
Consults for conflict: the history of ethics consultation

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The very existence of ethics consultation reflects both the increasing complexity of modern medicine's ethical questions and our discomfort with the prospect of answering them alone. Two developments in the past century were instrumental in driving the development of ethics consultation—organ replacement therapy and intensive care. With the proliferation of extreme life-prolonging measures came the thorny difficulties in the withdrawal of such services or rationing when resources were poor. Insofar as “someone must,” lamented Dr. Karen Teel (a pioneer of ethics consultation), the physician “is charged with the responsibility of making ethical judgments which we are sometimes ill-equipped to make.” More than anything, ethics consultation has come to best satisfy a central desire of American health care—sharing the responsibility for tough decisions.

Today, ethics consultants are an important component of American health care delivery. They are found in 81% of hospitals and 100% of those with more than 400 beds. In one year (2006), 29,000 individuals performed 36,000 consultations, devoting 314,000 hours (1). By one account, ethics consultations are performed for 0.16% of all hospital admissions (2). In a relatively short time, a novel discipline has emerged and thrived in American hospital wards.

Born to serve the dual and reinforcing fears of futile care and medicolegal liability, the ethics consult has come to reflect both the increasing complexity of medicine's ethical questions and our discomfort with the prospect of answering them alone. The practice of ethics consultation developed slowly in the 1970s and 1980s, was essentially fully formed by 1987, and has proliferated since. It is now nearly ubiquitous (1). Then, as now, the matters of standards, credentials, and how we evaluate consultation are very controversial. Yet, despite the lack of clarity about fundamental aspects of this enterprise, ethics consultation flourishes. More than anything, ethics consultation has come to best satisfy a central desire of American health care—sharing the responsibility for tough decisions. Herein, this historical study of ethics consultation examines the practice's roots, the forces that shaped it, and the people responsible for its development.

MEDICAL ETHICS

Clinical ethics consultation is a relatively novel service that developed within the broader history of medical ethics.

The history of contemporary medical ethics—rich, broad, and mostly outside the bounds of this inquiry—began in 1802. Thomas Percival, an English physician, coined the term “medical ethics” in a widely circulated pamphlet wherein he unilaterally codified the professional ethic of doctors. The Percivillian code—which formed the basis for the American Medical Association's code of ethics—asserted the moral authority and independence of physicians in service to others, affirmed the profession's responsibility to care for the sick, and emphasized individual honor (3). The rigorous study of how this code translated to practice began in earnest as recently as the 1950s. Joseph Fletcher's *Morals and Medicine* (1954) was the first major work to closely examine the “knotty issues” of medicine, old (e.g., euthanasia) or new (e.g., artificial insemination) (3, 4). Fifteen years later, Paul Ramsey, a theologian, was the first to lay out a systematic approach to these issues that became known as bioethics. As he wrote in his seminal work, *The Patient as a Person* (1970), “I could put my questions to experts in many fields of medicine, overhear discussions among them, and begin to learn how teachers of medicine . . . themselves understand the moral aspects of their practice” (5, 6). Meanwhile, the discussion that Paul Ramsey began in the academy was slowly developing in the clinic. In 1949, Catholic hospitals began forming “medicomoral committees” to discuss and maintain Catholic values in health care delivery (7). The concept of an ethics committee, however, was slow to take a widespread hold.

THE PHYSICIAN'S DILEMMA AND THE ETHICS COMMITTEE

Notwithstanding the infancy of medical ethics, medical technology—and with it the scope and reach of medical interventions—was advancing spectacularly. By the mid 20th century, there were several signs that medical technology had outstripped the capacity of individual physicians to confidently navigate clinical medicine's ethical quandaries. Two developments were instrumental—organ replacement therapy and

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intensive care. Together, they led directly to the formation of ethics committees and, later, ethics consultation.

In 1960, Belding Scribner's Teflon arteriovenous shunt enabled outpatient hemodialysis for the first time. Immediately, there was far more demand for this procedure than supply. Concerned about fairness in rationing, the Seattle Artificial Kidney Center founded an "Admissions and Policy Committee." Composed of a minister, a lawyer, a businessman, a homemaker, a labor leader, and two physicians, this committee chose the patients who received the available dialysis slots. Shana Alexander, the journalist who immortalized the so-called "God-Squad" in her blockbuster *Life* magazine article, declared that "they decide who lives, who dies." A central theme in her interviews was the need to share in the responsibility of such weighty decisions. Indeed, Alexander sympathized with the hospital, arguing that "the medical fraternity should share the burden [of these decisions] . . . otherwise society would be forcing the doctors alone to play God" (8).

Dialysis and, later, the advent of renal transplantation raised the stakes on medical decisions at the end of life, for both those patients with and without a chance for survival. Accordingly, in 1968, Harvard famously commissioned a committee to provide a "definition of irreversible coma" (9). The fact of this report on "brain death" spoke not only to the problem of organ supply and determining from which bodies it is appropriate to harvest organs but also generalized difficulties in knowing when to terminate "life support." As they wrote, "Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation." At the same time, intensive care or "improvements in resuscitative and supportive measures have led to increased efforts to save those who are desperately injured." These efforts place a difficult burden on patients, "on their families, on the hospitals and on those in need of hospital beds already occupied by these comatose patients" (9).

Indeed, the linchpin in this history is the intensive care unit (ICU) and the technical advancements thereof. With the proliferation of extreme life-prolonging measures came the difficulties in the withdrawal of such services. In the context of a litigious society, a worry quickly developed about the consequences in withdrawing life support. There was a pervasive sense that physicians were duty bound to provide universal cardiopulmonary resuscitation and support. These were procedures whose benefit was a given, and thus the failure to provide them "might invite civil suits or criminal prosecution" (10). It was easy to start life support but stopping it or withholding it proved trickier. Patients were just as uneasy with life support. In 1969, the first "living will" emerged and slowly gained popularity (11).

End-of-life decisions in the ICU took on a fundamentally legalistic character which, in turn, led to the creation of ethics committees. Dr. Karen Teel, a pediatrician at the Children's Hospital of Austin, saw physicians "faced with the reality of a no-win situation." Insofar as "someone must," the physician "is charged with the responsibility of making ethical judgments which we are sometimes ill-equipped to make." "In good faith, he acts," "assuming a civil and criminal liability." Teel referred to

the "God Squad" (as Seattle's committee was known colloquially) and argued that all hospitals ought to provide a mechanism to share in the responsibility of such tough decisions, one that would "provide a regular forum for more input and dialogue in individual situations and . . . allow the responsibility for these judgments to be shared." Crucially, she published these thoughts in a 1975 article entitled "A Physician's Dilemma" in a law review journal (12).

As it happens, shortly thereafter, the Karen Ann Quinlan legal saga was coming to a close. As a frail college student in New Jersey, Ms. Quinlan aspirated after an accidental overdose of benzodiazepines and alcohol, resulting in a persistent vegetative state. Her parents eventually decided to terminate ventilation. Her doctors, however, worried about the implications and resisted. The result was a definitive, landmark legal battle. Judge Richard J. Hughes presided and ruled the extubation legally sound. And in setting this precedent, he cited Teel, urging all hospitals to adopt her proposal for an ethics committee (13).

Ethics committees appeared around the country but were not successful in addressing their motivating concerns. The Beth Israel Hospital in Boston was a leader, forming an ad hoc committee of physicians and nurses to help treating physicians determine if a "do-not-resuscitate" order was appropriate for those patients who were competent to choose and not "irreversibly and irreparably ill" (14). It could be left to the physician alone to discuss the order with the committee, if the patient was, in fact, irreparably ill. This committee indirectly addressed the fear of litigation by sharing responsibility. Above all, it served to mitigate for treating physicians the feelings of guilt and uncertainty bound up in forgoing resuscitative measures (personal correspondence, Dr. Rabkin). Across town, the Massachusetts General Hospital organized the "Optimum Care Committee" to address the care of the hopelessly ill patient and the utilization of critical care resources. Its mandate, far more expansive than Beth Israel's, was to determine "what would be the best thing to do for the patient" (15). Controversy followed with many unanswered philosophical questions: To what end? In whose service? Who joins? What sort of background was required for membership? (16, 17).

No one had satisfactorily addressed the concerns of conflict of interest and authority before the fact of the committee, let alone what an ethics committee would actually do on a day-to-day basis. This had practical consequences. For example, the ethics committee at Montefiore Medical Center was established in 1977, quickly became a "discussion group," and floundered "because of lack of clear direction well into the 1980s" (18). Furthermore, there remained a widespread concern that the removed committee was an inappropriate mechanism to solve the dilemmas of the bedside (17). Five years into the committee era, the fear of legal liability had only worsened. One observer remarked, "It has become almost impossible for some classes of patient to die without a court order" (19). Hospitals began deliberately choosing to not start new committees (20). In 1982, only 1% of US hospitals had adopted ethics committees (21). The *physician's dilemma* persisted.

“PSYCHIATRIC CONSULTATION MASKING MORAL DILEMMAS IN MEDICINE”

Confronting modern ethical dilemmas alone at the bedside, clinicians yearned for support. For this, they often turned to psychiatrists, asking consultants to weigh in on what turned out to be fundamentally ethical troubles. Clinicians began using the accessible language of psychiatry to frame their dilemmas. Dr. Mark Perl, a psychiatrist, exposed this practice with a case series in the *New England Journal of Medicine*. One patient with metastatic osteosarcoma refused treatment. Her oncologist consulted Perl for the management of “depression.” Another case involved a brain-dead patient whose wife refused organ donation, preferring to take him home on a ventilator. The neurosurgeon consulted Perl, again to manage *her* depression. Perl argued that the mechanism of psychiatric consultation was inappropriate for these conflicts and therefore declined to “lend authority to another physician in influencing a patient’s decisions (so as to conform to that physician’s desires)” (22). There was a growing demand for a consultant to sort out clinical ethical questions.

THE ETHICISTS

Across the country, a small group of “ethicists” began to offer consultations. Professional ethicists—academics trained in various disciplines of the humanities—were increasingly available on hospital campuses. Largely, they were teachers of medical students, asked to guide students through the ethical questions engendered by the modern physician’s dilemma. Indeed, the proliferation of ethicists occurred concomitantly with the above developments during the 1970s: in 1972, 4.2% of medical schools had formal medical ethics curricula, and by 1982, 72.8% did; that percentage has remained about the same (78% in 2004) (23, 24). The pioneers of the field at this time included John Fletcher (philosopher; National Institutes of Health), William Winslade (lawyer and psychoanalyst; University of California at Los Angeles), John Golensky (minister; California), Ruth Macklin (philosopher; Albert Einstein), among many others. Foremost in this group was the philosopher Albert Jonsen. It is likely that he was the first ethicist at the bedside sometime in the early 1970s at the University of California at San Francisco, where he taught ethics to medical students when Dr. William Tooley (neonatologist) asked Jonsen to initiate bedside teaching in the neonatal ICU (personal correspondence, Dr. Jonsen). Jonsen is also responsible for training many of the most important figures in the field, including Bernard Lo (University of California at San Francisco) and John Golensky. Golensky, in turn, was responsible for developing ethics consultation services in countless hospitals across the nation, including those within the Kaiser Permanente system (personal correspondence, Dr. Golensky). These ethicists were busy and they were in demand.

The first ethics consultation in the published record was conducted by such an ethicist. Dr. Ruth Purtilo, a professor of ethics and physical therapy at the University of Nebraska, published her case in the *New England Journal of Medicine*. The patient was a critically ill neonate with gastroschisis. Her consultation “entailed an in-depth analysis of the moral obligations, rights, responsibilities, and considerations of justice that bear

on the infant’s situation” (25). She helped the physicians work through their thoughts, ultimately providing “reassurance that the clinicians had all the pertinent ethical data needed for assessing the ethical problem.” Confirming the problem with committees, she lamented that “in our hospital, most cases in which a clinician can benefit from a sympathetic and skilled ethicist never reach the committee” (25). Consulting ethicists provided one solution to the *physician’s dilemma*.

CLINICAL ETHICS

Meanwhile, in Chicago, Dr. Mark Siegler became the director of the University of Chicago’s new medical ICU in 1972. Quickly he found that “there was no place to send my housestaff and students to find answers” to the troubling questions engendered by intensive care (26). He was not alone. While increasing numbers of nonmedical academics were specializing in medical ethics, starting journals (*Hastings Center Report*, 1971) and departments (Kennedy Center at Georgetown, 1971), these people were predominantly concerned with theory. There was a critical gap for practicing clinicians seeking guidance in ethics. The Kennedy Center began offering immersion courses in medical ethics. However, in the words of one observer, they were “long discussions on rather esoteric, theoretical and philosophical problems, at the expense of more practical topics of interest to the average physician” (27). The field of biomedical ethics often had little to do with day-to-day medicine. Its “language of theory was not helpful in resolving the dilemmas of practice” (26). Disturbed by “the lack of involvement by physicians” in biomedical ethics, Siegler brought a refocus on physicians and their training to tackle the dilemma (28). This was revolutionary. “It is clear by now,” he observed, “that medicine has merely reacted to, rather than anticipated or participated in, most major developments in biomedical ethics” (28). The medical establishment was trying to divide the clinical from ethical by fostering a class of ethical arbiters. Siegler spoke out against this. “The distinction that is to be made between clinical decisions and ethical ones is an invidious, but unfortunately misguided, one.” The treating physician, ultimately accountable to the patient, cannot “rely on the false courage of the noncombatant” (28). Medicine, more “than a technical service delivered like auto-repair or plumbing,” has inextricably linked technical and ethical dimensions (29).

In 1978, Siegler coined the phrase “clinical ethics” in a paper where he argued that “whatever else medical ethics is, it must have something to do with the practice of clinical medicine” (30). Siegler’s clinical ethics is an approach to the difficult questions of patient care that is a fundamentally bedside procedure, aimed at bedside clinicians. He saw the solution to the “physician’s dilemma” in education and training. He was, from the outset, inspired by the words of Sir William Osler:

In what may be called the natural method of teaching, the student begins with the patient, continues with the patient, and ends his study with the patient, using books and lectures as tools, as means to an end. . . . The best teaching is that taught by the patient himself (30).

Siegler's model of clinical ethics begins and ends with the patient, its aims derivative of and guided by the patient-doctor relationship. This puts Siegler at odds with the prevailing concept of medical ethics, wherein nonphysicians were providing the bulk of the consultations. Siegler's vision involves training physicians to conduct ethical medicine and, perhaps, to involve trained physicians as ethics consultants where needed. This conflict has never been resolved but compromises have been made. Thus, in 1980, Siegler joined with Albert Jonsen and William Winslade to draft a pocket guide for clinical ethics aimed at all clinicians. Over 2 weeks, in Jonsen's house overlooking the San Francisco Bay, they developed the famous "four box method" that importantly orients all ethical discussions to consider first the medical indications, followed by patient preferences, quality of life, and other contingencies. *Clinical Ethics* (1982) is actually a step-by-step guide to the ethics of medicine organized by clinical scenario. Cases are presented—e.g., "The Problem Patient: Critically Ill"—the ethical dimensions are dissected, and recommendations are made (31). Clinical ethics consultation, provided by a physician or not, now had a process and a manual.

THE SOCIETY FOR BIOETHICS CONSULTATION

By 1985, far from having practice standards, it was still not even clear who should consult or what a consult should look like. To unite the pioneers of consultation, John Fletcher convened a conference on ethics consultation at the National Institutes of Health. Sixty-one people were in attendance; 31 (51%) had PhDs, 8 (13%) had MDs, 8 (13%) had JDs, and 14 had other degrees. Thirty-eight consultants participated in a survey on their practices. Nineteen (53%) kept records in the chart of their consultations, 8 (21%) made medical rounds, and only 11 (29%) were employed by hospitals with ethics committees (32). The most frequent issue encountered was "removal of life support in terminal cases." Thirty-nine consultants participated in another survey about the conference itself. The group praised the conference for its "sharing of diverse experiences and ideas" and being "the beginning of attention to ethical consultants." However, there were many criticisms, including a "lack of a formal discussion on what participants actually do with regard to consultation—their roles and aims." One participant even asked, "Should this breed of technician be encouraged?" The most contentious issue was credentials. Indeed, the attendees were split across this fault line. John Golensky argued that consultants "needed credentials and defined skills," while Siegler and his fellow, Dr. John La Puma, disagreed. La Puma emerged as the strongest advocate of the physician-as-consultant position. In the end, no compromise could be struck at this meeting (personal correspondence, Dr. Golensky).

Eleven of the participants gathered at the National Institutes of Health in early 1986 and agreed to found the Society for Bioethics Consultation (SBC), the first organization dedicated to consultation. It had three aims: to sponsor conferences, raise funds for training grants, and help organizations

develop their own training programs. John Fletcher lamented in a memorandum that interested graduate students and professionals had no one to guide them, that "no organized body is working on the problem. . . . Why not us?" The SBC planned three conferences across the nation between September 1987 and March 1988. However, interest was very weak. The lack of cohesiveness at the prior meeting had dampened general enthusiasm for the society. So few had registered, including three of the 61 attendees of the 1985 conference, that all conferences were cancelled (archived memoranda, Moody Medical Library).

THE CLINICAL ETHICIST

In the mid 1980s, a young resident at the West Los Angeles Veteran's Administration attended a grand rounds on clinical ethics by Dr. Bernie Lo. That resident was Dr. John La Puma. Today he is the "Chef MD." At the time, he was an ethically minded resident invited to have lunch with Lo. At that lunch, Lo told him about a brand new sort of fellowship getting started up for people like him at the University of Chicago led by Mark Siegler. La Puma left for Chicago after residency as a member of the first class of fellows at Siegler's MacLean Center for Clinical Ethics (personal correspondence, Dr. La Puma).

During his fellowship, La Puma set up in a community hospital a weekly case conference to discuss clinical ethics with the ward clinicians and covertly promoted and developed his own consult service. Despite his work being informed at every level by Siegler, Siegler himself thought—at least at the time—that ethics consults were intrusive and potentially harmful to the core relationship between the primary doctor and patient. Siegler believed that the primary doctor was the rightful target of clinical ethics education and interventions. Meanwhile, La Puma was working hard to legitimize the practice to his mentor. He collected 27 experiences which dealt, by and large, with finality and the do-not-resuscitate discussion. Then, unbeknownst to Siegler, he published them in the *Western Journal of Medicine* (33).

Perhaps owing to the strength of its foundations, the method that La Puma employed and reported for his consultations remains essentially unchanged to this day. Two features of the La Puma-Siegler method ought to be highlighted. First, La Puma made sure to expand the social history, asking not how many packs per day but deeper questions about worldview to get at where the patient was coming from. Second, and crucially, unlike Jonsen and Purtilo before him, the consultant would do a physical exam and review laboratory values. True to the "four box method," La Puma began by reviewing the chart and grounded his recommendations in the medical indications. Borrowing the style and structure of a traditional medical consult, the La Puma-Siegler method lent immediate credibility to the ethics consult.

STANDARDS AND EVALUATION

By 1987, ethics consultation had matured. There was a manual, a published record of experiences, a series of journals devoted to the subject, and a growing number of textbooks.

Little has changed since. Since 1992, the Joint Commission on the Accreditation of Healthcare Organizations has required all of its approved hospitals to construct means for resolving ethical conflicts. In 1996, a consensus statement was preparing describing the aims of consultation:

... a service provided by an individual consultant, team, or committee to address the ethical issues involved in a specific clinical case. Its central purpose is to improve the process and outcomes of patient care by helping to identify, analyze, and resolve ethical problems (34).

In 2000, a joint task force of the SBC and Society for Health and Human Values published the recommendations that nearly crushed the society in 1985. They compromised, recommending that “individual consultants, teams, or committees should have the core competencies for ethics consultation,” that an “evaluation of process, outcomes, and competencies is needed,” but that there “ought not to be any requirement for the certification of individuals and accreditation of programs” (35).

Despite roughly 30 years of service, the issues addressed have not changed, with goals of care and medical futility representing 54%, and withholding or withdrawing measures the focus of 52% of consultations at one center (36). And despite the task force recommendations, only 15% of all consultations had any form of external review of their services (1). Meanwhile, 45% of consultants in one survey reported receiving only informal, on-the-job training, while 73% of consultants at pediatric hospitals reported informal training and 40% worked in hospitals without formal guiding policies (37). The literature still sees calls for studies to identify “indicators that lead to ethics consultation . . . and the enumeration of the various ethical skills, such as dispute resolution, utilized during ethics consultation” (38).

We are still trying to figure out how to evaluate ethics consultation. In the past two decades, owing to amazing concerted efforts, ethics consultation has been involved in two ambitious multicenter clinical trials, one of which was even randomized. Only one, however, showed that ethics consultation had any effect, measured by resource utilization in patients who would not survive to discharge (39, 40). It is not clear that ethics consultation or committees can or even ought to be evaluated by a randomized trial (41). After all, it is possible that the greatest role of the ethics consultant is the sharing of responsibility, an effect that cannot be measured in patient outcomes.

CONCLUSION

The history of ethics consultation reflects the developments of modern medicine. Ethics consultation is a hospital service providing support for clinicians that developed in response to the practical bedside difficulties inherent to the era of organ replacement/transplantation and brain death. The credibility of ethics consultants will be adjudicated less on the basis of their credentials than on their ability to address Karen Teel’s *physician’s dilemma*—to soothe the anxiety and share the responsibility for difficult medical decisions.

1. Fox E, Myers S, Pearlman RA. Ethics consultation in United States hospitals: a national survey. *Am J Bioeth* 2007;7(2):13–25.
2. Tapper EB, Vercler CJ, Cruze D, Sexson W. Ethics consultation at a large urban public teaching hospital. *Mayo Clin Proc* 2010;85(5):433–438.
3. Bean W. Thomas Percival (1740–1804): codifier of medical ethics. *JAMA* 1965;194(12):1319–1320.
4. Fletcher J. *Morals and Medicine*. Princeton, NJ: Princeton University Press, 1954.
5. Ramsey P. *The Patient as a Person*. New Haven, CT: Yale University Press, 1970.
6. Jonsen A. *The Birth of Bioethics*. Oxford, UK: Oxford University Press, 1998.
7. May WW. The composition and function of ethical committees. *J Med Ethics* 1975;1(1):23–29.
8. Alexander S. They decide who lives, who dies. *Life*, November 9, 1962.
9. Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death. A definition of irreversible coma. *JAMA* 1968;205(6):337–340.
10. Burns JP, Edwards J, Johnson J, Cassem NH, Truog RD. Do-not-resuscitate order after 25 years. *Crit Care Med* 2003;31(5):1543–1550.
11. Bok S. Personal directions for care at the end of life. *N Engl J Med* 1976;295(7):367–369.
12. Teel K. The physician’s dilemma: a doctor’s view: what the law should be. *Baylor Law Review* 1975;27:6–10.
13. In the Matter of Quinlan. 70 N.J. 10, 355 A.2d.647, 1976.
14. Rabkin MT, Gillerman G, Rice NR. Orders not to resuscitate. *N Engl J Med* 1976;295(7):364–366.
15. Brennan TA. Ethics committees and decisions to limit care. The experience at the Massachusetts General Hospital. *JAMA* 1988;260(6):803–807.
16. Veatch RM. Hospital ethics committees: is there a role? *Hastings Cent Rep* 1977;7(3):22–25.
17. Levine C. Hospital ethics committees: a guarded prognosis. *Hastings Cent Rep* 1977;7(3):25–27.
18. Rosner F. Hospital medical ethics committees: a review of their development. *JAMA* 1985;253(18):2693–2697.
19. Morison RS. Reflections on morality and medicine: bioethics after two decades. *Hastings Cent Rep* 1981;11(2):8–12.
20. Esqueda K. Hospital ethics committees: four case studies. *Hosp Med Staff* 1978;7(11):26–30.
21. Youngner SJ, Jackson DL, Coulton C, Juknialis BW, Smith EM. A national survey of hospital ethics committees. *Crit Care Med* 1983;11(11):902–905.
22. Perl M, Shelp EE. Psychiatric consultation masking moral dilemmas in medicine. *N Engl J Med* 1982;307(10):618–621.
23. Fletcher J, Quist N, Jonsen AR, eds. *Ethics Consultation in Health Care*. Ann Arbor, MI: Health Administration Press, 1989:53.
24. Lehmann LS, Kasoff WS, Koch P, Federman DD. A survey of medical ethics education at U.S. and Canadian medical schools. *Acad Med* 2004;79(7):682–689.
25. Purtilo RB. Ethics consultations in the hospital. *N Engl J Med* 1984;311(15):983–986.
26. Siegler M. The contributions of clinical ethics to patient care. *Forum: Trends in Experimental and Clinical Medicine* 1997;7:244–253.
27. Moore CB. This is medical ethics? *Hastings Cent Rep* 1974;4(5):1–3.
28. Siegler M. Clinical ethics and clinical medicine. *Arch Intern Med* 1979;139(8):914–915.
29. Kass LR. Ethical dilemmas in the care of the ill. I. What is the physician’s service? *JAMA* 1980;244(16):1811–1816.
30. Siegler M. A legacy of Osler. Teaching clinical ethics at the bedside. *JAMA* 1978;239(10):951–956.
31. Jonsen A, Winslade W, Siegler M. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. New York: MacMillan, 1982.
32. Bernel J. Ethics consultants: a self-portrait of decision makers. *Hastings Cent Rep* 1985;15(6):2.

33. La Puma J. Consultations in clinical ethics—issues and questions in 27 cases. *West J Med* 1987;146(5):633–637.
34. Fletcher JC, Siegler M. What are the goals of ethics consultation? A consensus statement. *J Clin Ethics* 1996;7(2):122–126.
35. Aulisio MP, Arnold RM, Youngner SJ. Health care ethics consultation: nature, goals, and competencies. A position paper from the Society for Health and Human Values-Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation. *Ann Intern Med* 2000;133(1):59–69.
36. Swetz KM, Crowley ME, Hook C, Mueller PS. Report of 255 clinical ethics consultations and review of the literature. *Mayo Clin Proc* 2007;82(6):686–691.
37. Kesselheim JC, Johnson J, Joffe S. Ethics consultation in children's hospitals: results from a survey of pediatric clinical ethicists. *Pediatrics* 2010;125(4):742–746.
38. Nilson EG, Acres CA, Tamerin NG, Fins JJ. Clinical ethics and the quality initiative: a pilot study for the empirical evaluation of ethics case consultation. *Am J Med Qual* 2008;23(5):356–364.
39. SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients. The study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT). *JAMA* 1995;274(20):1591–1598.
40. Schneiderman LJ, Gilmer T, Teetzel HD, Dugan DO, Blustein J, Cranford R, Briggs KB, Komatsu GI, Goodman-Crews P, Cohn F, Young EW. Effect of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: a randomized controlled trial. *JAMA* 2003;290(9):1166–1172.
41. Chen YY, Chen YC. Evaluating ethics consultation: randomised controlled trial is not the right tool. *J Med Ethics* 2008;34(8):594–597.