a higher likelihood of conformity with the agreement. Achieving concurrence among the parties may be facilitated by an ethics consultant.

What if the anesthesiologist disagrees with the surgeon's or patient's desires?

What if the anesthesiologist believes the surgeon's or patient's desires to be in conflict with standard of care?

If conflicts are irreconcilable, the "anesthesiologist should withdraw in a nonjudgmental fashion, providing an alternative for care in a timely fashion."⁷ If the proposed interventions "conflict with generally accepted standards of care, ethical practice or institutional policies, then the anesthesiologist should voice such concerns and present the situation to the appropriate institutional body."⁷ If time does not permit pursuing such alternatives, then the anesthesiologist is directed to provide care "with reasonable adherence to the patient's directives ..."⁷

DNR in Emergency Situations. DNR in an emergency situation without time to clarify a patient's wishes is inherently different. The traditional bias of providing treatment in the absence of a clear decision not to treat should hold for the anesthesiologist in the emergency situation. A simple and all-too-real example may be the patient who arrives in the emergency room in respiratory distress. Medical judgment dictates rapid tracheal intubation, but a relative might insist that the patient does not wish to be intubated if he will "get stuck on a ventilator." The relative may even claim to have a "form" at home. While no reason exists to disbelieve the relative, the consequences of the relative misinterpreting the patient's preferences are irreversible.

In this scenario, the best option is to intubate the trachea and provide support. After the patient's condition is stabilized, the patient's preferences can be clarified and implemented. The ability to give the patient a trial of therapy such as mechanical ventilation is one of the better ways to fulfill this patient's end-of-life desire to be the recipient of resuscitative efforts without the possibility of "getting stuck on the ventilator." If the time-limited trial is unsuccessful or tracheal intubation is inconsistent with the patient's preferences, then the mechanical ventilation can be withdrawn consistent with the patient's goals.

DNR in the O.R. for Pediatric Patients. For pediatric patients, the anesthesiologist needs to involve the patient, surrogates and other caregivers such as surgeons, intensivists, pediatricians and nurses in determining what is in the best interests of the child. While it is immensely difficult to define what is a benefit and what is a burden, it is helpful to consider the guidelines set forth by the American Academy of Pediatrics.¹⁰ Benefits include prolongation of life under certain circumstances, improved quality of life (such as reduction of pain or the ability to leave the hospital) and increased enjoyment of life. Burdens may include intractable pain and suffering, disability and events that cause a decrement in the quality of life as viewed by the patient. These guidelines may be helpful in considering short- and long-term goals and putting into appropriate context specific fears like long-term ventilatory dependency, pain and suffering.

Redirecting Care at the End of Life. DNR orders address only one aspect of end-of-life care. In the 1990s, some institutions have moved beyond the DNR policies to address these issues more globally. The Joint Commission on Accreditation of Healthcare Organizations now requires hospitals to have comprehensive guidelines for redirecting end-of-life care, away from therapies that prolong the dying process and toward therapies that promote comfort. These policies should emphasize what will be done to promote comfort, not what will not be done to prolong life. "There is nothing

more we can do" is not an appropriate comment to dying patients and their families.

Other Directives to Refuse Care. Advance directives can help a person discuss end-of-life issues with loved ones and physicians prior to the emotional upheaval associated with that time. Advance directives are instructions a competent patient completes to guide care if he or she should become incompetent.

There are two types of advance directives: **living wills** and **health care proxies** (also known as durable powers of attorney for health care decisions).¹¹⁻¹³ Living wills allow patients to state what kind of interventions they would want in different clinical situations. For example, living wills may declare whether patients would want resuscitation or dialysis if they were in a persistent vegetative state. Health care proxies, on the other hand, permit patients to designate surrogate decision-makers to make decisions for them should they become unable to make such decisions for themselves.

Living wills have been criticized for not being able to reflect all of the subtle differences that inevitably characterize real clinical situation. Although they can provide a general idea about the wishes of the patient, living wills can be very difficult to apply in specific clinical settings. For this reason, some prefer the greater flexibility provided by the health care proxy, where the surrogate decision-maker is able to take all of the specific details into consideration when making clinical decisions. Further, this allows assignment of surrogacy in situations where the preferred surrogate is not a family member. Surrogacy is not effective, however, for patients who do not make their preferences clearly known to the surrogate prior to losing decision-making capacity. Given the strengths and weaknesses of each approach, some believe that a combination of the two (a designated proxy with some written form of preferences) may be the best option.

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**ETHICAL GUIDELINES FOR THE ANESTHESIA CARE OF PATIENTS
WITH DO-NOT-RESUSCITATE ORDERS OR OTHER DIRECTIVES
THAT LIMIT TREATMENT**

**(Approved by House of Delegates on October 13, 1993 and last amended on
October 21, 1998)**

*These guidelines apply to competent patients and also to incompetent patients
who have previously expressed their preferences.*

- I. Given the diversity of published opinions and cultures within our society, an essential element of preoperative preparation and perioperative care for patients with Do-Not Resuscitate (DNR) orders or other directives that limit treatment is communication among involved parties. It is necessary to document relevant aspects of this communication.
- II. Policies automatically suspending DNR orders or other directives that limit treatment prior to procedures involving anesthetic care may not sufficiently address a patient's rights to self-determination in a responsible and ethical manner. Such policies, if they exist, should be reviewed and revised, as necessary, to reflect the content of these guidelines.
- III. The administration of anesthesia necessarily involves some practices and procedures that might be viewed as "resuscitation" in other settings. Prior to procedures requiring anesthetic care, any existing directives to limit the use of resuscitation procedures (that is, do-not-resuscitate orders and/or advance directives) should, when possible, be reviewed with the patient or designated surrogate. As a result of this review, the status of these directives should be clarified or modified based on the preferences of the patient. One of the three following alternatives may provide for a satisfactory outcome in many cases.
 - A. Full Attempt at Resuscitation: The patient or designated surrogate may request the full suspension of existing directives during the anesthetic and immediate postoperative period, thereby consenting to the use of any resuscitation procedures that may be appropriate to treat clinical events that occur during this time.
 - B. Limited Attempt at Resuscitation Defined With Regard to Specific Procedures: The patient or designated surrogate may elect to continue to refuse certain specific resuscitation procedures (for example, chest compressions, defibrillation or tracheal intubation). The anesthesiologist should inform the patient or designated surrogate about which procedures are 1) essential to the success of the anesthesia and the proposed procedure, and 2) which procedures are not essential and may be refused.
 - C. Limited Attempt at Resuscitation Defined With Regard to the Patient's Goals and Values: The patient or designated surrogate may allow the anesthesiologist and surgical team to use clinical judgment in determining which resuscitation procedures are appropriate in the context of the situation and the patient's stated goals and values. For example, some patients may want full resuscitation procedures to be used to manage adverse

**ETHICAL GUIDELINES FOR THE ANESTHESIA CARE OF PATIENTS
WITH DO-NOT-RESUSCITATE ORDERS OR OTHER DIRECTIVES
THAT LIMIT TREATMENT (CONT'D.)**

clinical events that are believed to be quickly and easily reversible, but to refrain from treatment for conditions that are likely to result in permanent sequelae, such as neurologic impairment or unwanted dependence upon life-sustaining technology.

- IV. Any clarifications or modifications made to the patient's directive should be documented in the medical record. In cases where the patient or designated surrogate requests that the anesthesiologist use clinical judgment in determining which resuscitation procedures are appropriate, the anesthesiologist should document the discussion with particular attention to the stated goals and values of the patient.
- V. The medical record should also indicate if or when the original, pre-existent directive to limit the use of resuscitation procedures will be reinstated. This should generally occur when the patient leaves the postanesthesia care unit or when the patient has recovered from the acute effects of anesthesia and surgery.
- VI. It is important to discuss and document whether there are to be any exceptions to the injunction(s) against intervention should there occur a specific recognized complication of the surgery or anesthesia.
- VII. Concurrence on these issues by the primary physician (if not the surgeon of record), the surgeon and the anesthesiologist is desirable. If possible, these physicians should meet together with the patient (or the patient's legal representative) when these issues are discussed. This duty of the patient's physicians is deemed to be of such importance that it should not be delegated. Other members of the health care team who are (or will be) directly involved with the patient's care during the planned procedure should, if feasible, be included in this process.
- VIII. Should conflicts arise, the following resolution processes are recommended:
 - A. When an anesthesiologist finds the patient's or surgeon's limitations of intervention decisions to be irreconcilable with one's own moral views, then the anesthesiologist should withdraw in a nonjudgmental fashion, providing an alternative for care in a timely fashion.
 - B. When an anesthesiologist finds the patient's or surgeon's limitation of intervention decisions to be in conflict with generally accepted standards of care, ethical practice or institutional policies, then the anesthesiologist should voice such concerns and present the situation to the appropriate institutional body.
 - C. If these alternatives are not feasible within the time frame necessary to prevent further morbidity or suffering, then in accordance with the American Medical Association's Principles of Medical Ethics, care should proceed with reasonable adherence to the patient's directives, being mindful of the patient's goals and values.
- IX. A representative from the hospital's anesthesiology service should establish a liaison with surgical and nursing services for presentation, discussion and procedural application of these guidelines. Hospital staff should be made aware of the proceedings of these discussions and the motivations for them.
- X. Modification of these guidelines may be appropriate when they conflict with local standards or policies, and in those emergency situations involving incompetent patients whose intentions have not been previously expressed.

Case 1, Part 1

DNR Scenario

Your case today is a 25-year-old HIV male currently beginning his third bout with *Pneumocystis carinii* pneumonia. He is scheduled for an indwelling central line. He explains that his worst fear is being in the ICU with a breathing tube. In fact, as he says, “I want nothing done that will prolong my life.”

You spend several hours with him. He is a genuine, thoughtful, sincere person, who appears unaffected by the morphine infusing in his last remaining IV site.

- 1) What obligations should the anesthesiologist consider before having this discussion?
- 2) Should the surgeon and primary care physician/hospitalist be included in this discussion?
- 3) What role does the current IV morphine play? Are the words “thoughtful, sincere person” critically important?
- 4) What precise issues should be discussed with the patient?

Case 1, Part 1
Instructor's Notes

1) Anesthesiologists need to consider their obligations to the patient, other caregivers and themselves. The results of these obligations center on the idea of getting the DNR order right. This includes educating the patient, documenting correctly and communicating correctly. This will minimize confusion.

2) The surgeon and primary-care physician/hospitalist must be included in the discussion. If the patient wants a goal-directed order, the attending physicians need to agree, and they need to HEAR THE SAME THING. Furthermore, other pertinent caregivers should be included: the intensivists and nurses, who may be caring for the patient postoperatively and may need to participate in withdrawing care, the primary care physicians, for both the above reasons and their ability to communicate with the patients, and perhaps family members so there is no question as to the patients wishes.

3) Depends. The participants in the discussion need to assess whether the patient has decision-making capacity (see **Module A, Introduction to Informed Consent, and Module B, Who Speaks for the Patient**). Remember, the morphine may give the patient better decision-making skills because he will not be as distracted by pain.

4) The patient should know what his options are for defining resuscitation in the operating room. Discuss with him the benefits among revoking the DNR order, using a procedure-directed order and a goal-directed order. No matter which option he chooses, start by helping him understand and establish his generalized goals:

- What is his life expectancy?
- How much burden is he willing to undergo to stay alive?
- What does he consider an acceptable quality of life?
- Does he have any events coming up?

Explain to him the procedure and the types of anesthesia available, along with their respective risks and benefits.

Then, the DNR order can be obtained with the appropriate persons present.

Case 1, Part 2

The patient has decided that he wants monitored anesthesia care and no resuscitation. He desires to use a goal-directed order and declares that resuscitation attempts should occur only if the adverse events are believed to be both *temporary* and *reversible*, in the clinical judgment of the attending anesthesiologists and surgeons. You are happy with that, but the surgeon appears uncomfortable and tries to talk the patient out of it (and into revoking the DNR order). The patient is steadfast in his desire to retain his DNR status.

The surgeon pulls you outside and suggests to you that he will not kill his patient, and he will not expose himself legally. He suggests that the both of you agree with the patient, but in the operating room provide full resuscitation.

You discuss with him why it is reasonable to follow the patient's preferences and retain the DNR order, and the surgeon relent and agrees to the patient's request.

- 1) What should you talk about with the surgeon? How can you respond to the proposal?
- 2) If the surgeon and patient were to make a deal that you could not abide by, can you withdraw from this patient's care?
- 3) Should you tell the patient about the surgeon's potential duplicity?

Case 1, Part 2
Instructor's Notes

1) Initially, respond to the surgeon with sympathy and understanding. Getting into a shouting argument now will not help anyone. Explain the concept of patient autonomy, benefits and burdens, and the right to refuse therapy. Show him the ASA and ACS statements that promote re-evaluation of the DNR order. If he is legally uncomfortable, suggest that he call hospital counsel for reassurance.

2) If the patient and surgeon were to make a pact that you cannot accept, you may definitely withdraw from that patient's care if the procedure is not emergent. If the procedure is emergent, the weighing of the rights of the patient versus the rights and duties of physicians are more complicated, but in general, lean toward providing the care the patient requests.

3) This is by definition a difficult question. There is no easy answer. If you believe the surgeon intends on lying to the patient, you are obligated to bring it to someone's attention, be it someone in administration, the department of surgery or the department of anesthesiology. Naturally, you do not want to be in the policeman's role, especially if you are in essence calling someone a liar. Perhaps the best approach would be to be forthright with the surgeon, and, if you still are in doubt, tell the surgeon that you plan on further action and that he is welcome to participate in the discussion with you.

Case 1, Part 3

During the placement of the central line, the patient's heart rhythm goes into ventricular fibrillation. Thinking it is *temporary* and *reversible*, you and the surgeon proceed with resuscitative therapy. After several minutes, it is clearly not successful, so you suggest you stop, in accordance with the patient's wishes. The surgeon, who has agreed with both the patient and the anesthesiologist as to the conditions of surgery, glares at you and begins CPR.

1) What will you do?

Case 1, Part 3
Instructor's Notes

Unfortunately, this can happen whether a procedure- or goal-directed order is used, whether it is the surgeon or the anesthesiologist who “breaks rank” and whether the event is truly temporary and reversible.

While the tendency is to become angry and, possibly, righteous, I am not sure this is such a big deal. Consider that it is difficult to allow a patient to die, to “give up.” Further, consider that many of us will be unable to truly know what we would do when push comes to shove. A little tolerance and understanding is a reasonable approach to this situation. reasonable here.

You could ask the surgeon whether he wants to continue because:

- 1) He still thinks it is temporary and reversible, or
- 2) He has a reason for not adhering to following the patient's directive.

Depending on his thinking, you can have a discussion about reasons and not about emotion. In my opinion, it is unlikely that you will be successful. If it is a question of whether the event is temporary or reversible, the objector may be satisfied with a few more rounds until it is clear. On the other hand, he might not be satisfied, no matter.

Keep in mind the goal is to fulfill the patient's wishes. Bringing him back to the ICU for a short period of time to clarify matters is not wholly inconsistent with his wishes — as long as the team is emotionally and ethically capable of withdrawing care. In other words, the increased certainty of a poor prognosis that a short period of time may bring is probably well worth whatever extra minimal burden it imposes. That is why it is important to bring in the intensivists and primary care givers for this discussion, so that if and when it is appropriate, care may be withdrawn.

An anesthesiologist's obligation does not end when dropping the patient off in the ICU. The anesthesiologist's obligation to the patient is to ensure that the patient's wishes for operating room care are followed; in this case, the ramifications of that agreement carry over to the ICU.

Case 2

Pediatric DNR

N.B. Futility of Care. Futile care can play a role in determining DNR recommendations as this following case shows. If needed, consult **Module F, Medical Futility** for a discussion about the concept of futility, and **Module C, Informed Consent: Special Issues in the Care of Children** for a discussion of pediatric informed consent.

An 8-month-old boy with Trisomy 13 and surgically unrepairable heart disease presents for an elective repair of a hernia.

- 1) With such a sick child, why even perform the operation?
- 2) What do you need to tell the parents about the anesthesia? What should you discuss about postoperative care?
- 3) The parents are still uneasy and not sure what to do? How can you help them?
- 4) The child dies intraoperatively. You feel awful. Should you have done the case?

Case 2, Instructor's Notes

1) A reasonable question. Patients with Trisomy 13 have a limited life span and are mentally retarded. But, again, the question must be stated more correctly: Why risk death for a hernia repair in a child with a limited life span? Stating the question this way brings out the relative benefits and burdens.

The parents are concerned that the child's bowel could incarcerate through the large hernia. If that were to happen, he would then need emergency surgery. On the other hand, although the risks of surgery and anesthesia are great, performing it electively has several advantages: experienced and rested caregivers, optimized physical status and the ability to delay the surgery if that option becomes desirable. The mother expresses the dilemma as "we're damned if we do and damned if we don't."

When viewed in the same light, it may be appropriate to consider a perioperative DNR order, if it becomes apparent that the burdens of continued therapy outweigh the benefits.

2) Be thorough and precise in this discussion. Anesthesia is the significant risk in this operation, the likelihood of morbidity and mortality is high, and the parents actively intend to use the information you give them in making the decision. Disclosure not only should include the risks and benefits, but also the likelihood of events occurring and where this information comes from.

Emphasize that medicine and anesthesiology do not have extensive experience anesthetizing patients with Trisomy 13. The ramifications of undergoing the stress of surgery is unknown in this debilitated patient. Therefore, the information you give them should be taken with the caveat that the knowledge is not really "tested" in their son's population.

You can discuss the possibility of avoiding general anesthesia through regional techniques such as a continuous caudal anesthetic. Explain your experience with the technique and what

the literature says about it. Be clear that this is a very unusual case. When you offer opinions to the parents, be sure to qualify them 1) by acknowledging they are in part based on "gut" feelings and 2) by giving rough percentages (e.g., 50-75 percent chance of mortality). To be able to make an informed choice, offer to arrange for the parents to discuss the issues with other experienced pediatric anesthesiologists and then offer them time to make the decision.

Explain further that the result of the multiple variables in this case point strongly to either a goal-directed DNR order or a revocation of the DNR order, with postoperative re-evaluation. In addition to psychologically preparing the parents for postoperative difficulties, you need to start them thinking about how aggressive they wish to be during the postoperative period.

3) One way you can reassure the parents is by validating their feelings that this is a tough decision, one that can be "wrong" either way. Discuss with them the best interests concept (see **Module C, Informed Consent: Special Issues in the Care of Children**) and your belief that either choice is acceptable treatment.

Consider offering an ethics consultation. The consultant can walk them through the information, making sure they understand the issues. The consultant will also validate their feelings and provide further confirmation as to the validity of their choice. The consultant can also offer emotional support.

4) Yes, as long as choice to proceed resulted from a good decision-making process. Bad outcomes do not necessarily mean a mistake was made. In these kinds of cases, you have to expect some deaths, otherwise the decision of whether to proceed would not be so difficult. **Even expected deaths may be overwhelming.** It is not unusual to have feeling of anger and guilt after something like this. While some introspection is good, discussion with selected colleagues is often therapeutic. When needed, short-term professional therapy for an acute crisis can help you regain perspective, and such avenues should be made available and encouraged.

Special Teaching Method

Several year ago, a close elderly relative asked me to help him complete a perioperative DNR order and to become his durable power of attorney for health care matters. This well-educated man had a significant lack of understanding of the options available to him.

Residents should seek out a parent or close friend. They should discuss with them how they might want to document their DNR status, particularly if they had to go to the operating room. The residents should probe their thinking, looking for inconsistencies and misunderstandings.

MEDICAL FUTILITY: DECISION-MAKING FOR FUTILE MEDICAL INTERVENTIONS

WHAT IS MEDICAL FUTILITY? WITH RECENT technological advances, medicine has been able to keep terminally ill patients alive for longer periods of time without curing or ameliorating their underlying disease.¹ The widespread use of artificial feeding and nutrition, ventilator support, cardiopulmonary resuscitation (CPR) and renal dialysis has meant that more people are living longer with diseases previously believed lethal. Yet life-sustaining interventions can be a double-edged sword. Although life may be preserved, patients may find themselves confined to hospitals, unable to meaningfully interact with, or obtain comfort and support from, others. Anesthesiologists are faced with decision-making relating to medical futility in both the intensive care unit (ICU) and operating room (O.R.) settings. A decision to limit care is not uncommon during the ICU stay of critically ill patients. Do-not-resuscitate (DNR) orders have been applied when a patient has failed aggressive ICU care. DNR has, in many cases, become a ritual first step before the next set of negotiations to limit further invasive therapy or to decide when to withdraw life support. The goal of this educational module is to highlight concepts and concerns related to medical futility and to promote its discussion.

It is helpful to note that the term “futile” refers to a *specific* medical intervention applied to a *specific* patient at a *particular* time. It does not refer to a situation generally or to a medical treatment globally. Nor should “futile” be used to refer to a patient, or to care, as this may convey the impression that the patient is being abandoned or that comfort measures will no longer be undertaken. In its simplest form, futile medical treatment is defined as that treatment which fails to achieve the goals of medical therapy.² This definition includes: failure to prolong life, failure to achieve a patient’s wish, failure to achieve a physiologic effect on the body and/or failure to achieve a therapeutic benefit for the patient.³ Building on this definition, Schneiderman et al. state that as

long as the patient can appreciate and make use of such interventions as air flow and blood flow, which a permanently unconscious patient cannot, treatment is not futile.⁴ In other words, “when physicians conclude (either through personal experience, experiences shared with colleagues or consideration of published empiric data) that in the last 100 cases a medical treatment has been useless, they should regard that treatment as futile. If a treatment merely preserves permanent unconsciousness or cannot end dependence on intensive medical care, the treatment should be considered futile.”³ However, this definition is just one end of the spectrum. In contrast, Truog and colleagues advocate the application of strict physiologic definitions of futility, arguing that the Schneiderman definition is subject to value judgments and statistical uncertainty.⁵ By adopting strict physiologic parameters to define futility, the immediate effect of an intervention can be differentiated from the more uncertain questions of prognosis.

Medical Futility Is a Concept That Does Not Exist in a Vacuum. It is potentially useful, but only in the social context that provides a framework for its use, which needs to include a broad consensus about the purpose of medicine and the nature of the physician-patient relationship.⁶ Furthermore, it can be judged in relation to the four traditional pillars of modern bioethics: beneficence, nonmaleficence, patient autonomy and social justice.

Beneficence refers to the moral obligation to act for the benefit of others. The question must be asked whether or not a given intervention is for the good of the patient. But to do good can be viewed in a number of different lights. Is what is good for the individual patient good for a society? Is the intervention likely to do limited good for the patient? It should be understood that each individual has a different concept of what is good for himself or herself. A balance of the benefits, costs and risks of each

intervention should ideally be taken, in order to come to a consensus judgment as to the appropriateness of care. Implicit to this analysis is the concept of the value and quality-of-life adjusted years that will occur subsequent to the medical intervention.

Nonmaleficence directs health care providers to “do-no-harm.” This dictate is often used in conjunction with the principle of beneficence. However, injunctions to not harm are sometimes more stringent than the obligations to act to the benefit of others. To do no harm can be examined in many contexts, one of which is withholding versus withdrawing treatments. Although not universally accepted, most ethicists find no moral difference between noninitiation of a therapy and its discontinuation.⁷ However, it appears that many physicians are more uncomfortable with discontinuing therapy once it has begun than with not beginning the therapy in the first place.⁸ Intense scrutiny of decision-making at the end of life, the difficulty of being personally associated with a given decision, and liability concerns may all contribute to these findings. These concerns may lead to an environment in which nonbeneficial therapies are continued long after they had provided any benefit. Concerns over the ability to discontinue a given therapy at a later date also may contribute to this environment. However, acting in accordance with the President’s Commission on Bioethical Issues, which finds that there is no difference between withholding and withdrawing care, therapy can be initiated when appropriate without concern that later discontinuation will be impossible.⁹

Patient autonomy was not a concern in American medicine until the middle of this century. The right to consent to or refuse treatment is based upon the ethical principle of autonomy. Otherwise stated, this principle states that the patient has the right to make decisions for himself or herself which others must respect. Judicial ruling¹⁰ played a role in the advancement of the informed-consent paradigm of medical decision-making over the paternal paradigm, which is largely based on the concept of beneficence: “*Every human being of adult years and*

sound mind has a right to determine what shall be done with his own body ...” (1914).¹¹ “*A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.*” (1957)¹²

Throughout the 1960s and 1970s, this paradigm of self-determination gained strength. However, during the 1980s and 1990s, in the face of increasing malpractice litigation and the increasing economic burden of end-of-life care, the paternal paradigm has regained strength. By 1991, in an effort to maintain the right of patient autonomy, the Patient Self Determination Act was passed, stating that all patients admitted to hospital must be informed about their right to prepare advance directives and to refuse life-prolonging treatment.¹³

Social justice dictates that the good of society be considered when making judgments about individual people. This principle suggests that there should be a fair allocation and distribution of limited health care resources. The inability to discontinue medical treatment that is deemed futile may be to the detriment of other patients who might be refused not only sophisticated care but even access to basic medical care, thus, counter to the dictates of social justice.¹⁴ Under such circumstances, there appears to be a need to give authority to the reasonable medical decision to discontinue futile care. In the setting of developing nations, the ethics of scarcity play a role in the rationing of medical care away from those cases deemed to be medically futile.¹⁵ High technology interventions near the end of life exact a high cost both in human and economic terms. Advances have helped prolong life and its quality for many; however, for others, it has transformed the process of dying into an extended medical nightmare.¹⁶ There is a pressing need to develop rational guidelines for end-of-life medical interventions to ensure the primacy of patients’ best interests, protect the integrity of the doctor-patient relationship and affirm the duty of the medical establishment toward society at large. Proposed guidelines need to be developed with involve-

ment of all relevant medical specialties and negotiated, reviewed and ratified by the lay public.

Ethical Obligations of Physicians. The matter of DNR in the OR is increasingly a matter of ethical conflict (see **Module E, Perioperative Orders to Limit Resuscitation**). Anesthetic care implies the provision of resuscitative care as necessary. Interventions such as intubation, ventilation and the administration of vasoactive substances may be regarded as resuscitative efforts. In consideration of policies automatically suspending DNR orders prior to anesthetic care, the role of DNR in the peri-anesthesia and peri-surgery period was widely contested in 1991.¹⁷ Some advocates feel that the imposition or provision of guidelines limits the individual anesthesiologist's autonomy. They suggest perioperative suspension of the DNR order for a limited period of time, with the assurance that therapeutic procedures instituted during surgery will be discontinued post-operatively in conformance with the DNR order and if the underlying disease process turns out to be nonreversible.¹⁸

By focusing the questions of "what are we trying to achieve" and "are we able to do it," the discussion of futility has added a qualitative dimension to decision-making at the end of life.¹⁹ Again, there is ambiguity because each person has a different perception of what his or her individual goals are for the quality and duration of their lifetime. Health care professionals have a responsibility to offer only those life-sustaining efforts that have a reasonable chance of being beneficial. Some advocate that futility policies should permit treatment-limiting decisions to be made without the agreement of the patient or surrogate at times, but also that such policies must provide opportunities to challenge a judgment of futility.²⁰ Others advocate the use of "futility clauses" for use in do-not-resuscitate policies.²¹ The futility criteria for limiting treatment should be recognized as a means of fostering communication and discussion regarding benefits, harms and medical goals. One study found that some physicians may inappropriately use their prerogative over medical futility as

a means to guard their professional autonomy against perceived threats.²²

Medical Futility Is a Polarizing Concept. Medical futility is a concept that is criticized for a number of reasons, including: 1) it is simply an attempt to increase the power of the physician over the patient, 2) no professional or societal consensus has been made regarding a definition of medical futility, 3) futility is a value-laden determination, at the level of both society and the individual, the seizure of which by medicine is inappropriate unless a value-free or strict physiologic definition of futility is used, and 4) futility is an unnecessary concept because cost considerations will ultimately dictate all decisions.²³

It is simply an attempt to increase the power of the physician over the patient. For advocates of patient autonomy, the notion of unilateral declarations of futility is disturbing. Historically, however, the concept of futility has been integral to medicine since the beginning of care. When a physician had no options to promote health or combat disease, further care was deemed futile. It was not until health care technology advanced to the point of producing intermediary stages between health and death that medical futility became a point of contention. In modern times, medical law and ethical theory have clearly established the patient's right to refuse unwanted treatment based upon a respect for the individual's values and choices.²⁴ In this setting of the supremacy of patient's rights, it is unlikely that the physician's power over the rights of patients would be unchallenged. Even when hope in the power of medicine exceeds its abilities, patient advocates argue that patients and families are entitled to these hopes and that medicine is duty-bound to serve them. Somewhere in between these arguments lies a middle ground known as the "Don't offer, perhaps, but please discuss" consensus.²⁵ This compromise calls for a "process of shared understanding and collaborative planning that requires truth telling and talk about the rights ... as the starting point for a conversation about how to reconcile our individual wants with our collective needs."²⁶

No professional or societal consensus has been made regarding a definition of medical futility. Since its start in 1986, public debate on the subject of futility has grown more polarized. “Neither side is able to agree on the basic principles that must be shared in order to hold rational discussion, let alone resolve disagreement.²⁷ This is evidenced in the spectrum of definitions that can be given for medical futility and the polarization of thought on the subject. However, recent years have witnessed an agreement by both ends of the spectrum that improved communication is necessary and that a societal consensus must be developed.

Futility is a value-laden determination, the usurpation of which by medicine is inappropriate unless a value-free or strict physiologic definition of futility is used. There are those who rely upon physiologic definitions of medical futility to provide value-free determinations of what is and is not medically futile.⁵ This view tends to place primary value on organ function and is incompatible with the standard of medical practice in America. It is also a value-choice to focus on such parameters and stray from the patient-centered tradition of medical practice. The objective of the practice of medicine is not to achieve a simple physiologic effect, but rather to promote the welfare of the patient. In 1987, the Hastings Center noted the distinction between physiological and non-physiological futility when it stated:

In the event that the patient or surrogate requests a treatment that the responsible health care professional regards as clearly futile in achieving its physiological objective, and so offering no physiological benefit to the patient, the professional has no obligation to provide it. However, the health care professional’s value judgment that, although a treatment will produce physiological benefit, the benefit is not sufficient to warrant the treatment, should not be used as a basis for determining a treatment to be futile.²⁸

Therefore, in the simplest of terms, decision-making related to medical futility should be

based upon the scientific evidence that shows physiological futility (“can’t work”) rather than insufficient benefit (“it’s not worth it”).

Futility is an unnecessary concept because cost considerations will ultimately dictate all decisions. Some fear that the concept of futility will begin a slippery path to the arbitrary limitation of costly treatments. However, upon closer examination, futility, rationing and cost-containment are distinct concepts. Additionally, the evidence relating DNR orders and resource utilization in the ICU setting is conflicting.^{29,30} Most recently, researchers have found that the use of DNR orders, particularly early in the ICU stay, may be associated with a significant reduction in resource use. Thus, medical futility stages a battle between the value of autonomy, to use or decline specific interventions, and the desirability of decreasing medical resource consumption with the application of Spartan measures. The traditional medical “cost-benefit” analysis was between the likelihood of successful therapeutic intervention and that of patient discomfort or suffering. Economic cost has now become a widely present reality and cost is often a concern. Perhaps this is unavoidable in a finite world, but it is still a glaring change from concepts of the recent past. To some, the argument for medical futility is that it provides justification for the use of cost-allocation schemata without the need to define a fair procedure for resource allocation. For others, if brought into a public forum, cost-allocation and rationing of services is justifiable because they reflect the needs of the society to which they are applied. By explicitly stating criteria for allocation and cost considerations, the value-driven definitions of medical futility can be judged more clearly against a standard acceptable to the community. An example of this is Oregon allocation of Medicaid funds.³¹ Unfortunately, insufficient evidence is available to indicate that futility is applicable in enough cases to make a difference in the scarcity of medical resources.

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Case 1

DNR in the ER

You are called to the emergency room and asked to intubate Mrs. Z, a 75-year-old female with chronic obstructive pulmonary disease. She is a “frequent flyer” in the hospital, having been admitted to the ER and ICU on multiple occasions for respiratory care. During her last admission two weeks ago, she required mechanical ventilation for three days. As a result, she signed a “do-not-intubate” order to prevent having to undergo “that experience” again. The ER physician tells you that you have to intubate her now.

- 1) How do you respond to your ER colleague?
- 2) What are your concerns?

Case 1, Instructor's Notes

1) The concerns in this case center around patient autonomy. If the decision to forgo future intubation and mechanical ventilation was made by the patient with a clear understanding of the consequences of not intubating her, her wishes should be honored.

Another issue which may or may not be relevant to this scenario is the issue of professionalism. Anesthesiologists should not follow a direction to intubate a patient when they believe it is wrong. Now, of course, this needs to be tempered with common sense. If the situation were unclear, an anesthesiologist can always intubate the patient in the urgent situation and withdraw ventilatory therapy after clarifying the situation.

2) In this scenario, her goals for her medical care, although divergent from those of the physicians, clearly indicate her preferences. Of course, if she is still conscious and has “changed her mind,” then her (new) autonomous choice must be respected.

Case 2

Futility in the Operating Room

At 3 a.m., the operating room takes a booking for an exploratory laparotomy on a 82-year-old male, Mr. X, who is thought to have ischemic bowel. He is brought down to the operating room, and his family is by his side. He is frail looking, 5-foot 11-inches tall and 100 pounds. His abdomen is doughy and painful to palpation, his lips are blue and his extremities show signs of hypoperfusion. He looks at you, says nothing and points to the DNR order taped to the front of his chart. The DNR order specifies various levels of care. It specifically states that intubation and vasoactive medications are to be avoided. It does allow the use of blood transfusions. As you begin to question him, you realize that he is “mentally with it.”

His family is increasingly agitated, wondering why you are asking so many questions, concerned that the delay will adversely affect his care. They want the surgery done. The surgeon, a good friend, takes you aside. She says she feels that the surgery is a last-ditch effort, that she is uncomfortable about performing the surgery but that she is also uncomfortable with the consequences of not performing the surgery. The patient eventually states that he understands your concerns about his refusal of intubation and vasoactive drugs and is willing to proceed with the anesthetic and operation without restriction. You place an arterial and pulmonary artery catheter. During the operation, you are faced with hypotension that is unresponsive to fluid therapy. You begin a dopamine infusion, which corrects the hypotension and improves the urine output.

The surgeon finds 2.5 feet of dead bowel, which she removes. An expeditious closure follows, as does transport to the ICU. By post-operative day number two, the ICU team is unable to wean the dopamine infusion, and a chest film shows ARDS. The family wants to speak with you about your decision to intubate the patient and start the dopamine infusion.

- 1) What questions do you ask Mr. X?
- 2) What issues or concerns will you discuss with Mr. X?
- 3) How do you justify your use of a vasoactive infusion to the family?
- 4) What do you recommend to the family as the next step?

Case 2, Instructor's Notes

1) The question that must be answered is whether or not Mr. X understands that intubation and resuscitation are a means of facilitating a potentially curable condition.

2) Mr. X's specific concerns surrounding the role of intubation and vasoactive support should be discussed. It should be emphasized that intubation and resuscitation are the means of facilitating a potentially curable condition. Assurance should be given that should the procedure not be viable or his condition inoperable, his wishes will be honored forthright.

3) You should explain your thought process and let the family know that this outcome was within the realm of possibility in this clinical scenario. The use of vasoactive infusions is considered an appropriate action to take in this setting.

4) A frank discussion should ensue surrounding the probable outcomes of care in this setting. The patient's wishes should be honored as he was promised prior to the surgical procedure.

Case 3

Enough Already, Let Me Die

As a resident in the ICU, you are told to place a central line in Mr. Y so that total parenteral nutrition (TPN) can be started. He is a 56-year-old male with a history of disseminated squamous cell carcinoma of the lung, involving metastases to the liver, lung and bone. He is refusing central line placement, stating that he is in pain and just wants to die.

On further questioning, he states that he understands the implications of refusing parenteral nutrition. The ICU attending and the family have also spoken about the medical options and they want to start TPN.

1) How should you proceed when he refuses central line placement?

2) What biomedical ethics issues should play a role in your decision-making process?

Case 3, Instructor's Notes

1) The patient's concerns regarding placement of the central line should be explored. If the line is being placed for TPN or for the administration of pain medication, he should be informed of such. His continued comfort in this terminal stage of life should be the focus of the discussion.

2) The principles of respect for autonomy, beneficence and nonmaleficence all play a role in this clinical scenario. Although a resident is not the official decision-making physician in this situation, responsible behavior cannot be replaced by "just following orders."

MEDICAL FUTILITY

Special Teaching Method

Medical Futility

The goal of this exercise is to understand the different views of “futile care.”

Discuss the following questions:

- 1) What is a “good” quality of life?
- 2) How often does a therapy have to be successful to be considered highly, moderately, somewhat or rarely successful? What words do you use to advise a patient on the success of a procedure? How can you convey to the decision-makers the quality of the information you are giving them?
- 3) Should cost matter? How much is too expensive? Should it make a difference whether the therapy is paid by the individual, insurance companies or society?

REDEFINING DEATH:

Ethical, Legal and Medical Implications of Brain Death Determination in Anesthesia Practice

IN THE PAST, DEFINITIONS OF DEATH WERE NEEDED largely so that living patients were not mistakenly treated as though they were dead. Death was defined by recognizing that certain physical events such as cessation of respirations and pulse were irreversible and could be counted on to reliably indicated that death had occurred. **Two medical advances of the middle of the 20th century challenged society and medicine to re-examine the definition of death: the development of artificial respiration and circulation and advances in organ transplantation.**

With the development of ventilators after the polio epidemics of the middle century, it became difficult to differentiate between patients who were alive and those who had, through the support of medical technology, merely retained the appearance of life. Some advances in medicine were viewed with growing alarm by patients and families who expressed fears of being sustained by “machines” long after meaningful existence had ended. As respect for patient autonomy became an increasingly important ethical principle in the medical treatment of patients, doctors and patients alike became concerned that some expensive and invasive therapies, while life-sustaining, might not always be consistent with the personal goals and values of the patients they served.¹

Public concerns over the expense, indignity and potential futility of some medical therapies increased, just as advances in organ transplantation forced the medical profession to examine closely whether ancient definitions of death were adequate in the face of advancing medical knowledge and societal needs.

Redefining Death. In 1968, the Ad Hoc Committee of the Harvard Medical School, headed by Henry K. Beecher, M.D., the first chairman of anesthesiology at Harvard, con-

vened to re-examine definitions of death. Their stated mission was twofold: 1) to define death so that relatives of dead patients could be informed and scarce medical resources such as ICU beds could be reallocated to living patients, and 2) to identify dead people from whom vital organs could ethically be obtained for transplantation.³⁻⁵

The committee offered a new definition of death, based on death of the whole brain. The definition required that:

- 1) The patient be in a coma with absence of spontaneous respirations, lack of spontaneous movement, dilated pupils, absence of cephalic reflexes and postural responses, and isoelectric EEG and;
- 2) The examination of the patient had to be accomplished on two separate occasions, 24 hours apart, and without the contribution of other factors that might mimic death such as toxins and hypothermia.

It was several more years before the Institute of Neurological and Communicative Disorders and Stroke Collaboration Study (1970-1972) confirmed in prospective studies that the Harvard criteria reliably identified patients who would never recover neurologic function and could be reliably considered dead.⁶

With only a medical definition of whole brain death, discontinuance of medical care or vital organ harvest based on a diagnosis of whole brain death nevertheless remained homicide in legal terms. In 1979, members of the American Medical Association, American Bar Association and National Conference of Commissioners on Uniform State Laws met and formulated a “Model Brain Death Act,” which legally recognized whole brain death as a legal and not merely medical definition of death.⁷ All 50

states now have statute recognition of whole brain death as a legal means of defining death.

Criteria for Brain Death. Brain death is defined as the total and irreversible loss of function of the whole brain, including the brainstem. The diagnosis can be established medically with a physical examination and an apnea test, although institutional policy may require additional confirmatory tests.⁸ The process for establishing a diagnosis of brain death is as follows:

- 1) Rule out reversible causes of apparent coma such as depressant drugs, neuromuscular blockade, hypothermia and shock.
- 2) Demonstrate that cortical responses to painful stimuli, including decorticate and decerebrate posturing, are absent. (Minor flexion of extremities in response to local pain, which represents a spinal cord reflex and not cortical activity, is acceptable.)
- 3) Demonstrate that the patient has no pupillary response to light, corneal reflex, gag, cough or swallowing response to posterior pharyngeal stimulation. Doll's eyes reflex must be absent as must be a cold-caloric response.

The doll's eye reflex (also called the oculocephalic reflex) is obtained by rapidly turning a patient's head side to side and forward and back. The eyes of a comatose patient with an intact brain stem (and therefore not brain-dead) move opposite the movement and end up looking forward as they were prior to movement (the doll's eyes movements). The eyes of a comatose patient with a brainstem lesion will not exhibit the doll's eyes movements. The cold-caloric stimulation test involves injecting ice water into the ear canal. A normal awake patient shows nystagmus. A patient with a brain stem lesion exhibits no nystagmus.

- 4) The patient must demonstrate no response on a properly conducted apnea test.

Confirmatory tests are listed in **Table 1**. These tests are optional medically but may be required by some institutional policies. In some

cases, confirmatory tests are needed because the clinical status of the patient may confound the clinical exam or prevent a proper apnea test, which is described in **Table 2**.

Brain death determination in adults requires two tests at least six hours apart. In children under one year of age, a longer period of observation is required. Some authors suggest examinations must be stable for 24 hours for children between two months and one year, and for 48 hours in children between seven days and two months. Diagnosis of brain death in infants less than seven days old is not currently supported by all authorities, due to lack of data.⁹

Public Fears About Vital Organ Transplantation. From the beginning of vital organ transplantation, and despite extensive efforts to educate and motivate people about organ donation, public sentiments can be characterized as ambivalent. In 1994, 94 percent of Americans were aware of organ transplantation and of the critical shortages in transplantable organs, yet only 20 percent had signed organ donor cards. Americans were much more likely to agree to donate their relatives' organs (82 percent) than their own (43 percent).¹⁰ Why has the acceptance of organ donation lagged so far behind the need?

Reluctance to donate organs is in part connected with mistrust about the ability of physicians to accurately diagnose death. In the past, the diagnosis of death was obvious, even to non-physicians. But today, the dead may look much like other living patients in an intensive care unit, and families must rely on the presentation of test data by physicians to prove that a patient has died. Even when tests are unequivocal, over 50 percent of the lay public in recent polls still do not accept brain death as a definition of death.¹¹

Worse than fears that brain-death criteria are not reliable is the considerable public mistrust about the motivation of physicians to diagnose death accurately. Transplantation strains the traditional doctor-patient relationship because there is a conflict of interest for doctors between serving the best interests of the potential

BRAIN DEATH

donor and the needs of a potential recipient. In a 1986 report,¹² there were two primary reasons given by people surveyed about why they did not sign organ donor cards:

1) Fear that the doctor might harvest organs before they were really dead.

2) Fear that doctors might deliberately hasten death to obtain organs. A 1985 study of Swedish attitudes toward autopsy and organ donation indicated that people who were ambivalent about donating their organs were often afraid that they would not be dead at the time of organ harvest.¹³

Even the perception that patients might be intentionally or deliberately killed for their vital organs could have a devastating impact on the critically low supply of viable organs for transplantation.

Table 1:

Confirmatory Tests for Brain Death

Electroencephalogram (EEG)

EEG should be isoelectric. Many conditions can lead to a “quiet” EEG, which does not mean brain death has occurred, e.g., drugs and hypothermia. An isoelectric EEG is insufficient by itself to determine that brain death has occurred.

Cerebral Blood Flow Studies

These include angiography, nuclear flow scans and doppler flow studies. Absence of cerebral blood flow is diagnostic of brain death. Bed-side nuclear scans now make this a practical exam to include in brain death determinations. Doppler flow scans are sufficient, but many institutions do not rely on these studies due to their recent introduction into the diagnostic process.

Brain Stem Evoked Responses (BSERs)

These tests are simple, inexpensive and accurate, but many hospitals do not have the equipment or personnel to perform the tests. BSERs only test brainstem function and are not sufficient by themselves to diagnose brain death.

TABLE 2

Apnea Test

1. Rule out the presence of muscle relaxants and respiratory depressant drugs.
2. Allow patient's PaCO₂ to rise to 35-40 mmHg (many brain insult patients will be hyperventilated below their apneic threshold)
3. Oxygenate the patient for 15 minutes with 100 percent O₂.
4. Obtain arterial blood gases to confirm that the patient is not hypoxemic.
5. Disconnect the ventilator and apply a T-piece with 100 percent O₂ to permit passive oxygen flow and apneic oxygenation.
6. Monitor the patient's arterial blood gases throughout.
7. Allow apnea to persist long enough that arterial blood gases confirm that the patient's PaCO₂ has risen above 60 mmHg.
8. Confirm in patients with chronic obstructive pulmonary disease (COPD) that the PaO₂ was less than 60 mmHg, to prevent ablation of hypoxic pulmonary drive in such patients.

The test should be terminated for any of the following conditions:

1. The patient coughs, gasps or makes any kind of respiratory effort. The patient is not brain dead.
2. The patient becomes hemodynamically unstable and the instability cannot be easily managed with judicious use of vasopressors and/or fluids. The test is indeterminate, and confirmatory testing such as a cerebral blood flow study is required.
3. The PaCO₂ is above 60 mmHg in the absence of confounding factors and the PaO₂ is adequate (in the case of COPD patients the PaO₂ should be less than 60 mmHg to prevent ablation of hypoxic pulmonary drive), and the patient is hemodynamically stable. This test confirms absence of brainstem activity and, if coupled with a lack of cortical activity, confirms the diagnosis of brain death.

The Ethical Treatment of the Dead. A corpse does not possess autonomy, which is the ability to act on one's own. Once dead, the individual ceases to exist and does not technically have legal rights. This is not to be confused with a living individual expressing desires and having a right to have them implemented after death. The treatment of the dead, from an ethical standpoint, is dictated by principles of respect for their survivors and the culture to which they belonged. A principle of respect for human dignity might dictate that the remains of the dead not be mutilated, because it would violate a principle of respect for the people to whom the remains have value.^{14,15}

Ethical Treatment of the Unconscious, Living Patient.

Respect for Autonomy. Unconscious individuals, who may even be dying, while still alive retain rights that are protected both by ethical principles and by law. Such individuals no longer have autonomy, in that they either cannot make or cannot express choices. They nevertheless have similar rights to any other living patient.^{16,17}

Beneficence and Nonmaleficence. These concepts have evolved with medical advances and society's perception of the rights of patients. The act of beneficence refers to promoting not just life itself, but "good quality" life. Decisions about what constitutes a good life rests with the patient, who must live it. Individual values are based on experience, perception, culture, individual limitations and biases. Quality of life determinations are therefore patient-specific. Even surrogate decisions are poor reflections of patient wishes, at best (see **Module B, "Who Speaks for the Patient?"**). In the case of unconscious patients without previously expressed wishes, beneficence and nonmaleficence suggests that we err on the side of valuing life.¹⁷

Justice. This principle demands that an individual's worth not be judged exclusively on intellectual or physical attributes or on social status. "Vulnerable persons" such as the elderly, very young, handicapped or otherwise im-

paired individuals should not be treated differently with regard to respect for their autonomy and with regard to principles of beneficence and nonmaleficence. Ethical principles prohibit us from weighing the life of a potential donor against the life of a potential recipient, since no person's life has more or less intrinsic value than the next.¹⁷

The importance of the definition of brain death is that it separates individuals who are unconscious but living, and therefore must be ethically and legally treated with respect for their individual dignity and rights, from individuals who have died, and may be ethically and legally treated as corpses.

Can a Living Person Ethically Be Used as a Vital Organ Donor?

There was a failure of early attempts to define a set of individuals who retained biologic life but had lost all of their human qualities (had ceased to be "persons"). Ethicists and physicians were unable to define the qualities that comprise "personhood," and thereby identify strict and safe criteria to determine its loss. While many persons in persistent coma appeared to have lost qualities of personhood, experience demonstrated that such determinations were far from perfect.

The Case of Carrie Coons. In 1989, the New York State Supreme Court was forced to vacate an order permitting withdrawal of life-sustaining tube feedings when the patient in question, Carrie Coons, despite her physicians' predictions to the contrary, unexpectedly regained consciousness. She had suffered a massive stroke at age 86, and her sister requested that tube feedings be withdrawn. When Ms. Coons unexpectedly awoke and was able to express doubts about withdrawal of care, the court's order was vacated and tube feedings resumed.¹⁸

Misdiagnosis of Coma. A recent report in the *British Medical Journal* further cast doubt on the certainty of the diagnosis of permanent coma, when it was demonstrated that up to 43 percent of patients in a rehabilitation unit who were diagnosed as suffering from "vegetative state" were actually aware of their sur-

BRAIN DEATH

roundings and sometimes capable of communication under certain conditions.¹⁹

Defining death by loss of personhood poses several difficulties:

Vague Criteria. Criteria for loss of personhood are vague and probably cannot be separated from the values and biases of people formulating the criteria.

Uncertain Prognosis. Loss of “personhood” carries an uncertain prognosis, as opposed to brain death criteria. The uncertainty inherent in a diagnosis of loss of personhood carries the risk of increasing, rather than decreasing, public fears surrounding the ability and motivations of physicians to declare death accurately.

Other Issues

Anencephalic Newborns. In 1995, the American Medical Association Council on Ethical and Judicial Affairs rendered an opinion that use of anencephalic newborns as vital organ donors might be ethical, since such individuals had never possessed qualities associated with personhood. The opinion came under fire because of the uncertainty of diagnosing anencephaly and concerns that use of such infants might put physicians on an ethical “slippery slope” and place other vulnerable and handicapped members of society at risk.

What Is a Slippery Slope? The principle of nonmaleficence dictates that we should avoid acts which, even though beneficial individually, might lead us to then commit acts which, although similar, are morally objectionable. This can happen when no logical distinction can be drawn between an act which is “good” and one which is “evil.” This is the so-called *logical slippery slope*. It might be ethical, for example, to use anencephalic infants as vital organ donors, if we draw clear lines preventing the use of other vulnerable or handicapped infants.

A second type of slippery slope also exists, called the *psychological-sociological slippery slope*. In this situation, psychological or socio-

logical factors provide disincentive to draw logical, clear and appropriate distinctions between two different acts. For example, as the expense of medical care rises, the number of handicapped infants requiring care increases and the need for vital organs goes unfulfilled, there is danger that a gradual erosion of society’s distinctions between anencephalic infants and other handicapped infants could occur.

It is relatively easy to defeat a logical slippery slope argument by providing strict definitions and rules. It is more difficult, however, to guarantee society’s resolve to follow the strict rules, as strong disincentives to adhere to these rules escalate.

“Rules against killing in a moral code are not isolated fragments; they are threads in a fabric of rules, drawn in part from nonmaleficence, that support respect for human life. The more threads we remove, the weaker the fabric becomes.”²⁰

The Anesthesiologist’s Role. As physicians involved in the care of vital organ donors, it is critical for the assurance of our patients’ families, as well as the integrity of organ transplantation programs, that we be familiar with the ethical, legal and medical implications of brain death. It is the responsibility of any anesthesiologist taking care of a vital organ donor to review the chart to assure that conditions for declaration of brain death have been met. A sample checklist for chart review can be found in **Table 3**.

TABLE 3:

Checklist for Anesthesiologists

Etiology of Coma:

1) Check that all of the following were confirmed before testing:

- ☐ absence of sedation or
- ☐ absence of muscle relaxation (confirm with neuromuscular blockade monitor)
- ☐ absence of shock (systolic BP > 90 mmHg, or within 10 percent of patient's baseline)
- ☐ absence of hypothermia (temp > 32 degrees C, higher by some institutional policies)
- ☐ absence of metabolic or endocrine disorders that might contribute to coma

2) Clinical Examination (all must be checked to confirm diagnosis)

- ☐ no spontaneous movement
- ☐ no movement in response to pain, including supraorbital ridge pain, except movement due to spinal reflexes. These movements should be local, minor flexion responses only
- ☐ no seizures, or decerebrate, decorticate or dyskinetic movements or posturing

3) Brainstem reflexes (all must be checked to confirm diagnosis)

- ☐ absent pupillary response to light
- ☐ absent corneal reflexes
- ☐ absent cold-caloric responses
- ☐ absent pharyngeal reflexes
- ☐ absent cough with suctioning

4) Time between clinical assessments (one must be checked):

- ☐ at least six hours in adults
- ☐ at least 24 hours in infants between 2 months and 1 year of age
- ☐ at least 48 hours in infants under 2 months of age

5) Apnea test completed—see **Table 2**

6) Confirmatory tests (optional):

- ☐ EEG
 - ☐ Cerebral Blood Flow Studies
 - ☐ Brainstem Evoked Responses
-

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the dead from multiple cultural and religious perspectives, written by leaders in the field in each culture.

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BRAIN DEATH

Case

Dead or Alive?

An anesthesiologist is caring for a vital organ donor during organ harvest. The donor is a 41-year-old male who was declared brain dead by a neurologist after suffering a subarachnoid hemorrhage. Across town, a 21-year-old patient, comatose from acute liver failure secondary to mushroom poisoning, is being prepared for liver transplantation. A 32-year-old woman with post-partum cardiomyopathy is being prepared for heart transplant.

After skin incision but before organ harvest, the donor is noted to have falling oxygen saturations and rhonchorous breath sounds. As the anesthesiologist suctions the endotracheal tube for copious secretions, the donor coughs.

1) Use a systematic approach to evaluate and discuss the clinical ethical problem presented in this case (please refer to the four questions approach of analyzing an ethical dilemma discussed in **Module A: Implementation of an Ethics Curriculum: Getting Started**).

- a) What are the medical indications, risks and benefits for the patient?
- b) What are the quality-of-life expectations from the planned surgery and the alternative of no surgery?
- c) What are the patient's preferences?
- d) Are there any contextual features that should be considered?

2) Who is the patient in this scenario? Does the anesthesiologist have an obligation to the transplant recipients? What resources are available to the anesthesiologist to solve this problem?

Case, Instructor's Notes

I. The Four Questions

Question 1) Medical Indications. When we speak of medical indications for a given procedure, we are referring only to the indications pertinent to the patient undergoing the procedure. In the case of voluntary organ donation from an otherwise healthy patient, there are no medical indications for the donor to undergo organ harvest. The risks of donation depend on the organ being harvested. In the case of non-vital organ harvest, such as renal harvest, the risks to a donor are the risks of surgery and anesthesia such as bleeding, infection and death from surgery, as well as the risk of future renal dysfunction in the remaining kidney.

In the case of vital organ harvest, normally we are not speaking of risk to the donor, who must by legal and medical definition be dead at the time of harvest. There are no medical risks to a corpse.

But what if the donor is not dead? Coughing is not compatible with brain death, and therefore, this donor is not brain dead. Vital organ harvest will, with medical certainty, result in death.

Question 2) Patient Preferences. The patient is unable to communicate preferences in this case. Even if he carried an organ donor card, we cannot presume that because he expressed a wish that his organs be used after death, he would therefore be willing to be killed for those organs. Had he expressed such a wish, principles of beneficence, nonmaleficence and justice as well as the values of trust and respect for life would prohibit physicians from fulfilling such a wish.

Question 3) Quality of Life. Vital organ harvest will end this patient's life, and quality-of-life issues become moot. Not undertaking organ harvest will certainly leave the patient alive, at least temporarily, with minimal prognosis for recovery. While many of us might consider such a life not worth preserving for ourselves, it is a judgment that we cannot make for him,

since the decision would involve having the patient weigh his values, experiences and biases in determining what type of existence is a worthwhile one for him.

Question 4) Contextual Features. Vital organ harvest will benefit several other recipients, who at this point appear to have more attractive prognoses than the vital organ donor. But weighing the value of the worth of one individual (such as the donor) against the worth of the lives of another (such as a potential recipient) would violate medical ethical principles of justice, which state that no one individual's life is worth more than another's, regardless of the particular physical characteristics of that life.

Vital organ harvest from a living donor stands to seriously harm the public's trust that doctors will not sacrifice one patient for another and that every patient is treated with equal respect. One of the major causes of low rates of organ donation are public fears that they will not be dead at the time of organ harvest (such as with this patient), or that doctors will use them to benefit other patients. Vital organ harvest from this donor has the potential to render serious harm to future voluntary organ donations. Two recipients might benefit today from this donor's organs, but at the cost of potentially thousands of future patients who might be unable to get organs unless public trust can be enhanced. A small, current benefit is outweighed by the potential for overwhelming future harm.

Case Development:

At the center of this case is the question: should organ harvest proceed?

The donor does not meet medical, ethical or legal standards for death. Sacrificing the donor to obtain organs to benefit others violates principles of beneficence (to the donor and to society), nonmaleficence (to the donor and to organ transplantation programs) and justice (to the donor and to recipients). It would further harm trust between doctors and patients for future donations and could cause irreparable harm to the ability of physicians to obtain voluntary organ donations for future patients. Proceeding with vital organ harvest is almost certain to violate statutes in almost any state against homicide and may place all participants in peril of criminal prosecution.

While there are strong situational incentives to proceed, such as the knowledge that two recipients are awaiting transplant, with the almost certain pressure to proceed from medical colleagues, the process should be stopped.

Should pressure to continue the surgery arise, the anesthesiologist might consider calling upon the following resources to support a decision to abandon the procedure:

- 1) The hospital attorney
- 2) The hospital chief of staff or medical director
- 3) The hospital nursing director
- 4) The hospital ethics committee

The Rest of the Story ...

In a case similar to this one, the anesthesiologist immediately informed the surgeon of the patient's cough and of the implications that the patient was not brain dead. After initially objecting, the surgeon agreed that the procedure should be abandoned, because of the question of an invalid declaration of death, together with the potential legal implications of proceeding. The incision was closed, and the donor was returned to the ICU where he died several hours later of cardiac arrest. The liver and heart were not transplanted.

BRAIN DEATH

Special Teaching Method

Brain Death and Organ Transplantation

Learn about your own department's brain death and transplant policy.

- 1) How and where would you find your policy?
- 2) Is it consistent with this module? If not, what is different, and why?
- 3) What is your department's formal or informal policy on the assessment of a donor prior to organ harvest?

Professional Relationships in Medicine

Introduction:

The Accreditation Council for Graduate Medical Education has mandated education for medical residents of all specialties in the area of “professionalism,” loosely defined as a set of characteristics, including a “commitment to carry out professional responsibilities, adhere to ethical principles, and exhibit sensitivity to diverse populations.” The creation and promotion of an environment of professionalism in the workplace includes a commitment to an understanding and appropriate approach to both personal and professional relationships with co-workers. In this third module of the ASA Syllabus on Ethics, three authors approach workplace issues that physicians face with their colleagues, non-physician co-workers, and even their patients and/or patients’ families, including conflict resolution, sexual harassment, and intimate relationships between students and teachers. Each author reviews basic concepts in understanding professional relationships, summarizes controversies, suggests references and reading materials, and provides examples of teaching cases and discussions for use in resident or faculty education.

This module was developed/overseen and reviewed by members of the ASA Committee on Ethics reflecting the individual expert opinions of the authors regarding ethical problems and cases confronting clinical and research physicians in the practice of anesthesiology. However, the opinions expressed in these modules are those of the authors, and do not represent official positions or policies of the American Society of Anesthesiologists.

Section H

CONFLICT AND COMMUNICATION

David B. Waisel, M.D.

Conflict occurs daily in the operating theater. While *unresolved* conflict is bad, conflict itself can in fact be good. Conflict is often the first step to addressing issues, crystallizing problems and attempting resolutions. Indeed, the absence of conflict does not mean the absence of problems. A culture that prides itself on avoiding conflict likely has many unresolved and ongoing problems, and suppressing conflict is potentially dangerous. Conflict is a learning process that, while not necessarily enjoyable, promotes finding solutions and brings growth, change, and innovation.

“Good” conflict involves a clearly stated issue, followed by a rational and focused discussion. It is based on good faith negotiations and an attempt to understand the other party’s position. “Bad” conflict is based on intense or uncontrolled emotions or on self-centered competition, and it has inadequately declared goals.

Thus, it makes good sense to have an approach to resolving or managing conflict.

Types of Conflicts and Solutions

Understanding the type of conflict in which you are involved is important because it helps you manage expectations. **Short-term conflicts** involve negotiable disputes and generally need to be resolved within impending time constraints. Most conflicts with patients, physicians or other health care personnel about patient care are of this type.

Long-term conflicts involve questions about the distribution of resources and determination of authority, and they often are deeply rooted in personal values. **Conflict resolution** is the creation of an ongoing stable pattern of resolution. **Conflict management** involves control of the conflict, but not a resolution.

What Aggravates Conflict?

There is rarely only one problem at the heart of a conflict. The following categories of issues are arbitrarily dichotomized for the convenience of discussion.

1. *Core of conflict not recognized* — The core of the conflict is what the conflict is *really* about. Consider, for example, a conflict arising between an individual complaining about turnover time in a bellicose manner, and another who is insulted by the manner in which the problem is being addressed. The first individual may believe that the conflict is rooted in issues involving actual turnover time, while the second individual is more likely to frame the conflict in terms of proper respect and behavior. Disagreement over actual core of the conflict makes it difficult to resolve the conflict. Other disagreements over the core conflict may focus on issues such as justice, fairness, pride and morality.

2. *Complicating factors intervene* — Complicating factors obscure the core of the conflict, intensify the estrangement, and may prevent resolution of the core problem. They include, but are not limited to, mistrust, questions about facts, motives, personal preferences and stereotyping. Confusion about the core of the conflict leads to ambiguity about what the goals for resolution should be, which, in turn, leads to meaningless actions that often cause further problems and exacerbate misunderstandings.

3. *Framing problems* — Misunderstandings tend to arise from how individuals view, describe or interpret events—or “framing.” These views are rooted in individual values, experiences, and knowledge. Anesthesiologists should make an effort to recognize their framing, accept that others may have alternative framing, and develop strategies for understanding when inappropriate framing interrupts successful resolution. Framing a problem often leads to an adversarial or win-lose scenario that, in turn, leads to fights over power and further escalation. “Misframing” can impede effective communication and demonize the other individuals.

4. *Position-taking* — Position-taking is the act of converting the argument into an issue of “this is my position” and not “what is best or right here.” Position taking is the first step toward viewing resolution of the problem as a competition in which the focus is on winning and not resolution.

5. *Inadequate scoping* — “Scoping” refers to the process of identifying the parties involved and their level and extent of interest, and then determining which individuals are adversaries, allies, mediators, decision-makers and outside influences. Scoping problems may occur if there is a failure to identify all the issues or gather needed information, when different definitions of words like “good,” “appropriate” and “success” are adopted, and/or if conflict history and differences in communication are ignored. These mistakes can cause unstated motives to be assigned to others, and can lead to avoidance of communication, inflammatory actions and escalating problems. The outcome can be increasingly contentious behavior, polarization and personal attacks.

6. *Communication problems* — Communication problems are exacerbated when parties do not make themselves available for timely interaction, when the people key to communication and conflict resolution are not identified, and when “supporters” and

“nonsupporters” are not equally included in the exchange. A common communication problem for anesthesiologists may be the phenomenon of “staff room support.” “Staff room support” is the tendency to discuss the issue at hand only with like-minded individuals. Such behavior perpetuates your own beliefs by not allowing them to be sufficiently challenged. It also fosters emotional reactions, and turns “the other” into a one-dimensional adversary. Such behavior impedes conflict resolution.

In conflicts, we tend to be unclear, indirect, uncomfortable and poor listeners. Poor listeners often assume they know what others will say, or they are too busy preparing a response to hear what is being said. We also tend to hear what we want or expect to hear. Clarity of communication deteriorates when either party is ‘revved up’ by anger or mistrust. This leads to the “Let me tell you what you mean” syndrome, another version of the ever popular subcategory of “don’t confuse me with facts, my mind is made up.”

Another communication mistake is devaluation of the adversary, such as a mistaken belief that they have certain motives, based on rumor or stereotype. Stereotypes may be perpetuated when individuals focus on anecdotes and rare examples that, while not the rule, nevertheless support the stereotype. One result is that antagonists interact less often and more guardedly.

Managing Emotions

As conflicts progress, individuals may personalize the issues and experience feelings of enmity and mistrust. They become less free with information and more likely to negatively misinterpret what the other individual says. Nonverbal cues of anger and frustration further hamper the ability to send and receive messages, and they foster misinterpretation. Therefore, it is advantageous to focus on behaviors rather than motives or beliefs. For example, a statement such as “you need to turn the room over more quickly” focuses on a belief about the individual (that they are not working quickly enough), while the statement “You should make up your drugs for the next case if the opportunity arises during this case,” is a suggestion about a specific behavior that may help room turn over time.

Failure to Identify Options

A significant factor aggravating conflict can be the failure to identify options. This is most often a result of inadequate identification of the core of the conflict and ambiguous goals for resolution. Often, conflicts are framed in either a “this-or-that” manner, disregarding possible options. We ignore options because 1) we’ve never done that before, 2) we can’t do it (with no clear-cut reason), 3) we’re too busy being angry or laying blame to think about a resolution, 4) knowledgeable people are excluded from the discussion, 5) communication has failed, or 6) we’re too busy trying to win.

“If all you have is a hammer, everything is a nail”

Inability to identify conflicts and alternate resolutions is exacerbated by the tendency to do what we do best or to return to our limited repertoire of tricks. Thus, bullies bully, whiners whine, avoiders avoid. In medicine, there is a great deal of a “might-makes-

right” (“might” by authority, money or positions) mentality and its attendant fear of the power structure.

Disagreement About the Facts

Arguments about facts arise from questions about the data source, statistics, validity, importance and cause. Interpretation of facts, of course, often brings forth additional conflicts.

Not My Problem

The “Best Alternative To a Negotiated Agreement” is what an individual thinks will happen if the issue at hand is not addressed and a resolution is not sought. In other words, “Why should I try to achieve a resolution?” Failure to address the issue or seek resolution usually does not work.

Escalation

Escalation refers to an increase in the intensity of conflict. Escalation characteristically involves invoking “heavy guns” and bringing up more “stuff.” Issues then move from specific to general, with the number of parties increasing and the goal changing from “doing good” to winning. Minimizing escalation requires that individuals depersonalize both internal thoughts and external expressions, establish communication ground rules, and use respectful and effective language. “That’s not how we do it here,” is an example of language that is disrespectful, infuriating and off-putting and is actually saying “You are not one of us.”

Fixes for Conflicts

The fixes are simple in theory, but difficult in practice.

1. General principles

The basic premise for success is: be the “grownup” in the room. Avoid provocations, keep your eye on the ultimate goal, and preserve communication. Try to not get caught up in proving you are right, beating an adversary, or making a mountain out of a molehill. Most importantly from an ethical standpoint, avoid strategies that adversely affect patient care. *Practice* being the “grownup.” You are more likely to succeed in handling conflict if you are psychologically and intellectually prepared to manage the situation and achieve a solution. Attempt to focus on the question by redefining the problem in terms of interests, avoiding discussion of positions, and separating the antagonists from the problem, at least until tempers have cooled. Consider reasons underlying why individuals have differing positions.

2. Listen actively

Don’t think about the reply while the other person is talking. Pay attention to assumptions. Take the time to reevaluate issues; even those questions to which you think you know the answer. The other person may truly appreciate the opportunity to be heard. One common hindrance to active listening is the natural tendency to pre-rehearse conversations and to prepare a response to what we are certain the other person will say.

This prevents an appropriately reflective response to what the other person actually *does* say.

3. Acknowledge history

Some individuals refuse to let go of their comfortable and reaffirming perceptions of the world around them. Try to understand how your own history affects your ability to view the conflict, the participants, and the meaning of success. Use this knowledge to resolve conflict and not as a roadblock or bludgeon.

4. Get help

Obtain timely practical, ethical and legal consultation to help clarify facts and define pertinent issues, understand positions of those involved (including self), consider relevant principles and consequences, look for creative solutions, and accept the need to weigh the issues. Be prepared to be uncomfortable with the result.

5. Understand that “jerks” exist

The fact of the matter is that not everyone is a nice person. There are some standard ways of responding, or perhaps even not responding, to individuals who do not seem to prioritize the common good. Don't react to provocations, focus on facts, and avoid stereotyping and/or being distracted by previous conflicts.

Recommended Reading:

Ury W. Getting past No: Negotiating your way from confrontations to cooperation.
Bantam Doubleday Dell Pub, 1993.

Fisher R, Ury W, Patton B. Getting to Yes: Negotiating agreement without giving in, 2nd
Edition, PenguinUSA, 1991

Case: Could the Attending Be Wrong?

You have just completed placing an IV in a 20-year-old woman scheduled for a hysteroscopy. Following a moderate amount of midazolam, the woman tells you that she wants to talk more about the risks of surgery and anesthesia, and that she is not sure she wants to proceed. Your attending moans about whiny patients, mutters something about midazolam, and then directs you to “give her more until she is cooperative.”

The last patient of that day is a 30-year-old man scheduled for knee arthroscopy. Your day has been rather rocky, including difficult intravenous placements and airway managements, and a cancellation that led to a shouting match between your attending and the orthopedic attending. As you interview the patient, he tells you that he had a hamburger and fries 4 hours ago. You return to the operating room where you inform your attending (who broke you out to see the next patient) about the food; as you tell the attending, the surgeon interrupts, exclaiming, “Look, you guys have hurt me enough already. Just give him a little bit of sedation and I’ll do it under local anesthesia (monitored anesthesia care). You can do that, can’t you?” Your attending looks at you, shrugs, and tells you that although you should inform the patient about the risk of regurgitation and aspiration, you should also tell him that it is probably pretty safe to do it with local and a little bit of sedation.

How should you handle these conflicts?

Answer:

Although your attending bears the primary ethical and legal responsibility for the care of the patient, this fact does not excuse you from exercising your judgment. You should not participate in care that might jeopardize a patient's welfare. But conflict can sometimes be complex and subject to considerable interpretation.

How should you handle a disagreement?

1. Begin by discussing your concerns in private. You may not know enough to know whether the attending is making a legitimate choice, and you may feel uncomfortable in discussing your views. Focus on the specific issues that trouble you. Make the discussion a vehicle for learning and solution, and not one for attack. The discussion should lead to one of the following conclusions: 1) The attending’s rationale appears reasonable; 2) Although the attending’s rationale is not completely convincing, you find that the resulting care would be within acceptable boundaries; 3) You aren’t sure, but your concern is sufficient to preclude immediate involvement in the case; 4) You believe the attending’s choice is outside acceptable boundaries.

Obviously, if you find that the rationale presented by the attending is reasonable, proceed as planned. If you find the rationale incompletely convincing, but within acceptable boundaries, you must decide whether you wish to proceed. For example, many times in anesthesia we have to decide upon which risk or benefit to prioritize. Factors that play into whether you would want to participate in the patient’s care include how wrong you think the attending is and how strongly you hold your beliefs about the issue in question.

Competing issues may complicate your decision. You must balance the patient's needs with your sense of values and obligation to the patient, all within the context of your growing but still limited understanding of anesthesiology. You must be certain not to let emotions play into any decision that goes against the suggestion of your attending (are you having a difficult day?). In the same vein, be sure that personal factors (such as distrust or dislike of an attending) do not color your thinking. If you are unsure whether the attending's decision is outside of acceptable boundaries, but feel significantly uncomfortable with proceeding, consider recusing yourself from the case, or revisiting the issue with the attending in a setting more conducive to discussion, or inviting the attending to ask a third, objective party to join in the discussions.

Confronting an attending is difficult. You may be tempted to do no more than condemn the attending to your fellow residents. However, this course of action abdicates your ethical responsibility to the patient, and in the end, condemning anyone behind their back reflects on you as much as the condemned.

Case: Common Situations

Considering the principles discussed earlier in this section, discuss how the following problems should be approached.

Situation 1: A surgeon yells at you in the operating room, complaining about how slow the room is running and his need to catch an afternoon flight.

Situation 2: Following a failed labor epidural for analgesia, the patient accuses you of “doing something wrong and not telling me.”

Situation 3: As you place intravenous and arterial catheters in an anesthetized patient, you ask the nurse who is sitting on the other side of the room having a private conversation on the phone to help you hold the intravenous line as you secure it. The nurse responds, “That’s your job, not mine.” The same nurse already had made no effort to help you move the patient into the operating room, despite your request for such.

Situation 4: As the attending on call you are supervising two senior residents performing anesthesia for two very sick neonates. Your call team has one very junior resident left (it is August), and you get a stat call informing you that you have an emergent sick and bleeding “bring-back.” Feeling unable to handle all three cases safely, you follow written protocol and page the back up attending who is on call to help you. She tells you that she thinks you ought to be able to manage the situation and that she is not going to come to the hospital.

Special Exercise

In the week preceding this special exercise, residents should be instructed to pick one day and to write down every conflict in which they participate or that they witness during the operating room day. For each conflict they should answer the following questions: 1) who was the conflict between? 2) What was the conflict about? 3) Was the conflict resolved or swept under the rug? 4) Was the conflict reoccurring? and 5) in the resident's opinion, was the conflict being discussed *truly* the underlying problem? At the resident session, they should be asked to broadly characterize the conflicts they witnessed, and to consider how some of the examples could be handled in the future.

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Section I:

Sexual Harassment

Rosemarie Maddi, MD

In 1991, *Time* Magazine published an interview with Dr. Frances Conley, a prominent neurosurgeon from Stanford University describing gender insensitivity over a 25-year time frame. Several months later Anita Hill, a law professor, charged Judge Clarence Thomas, a Supreme Court nominee, of creating a hostile work environment with inappropriate sexual nuances. The allegations of Anita Hill and Frances Conley drew attention to sexual harassment in the workplace. Anita Hill had remained silent about her harassment for more than 10 years, and Frances Conley for more than 25 years.

The Equal Employment Opportunity Commission (EEOC) has published guidelines that define and describe sexual harassment. In 1980, EEOC studies indicated that one in four women will experience sexual harassment at work. The AMA has published these EEOC guidelines regarding legal rights for students, faculty and employees. The AMA definition states that “unwelcome sexual advance, request for sexual favors and other verbal or physical conduct of a sexual nature constitutes sexual harassment.”

Sexual harassment is regarded as sexual discrimination and thereby violates the Civil Rights Act of 1964 - Title VII. Sexual harassment is defined as a sexual advance or an unsolicited request for sexual favors or other verbal or physical conduct of a sexual nature. Sexual harassment may occur in various scenarios. The harasser may be a man or a woman. The victim may be of the same sex. The harasser may be a supervisor, a co-worker, or a supervisor in another area. The victim may be anyone who is offended by the comments and behavior. Finally, the harasser’s behavior must be offensive to the victim. Sexual harassment exists whenever an employee’s job performance is impaired as a result of an offensive, hostile or intimidating environment. Sexual harassment may present as verbal harassment or abuse such as inappropriate jokes or stories, inappropriate touching of an individual, and subtle or overt pressure for sexual activity.

In 1981, a survey of 25,000 United States federal employees reported that 42 percent of women and 15 percent of men had been the victim of sexual harassment in the preceding two years. Sixty-two percent described severe forms of sexual harassment and 27 percent had experienced actual or attempted sexual assault. In 1988, the United States Merit Systems Protection Board surveyed more than 24,000 employees regarding sexual harassment, using the EEOC definitions of sexual harassment, and the results were

similar to those of 1981. In the months following the Anita Hill testimony, allegations of sexual harassment increased by 40 percent.

What Is Sexual Harassment?

Sexual harassment is anti-social and unacceptable behavior that existed but was not acknowledged 20 years ago. In 1998, the General Whitley Council Agreement promoting equality and diversity in the National Health Service of Great Britain defines harassment as “action, behavior, comment or physical contact that is found objectionable or which causes offense.” It can result in the recipient feeling threatened, humiliated or patronized, and it can create an intimidating work environment.

United States federal law sets up two different claims of sexual harassment under Title VII. The first type of sexual harassment is *quid pro quo*, in which the person in charge demands verbal or physical sexual acts in order to obtain or retain a job. In *quid pro quo* cases, the employment itself is linked to demands for sex. The second type of claim is that of a hostile work environment. In this situation, the employee in the hostile work environment has several choices. The first choice would be to put up with the harassment. The other options were to oppose the harassment, and thereby increase the hostility or to leave the position. In 1986, the United States Supreme Court described the hostile work environment as an abusive workplace.

If a hospital and/or department does not recognize flagrant sexual harassment, then the institution faces serious liability. The losses to the hospital and department include absentee workers, decreased productivity, increasing health care costs, poor morale among co-workers and employee turnover.

The victim of the harassment must deal with humiliation, loss of dignity, psychological injury, physical injury, damage to the victim’s reputation, and damage to the victim’s career.

The broader spectrum of harassment includes but is not limited to:

1. Verbal or physical conduct of any sort that creates a hostile, intimidating or offensive work environment for another individual.
2. Verbal or physical conduct including comments or illustrations in a medical record that denigrates the quality of care provided by the hospital or any individual associated with the hospital.

Harassment is defined as verbal or physical conduct that denigrates or shows hostility or aversion to an individual including, but not limited to, that person’s race, creed, color, religion, sex, national origin, marital status or sexual orientation. Examples of harassment include epithets, slurs or negative stereotypes, intimidating or hostile acts, written or graphic material that denigrates or shows hostility to certain persons.

Sexual harassment is defined as:

1. Making unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature a condition of employment.
2. Creating an intimidating, hostile or offensive working environment pursuant to #1.
3. Retaliating against an employee for resisting or complaining about such conduct as stated in #1 and #2.

Common examples of sexual harassment include:

1. Unwelcome sexual flirtations and propositions.
2. Offensive physical conduct or physical closeness.
3. Use of words of a sexual nature.
4. Displaying sexually suggestive objects in the workplace.
5. Repeated requests for dates
6. Intense staring or other sexually intimidating nonverbal behavior
7. Sexual jokes
8. Direct and indirect suggestions that an employee's job security, conditions of employment, or opportunities for advancement depend in any way on the granting of sexual favors or relations.

Sexual harassment is *not* flirtation, flattery or any other acceptable behavior. It involves an absence of the element of choice that would exist in a normal relationship.

Sexual harassment is a potential threat to many areas of business including hospitals. Many organizations do not have policies in place to address this issue. Hospitals and all departments must adopt an aggressive, proactive policy and communicate this policy to all employees. Ongoing harassment results in low morale and a decrease in productivity.

In 1976, Redbook magazine published a poll of 9,000 women who responded to their questionnaire. Nine out of 10 women stated that they were victims of unwanted sexual advances at work. A search of the literature by Charney and Russell suggested that sexual harassment affected 42 percent of women and 15 percent of men in an occupational setting. In an educational setting, the numbers increased to 73 percent of women and 22 percent of men during medical training. Yet, very few victims will file a complaint. As a result, psychological and physical symptoms are manifest in over 90 percent of victims, but few will seek professional help.

In 1988, Frank, Brogan, and Schiffman published their database from the Women Physicians' Health Study consisting of 4,501 respondents. Of the respondents, 47.7 percent of women physicians reported gender-based harassment and 36 percent of women reported sexual harassment. The question asked of the participants was the following:

“Have you ever been harassed in a medical setting (i.e., received unwanted

physical or verbal attention, propositions, hostilities, or threats)? If yes, mark all situations that apply . . . This occurred: before medical school; during medical school; while an intern/resident/fellow; while in practice. This harassment was: (mark all that apply) gender-based but not sexual; sexual; lifestyle based; ethnically-based.”

In this database, sexual harassment was defined as harassment with a sexual physical component. Gender-based harassment means being female in a predominately male profession without a sexual or physical component. Almost half of the women reported harassment on the basis of gender and more than 30 percent reported sexual harassment. Recent graduates of medical school reported harassment more often. The incidences of harassment increased in specialties that are predominately male.

In 1993, Komoromy surveyed 133 internal medicine residents. The residents were questioned regarding sexual harassment. The status of the harasser and the effects of harassment were reported. Sixty-two percent of the residents replied. Eighty-three episodes of sexual harassment were reported. Twenty-four of the thirty-three women who responded reported that they had been harassed during medical school as well as residency.

Women are usually the victims of harassment, and it is thought that women are more likely to be victims because they lack the power. Thus, studies of harassment in the physician-patient relationship have focused on female patients and male physicians. However, in 1993, Philips and Schneider published a paper regarding sexual harassment of women physicians by patients. They randomly surveyed 599 licensed female physicians in Ontario. They asked the respondents to quantify and classify episodes of sexual harassment by male or female patients. Of the women physicians surveyed, 70 percent returned their questionnaires, and 340 of the women had been in practice for at least 15 years. Of the respondents, 321 women reported sexual harassment by a patient during their career. The types of harassment included suggestive looks, sexual remarks, suggestive gestures, gifts, date pressures, grabbing, inappropriate touching, rape and attempted rape.

The authors suggest in their discussion that medical school faculty members should provide sessions on harassment, techniques to prevent harassment and the need for protection. Perhaps then women physicians might be less vulnerable. Sexual harassment is frank abuse of power, and it is important that this problem be openly addressed. Perhaps as this issue is more frequently and openly discussed, women physicians will no longer be victims!

In 1989, Relman raised the following challenge to academic medical centers to “bend every effort to attract qualified students of both sexes and all racial and ethnic means who can respond to the unique challenges and rewards of our profession.” In this new century, women physicians must be the leaders of the future in medical schools, professional organizations and research institutions. In the opinion of this author, it is only with the increasing numbers of women in leadership that we will end harassment!

Editors' Note:

Which behavior constitutes sexual harassment lies at least in part in the perception of the victim, so long as that perception is consistent with those of a reasonable person, or the so-called "reasonable person standard."¹ The finding that sexual harassment has occurred should require proof of the offending behavior, as well as demonstration that the victim found the behavior harassing, a somewhat subjective standard. As in other forms of harassment, concerns are frequently raised that the subjectivity of the accusation presents the opportunity for accusations to be made for the purpose of counter-intimidation, for revenge, and because of mental or emotional instability.

Little objective data exist about the frequency of false harassment claims, whether of a sexual nature or not. Some authors have tried to draw comparisons between the incidence of false claims of rape or stalking, and false claims of harassment, but these comparisons are problematic at best. The data concerning false rape and stalking claims is sparse, not objectively verified in many cases, or frankly misrepresented in others.

A review of rape claims by the U.S. Air Force in 1992, for example, concluded that 60 percent of rape claims were false.² Apart from its stunning conclusion, the study is plagued by many very serious problems. The Tailhook[†] scandal was less than a year old at the time of publication, and subsequent investigations and acknowledgements of the extent of harassment and intimidation of women in the military only emerged over the 8 years following the scandal. During that time ranking military officials consistently and vocally downplayed the extent of the problem, raising the possibility that a permeating bias may have plagued the design and data analysis of what amounted to a nonscientific survey of cases. While 27 percent of the women in the study "admitted to filing a false claim, "the circumstances under which they recanted are not known, and coercion cannot be ruled out. For 55 percent of the women placed in the "false claim" category, the claims were never actually proven false; categorization was based solely on the opinions of the military reviewers.

In another study of stalking, of 349 subjects, 11.5 percent were judged to be false. Review of the data reveals that 70 percent of false claims were filed by delusional patients. For women in this study who were not obviously suffering from mental illness, only about 3 percent did not reflect actual stalking.³

The possibility of a false claim nevertheless urges caution in the management of sexual harassment allegations, with attention to the rights of both parties. Clear policies delineating unacceptable behavior, and setting forth processes to fairly review claims should be developed. When accusers feel too vulnerable to directly confront someone they believe is harassing them, a mechanism should be available by which safe discussion can occur between or on the behalf of the parties involved. Education about the nature and deleterious effects of sexual harassment should be a part of every medical education

[†] The "Tailhook incident" occurred in September, 1991 in Las Vegas, Nevada. A large group of male naval aviators attending a party for officers returning from Desert Storm were accused of committing multiple nonconsensual sexual acts and assaults on female colleagues. While the resulting scandal led to reprimands for some officers, no male officer was court-martialed or found guilty of a criminal act.

program; there is ample evidence that educational programs consistently decrease the number of claims of sexual harassment that are filed.

1. *Harris v. Forklift Systems, Inc.*, 114 S.Ct. 367 (1993).
2. McDowell, CP. *The false rape allegation in the military community*. Unpublished. Washington DC; US Air Force Office of Special Investigations, March 1983.
3. Sheridan LP, Blaauw E. *Characteristics of false stalking reports*. *Criminal Justice and Behavior* 2004; 31(1):55-72.

References and Suggested Readings:

1. Carr PL, Ash AS, Feldman RH, et al: Faculty Perceptions of Gender Discrimination and Sexual Harassment in Academic Medicine. *Ann Intern Med.* 2000; 889-896.
2. Frank E, Brogan D, Schiffman M: Prevalence and Correlates of Harassment Among US Women Physicians. *Arch Intern Med.* 1998;158: 352-358.
3. Komaromy M, Bindman AB, Haber RJ et al: Sexual Harassment in Medical Training. *N Engl J Med.* 1993; 328:322-6.
4. Charney DA, Russell RC: An Overview of Sexual Harassment. *Am J Psychiatry.* 1994; 151:10-17.
5. Lenhart SA, Evans CH: Sexual Harassment and Gender Discrimination: A Primer*for Women Physicians. *JAMWA.* 1991; Vol. 46, No. 3.
6. Richman JA, Flaherty JA, Rospenda KM, Christensen ML: Mental Health Consequences and Correlates of Reported Medical Student Abuse. *JAMA* 1992; Vol 267, No. 5.
7. Cassell J: The Woman in the Surgeon's Body. Harvard University Press, Cambridge, Massachusetts, London, England 1998.
8. Relman AS. The changing demography of the medical profession. *N Eng J Med.* 1989; 321(22):1540-2.

Case One

An Anesthesia resident states to a colleague that he plans to ask a patient to go out on a date. His colleague expresses some concern, which is dismissed by the resident stating that it has not been an issue in the past.

1. Have you ever been aware of a similar situation? Does the other resident have any responsibility to talk to his colleague?
2. Is this a frequent occurrence in medical school? In residency? In anesthesia practice? What are the issues?
3. Has the Residency Training Program developed and implemented firm guidelines about the ethical behavior of residents?

4. How does the Residency Program determine if this behavior is naive, thoughtless, indicative of stress or exploitative?
5. What if this behavior continues despite warnings to cease this behavior? When should the resident be referred for treatment? Probation?
6. Does the Residency Program have an obligation to report this behavior to a licensing board?

Case Two

A resident arrives at a large university hospital eager to begin her internship. During the orientation, the Chief of Anesthesiology addresses the new residents regarding their roles and responsibilities.

On her first day in the operating room, a senior attending greets the new resident. She soon experiences that whenever she encounters the senior attending, whether in the operating room or elsewhere, he often makes comments about her appearance. She is uncomfortable with the remarks and especially with the feeling that she is being singled out. She also notices that this senior attending often looks at her chest, and she is uncomfortable but does not want to confront this physician. She wants to run the other way when she sees him.

What should she do? What would you do in a similar situation?

Case Three

A woman faculty member of the Department of Anesthesiology has been asked to discuss a discreet issue by a colleague. It appears that a senior male faculty member has been overly affectionate with several junior women residents, and even women medical students on the anesthesiology service. The anesthesiology residents and medical students are clearly nervous and uncomfortable when this faculty member approaches them. How should the woman faculty member deal with this issue? Should the faculty member be discussing her concerns with this fellow staff person? Should the faculty member discuss these concerns with the Chair of the Department? How should the Department Chair respond? If the behavior does not change, should the faculty member be told to seek counseling?

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Section J:

The Student-Teacher Relationship in Medicine: Are Intimate Relationships Between Faculty and Medical Trainees Ethical?

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Health care professional licensing bodies, communities, and governments are paying increasing attention to the implications and negative consequences of sexual misconduct by physicians involving their patients. Education for professionals about appropriate personal boundaries between medical faculty and trainees, however, is almost nonexistent. Investigations have shown that teachers in the medical setting can be responsible for mistreatment and boundary violations with students, residents, and other trainees. Furthermore, studies now demonstrate a link between teacher-learner misconduct or harassment and later sexual misconduct by physicians with patients and trainees.

The problems of establishing, understanding, and enforcing appropriate behavioral norms between adult (over age 18) students and faculty are not new ones, and the ethical dimensions of the problems are complex.

On the one hand, Western culture values freedom of choice for mature individuals. Freedom of association is a basic ideal of democratic society and centers of higher education. Paternalism is discouraged. When the particular freedom of choice involves romantic or sexual pairing, the usual view is that such choices are of an intensely private and individual nature, and should not suffer the scrutiny and interference of governments and regulators. Nevertheless, society does recognize a role for regulatory interference in private relationships in certain circumstances, when the behavior may have perceived overwhelmingly negative effects on societal values, or when particularly vulnerable persons might be exploited. Domestic abuse, marital rape, and incest are examples of intimate behaviors that are now proscribed.

While not illegal, intimate relationships between teachers and their students are problematic for both individuals and institutions, may consciously or unconsciously exploit unequal power dynamics, and can degrade the educational process by calling into question the fairness and objectivity of academic evaluations. Such relationships create

the risk of favoritism or retaliation directed toward the student involved, can result in unjust treatment of other students, and can call into question the integrity of the faculty member or institution. At best, such relationships are fraught with risk for both the student and teacher, and are probably imprudent. At worst, such relationships can involve frank sexual harassment of either party.

Sexual relationships between medical trainees and teachers are common. In a recent survey of 345 Canadian medical students, 71 percent reported at least one incident of verbal, emotional, physical or sexual abuse during medical school. Of the respondents, 46 percent of women and 19 percent of men reported being sexually harassed. A 1990 survey by the American Association of Medical Colleges found that 60 percent of female medical graduates experienced sexual harassment or discrimination during medical school, of which only 10 percent reported the behavior. Non-reporters cited both a sense that reporting would be futile and a fear of reprisals. Harassers were more frequently, but by no means exclusively male. Studies of psychiatric residency programs found that 5 percent of residents had engaged in “consensual” sexual relationship with teachers. Many students reported an impaired sense of well being and took actions to avoid certain teachers, including changing specialties and dropping out of training as a consequence of such relationships.

Studies show that many trainees who engage in sexual relationships with teachers feel to some degree coerced to engage in the relationship, and the feelings of coercion tend to increase over time. Many did not feel free to break off relationships while the teacher was still supervising them. Many also reported that the relationship negatively impacted their career plans and their relationships with other teachers. The American Medical Association’s Committee on Ethical Affairs recommends that teachers be cautioned about the risks of coercion and exploitation in such relationships.

The 1990s saw a movement in most academic institutions to establish policies prohibiting or severely restricting intimate relationships between faculty and students. A survey of policies governing “consensual” faculty, student relationships conducted in 1995 revealed that at 189 four-year institutions with student bodies larger than 500, 32 percent had adopted such policies, and another 9 percent had such policies under consideration. In 2003, the University of California implemented a policy at all nine campuses which prohibits teachers from dating either students who are in their classes, or students *for whom they might reasonably expect in the future* to have academic responsibility. The policy has led to criticism that even non-intimate relationships between students and faculty members will be inhibited by rules that are far too paternalistic. Further, some argue that such rules are redundant when policies prohibiting sexual harassment are in place.

The problem with equating intimate relationships between medical trainees and their teachers with sexual harassment is that, while the issues involving such relationships may overlap those of sexual harassment, others are unique.

Cases of sexual harassment are generally of two types: quid pro quo harassment, in which sexual favors are demanded in return for job security or job promotion, and/or the creation through sexual actions, remarks, innuendo, or references of a hostile work environment that impede an individual's ability to carry out their job. Almost all cases involve individuals with unequal power and positions. The person being harassed may be worried about personal or professional harm if they do not participate in a sexual relationship or if they try to end hostile behavior in the workplace.

Sexual exploitation is wrong, because it is an example of using someone solely as a means, through coercive influence. It violates the autonomy of the person being coerced. Similarly, Dixon points out that deceiving someone to get them to engage in an intimate relationship, such as promising strong evaluations or recommendations, or professing emotional commitment where none exists, is wrong because it similarly violates the other person's autonomy.

Intimate relationships between faculty and students are often defended as private, "consensual" relationships between adults, but many professionals are concerned that no truly "consensual" relationship can be assured to exist when a teacher is in a position to affect the student's evaluations and future career prospects. For one thing, even when the teacher may not intend coercion or deception, the student may *believe* that their evaluations will suffer if they do not participate, or elevated if they do. Or the student may be in such desperate need of some perceived benefit from a professor, that they cannot practically refuse a sexual advance. Students dependent on financial aid that is contingent on grades, for example, may not feel they can reasonably refuse. Further, psychological factors, such as admiration of a valued teacher, or a desire for attention and affection from a respected colleague, may place the student in a psychologically vulnerable position. Studies suggest that even when such relationships begin consensually, they frequently result in fear, regret and disproportionate guilt on the part of the student as time goes on. Participation as a student in such a relationship is associated with future misconduct or abuse of students and patients.

Regardless of whether a student's acceptance of a quid pro quo relationship with a professor is voluntary, it is wrong because it results in an injustice to other students who perform similar work, but receive a lower, however deserved, grade. Awarding grades for sex devalues the degrees granted by an institution, since the evaluations are thus disconnected from academic performance.

Teachers face serious conflicts of interest if they engage in sexual relationship with students they are responsible for evaluating. They may unconsciously be unable to assign fair grades to someone with whom they are intimately involved, or with whom they have recently had a breakup.

The morality of a teacher's decisions to pursue an intimate relationship with a student depends in part on the accuracy of his or her judgment that the student's assent is truly voluntary, and on whether the professor is engaging in self-deception regarding issues of

coercion and academic fairness. Because these issues can be difficult to judge, ethical consideration weighs against such relationships in all but rare instances.

What about relationships between professors and students that are not under their direct supervision? While less concerning, there still exists some potential for conflicts of interest. The student may later unexpectedly come under the academic supervision of the faculty member, for example. The potential for the perception of unfairness among colleagues and students makes such relationships at least imprudent.

Many universities have chosen to deal with faculty-student relationships by proscribing intimate relationships between faculty members and their students so long as a supervisory relationship persists. In other words, once an intimate relationship develops between a student and teacher, the teacher is advised to withdraw him or herself from any of the supervisory or evaluation processes involving their intimate partner.

References and Suggested Readings:

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Teaching Assignments

Robinson, et al, at the University of Toronto developed a curriculum for education regarding physician-patient misconduct and teacher-learner relationships. They found that after attending teaching sessions consisting of lectures and a workshop, that 54 percent of faculty and 39 percent of other course participants stated they would change their clinical and teaching practices in a positive way.

Suggestions for teaching include didactic information regarding the medico-legal aspects of sexual harassment and misconduct, and case discussion. Teaching sessions should involve the students, both as trainees who may develop intimate relationships with faculty, and as future faculty involved with trainees.

CASE 1:

You are a single female attending in an anesthesia residency program (8-10 residents per year). Residents have training assignments at two hospitals: a county medical center, and a specialty children's hospital. There are 15 faculty members. One of the male residents is your age, and single. His residency performance is average; with evaluations ranging from "needs improvement" to "satisfactory." During some evening call shifts, your conversations with him reveal that you have many mutual interests outside of work.

Questions to consider:

1. Is it ethical to encourage further social interaction with your trainee, even if a sexual relationship is not intended?
2. What are the possible negative consequences of such a relationship? For you? For the trainee? For the program? Does the size of the residency program make a difference?
3. Should you excuse yourself from supervising this resident or participating in his evaluations?

CASE 2:

In the previous scenario, social interaction does continue. You have met the resident for coffee and conversation, and to go jogging on several occasions. It becomes clear that there is a mutual sexual attraction, and during coffee one day the resident hints that he wishes to pursue a more intimate relationship.

1. What are the ethical issues impacting consensual relationship between adult students and their teachers?
2. Would this relationship be truly “consensual?”
3. Does it matter which person initiates the relationship?
4. List the potential future impacts(s) of the relationship.

CASE 3:

In the above case, you indicate to the resident that you feel it would be unethical to pursue an intimate relationship with a trainee, largely because it might interfere with your ability to fairly evaluate/critique his performance. He states that he feels you can still be a fair teacher, and reminds you that “you are both adults” and have a right to pursue adult relationships. Discuss the pros and cons of this point of view.

CASE 4:

In the above scenario, while you tend to agree with the resident, you nevertheless feel uncomfortable with the situation, and explain that you do not wish to pursue further intimacy. You resolve mentally to not have any further social interactions. When he calls to go out for coffee, you ask him not to call again. A few weeks pass, during which the resident’s clinical performance has been deteriorating. He has received several unfavorable evaluations from colleagues. You are summoned to the Chairman’s office to discuss “a resident issue.” The Chairman informs you that the resident has filed a sexual harassment grievance against you, claiming that you pursued an inappropriate social and sexual relationship with him, which he refused. He notes that you now refuse to have anything to do with him, and he believes that because of you, other faculty members are turning in negative evaluations.

Discuss sexual harassment, its definitions and implications.