Medical Ethics

Consultations in Clinical Ethics—Issues and Questions in 27 Cases

JOHN LA PUMA, MD *Chicago*

Hospital consultations in clinical ethics are a new development in patient care. Physicians often have faced and resolved problems in clinical ethics—moral problems in the care of a particular patient—on their own. Few physicians have been trained or available to help solve clinical ethical problems in the hospital.

To clarify ethical problems and to teach methods of ethical analysis, a movement toward providing ethics consultations in the hospital has grown in the past several years.[1-5] The consultative function of hospital ethics committees has been suggested by philosophers, attorneys and the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.[6-8] Some authors, however, have wondered if the principles of clinical ethics can be used to help make clinical decisions in patient care.[10]

To address the need for ethical analysis and advice, a board-certified internist in a clinical ethics fellowship provided formal clinical ethics consultations in a university teaching hospital. To learn more about the types of cases that required analysis and assistance, we reviewed 27 consecutive, unsolicited clinical questions we received about individual patients, together with the ethical issues identified.*

Methods

All 27 consultations done from July 1985 to June 1986 during a fellowship in clinical ethics were retrospectively reviewed and analyzed. Although a formal consultation service did not exist, staff and house-staff physicians requested ethical assistance from clinicians in the Center for Clinical Medical Ethics (University of Chicago). When a consultation was requested, information was gathered by the clinical ethics fellow based on a model outline for ethics consultation (Figure 1). First, historical and laboratory information was gathered from the chart. The referring physicians were interviewed. The patient was then examined and, if able to communicate, was interviewed. Health care workers, family members, administrators and "significant others" were interviewed as needed. After the data had been gathered, the primary ethical issues were assessed. After discussing the issues with an attending physician-ethicist, suggestions were made for resolving the clinical question. References to legal precedents, hospital policies and the relevant medical and clinical ethics literature were cited and made available to the requesting service. The consultant either arranged or conducted (or both) family meetings, team meetings and case conferences in nearly all cases. Written consultations were placed in the progress notes and entitled "Clinical Ethics" or "Consultation Clinical Ethics."

The clinical question and primary ethical issue were identified in each consultation. The clinical question, posed by the referring physicians—such as, "Can we write a do-not-resuscitate order?"—was recorded at the beginning of each consultation report. The primary ethical issue identified by the consultant in his or her assessment or discussion—such as ethically appropriate indications for the order to not resuscitate—was defined using a basic method of clinical ethical decision making.[9]

A Case Example of an Ethics Consultation

Case 3. The patient, a 65-year-old woman with metastatic breast carcinoma, had been treated with chemotherapy, radiotherapy and surgical therapy. During her sixth week in hospital, she was transferred from another service to the medical intensive care unit (ICU) for treatment of sepsis. In her seventh hospital week, the patient refused the removal of a chest tube, placed for an empyema, saying that she wanted "no more surgery."

An ethics consultation was obtained to assess the patient's competency to refuse treatment. The consultant reviewed the chart, spoke with and examined the patient and interviewed physicians, ICU nurses and members of the family. The consultant noted that a prolonged hospital stay and the use of cimetidine, narcotic and benzodiazepine may alter a person's mental state. On examination with her son in the room, the patient knew and spoke of her previous pneumothorax, its new resolution and her continued immobilization by the chest tube if it remained. She did not know the procedure for chest tube removal.

The consultant found the patient to be competent but uninformed. The consultant also addressed her physicians' discomfort with the clinical situation. The consultant discussed with the team its frustration with the patient's severe physical illness, their discomfort with the "politics" of the patient transfer and their revulsion by her postoperative chest wall deformity.

The patient's competence was later affirmed by the medical team. One physician then explained the procedure for chest tube removal to the patient and her son together. The patient was reassured by her son that "surgery" was not

*Steven H. Miles, MD, provided invaluable assistance with analysis.

(La Puma J: Consultations in clinical ethics—Issues and questions in 27 cases. West J Med 1987 May; 146:633-637)

From the Center for Clinical Medical Ethics, the Division of the Biological Sciences, University of Chicago, and the Department of Medicine, The Pritzker School of Medicine, Chicago.

Dr La Puma is a Senior Fellow in Clinical Ethics and General Internal Medicine. This work was supported in part by the Henry J. Kaiser Family Foundation.

Reprint requests to John La Puma, MD, Senior Fellow, Center for Clinical Medical Ethics, Department of Medicine, Box 72, University of Chicago Hospitals, 5841 S Maryland Ave, Chicago, IL 60637.

involved. She then consented to the chest tube removal, before which the cimetidine and diazepam therapy was discontinued. The patient eventually recovered to leave the hospital.

Results

In all, 24 staff and house-staff physicians referred 27 patients for consultation (Table 1). Of the 27 patient referrals, 16 (59%) came from physicians in the Department of Medicine and 11 (41%) came from physicians in surgery, neurology, pediatrics and obstetrics/gynecology. Attending physicians made 16 referrals and house officers 11.

Patients ranged in age from 8 to 95 years (median 48.1); 12 (44%) were in the ICU, and 13 (48%) were able to communicate, verbally or nonverbally, with the consultant at the initial visit.

Of the 27 questions referred, 18 (67%) concerned the withholding or withdrawing of life-sustaining therapies; 7 of these specifically concerned orders not to resuscitate. Questions about the appropriateness of mechanical ventilation, intensive care, hemodialysis, feeding and hydration, antibiotics, heart and liver transplantation were among those received. Three questions of disagreement (physician-physician, physician-family and patient-family) were also received (Table 2).

Consultation requests always reflected a clinical question, although the consultant did not always identify it as the primary ethical issue. For example, in case 8, a competent 38-year-old man had previously refused therapy for metastatic penile carcinoma now infiltrating his left femoral artery. In the emergency department, his systolic blood pressure was 80 mm of mercury and his hemoglobin was 4 grams per dl. After transfusion and admission to the hospital, an ethics consultation was requested. The clinical question concerned the financial cost of additional units of blood and their perceived futility. In this case, the medical team's disappointment with this previously treatable, now terminal patient influenced the team's ability to separate individual patient need from the cost of needed medical care. Because of the patient's irreversible disease, the consultant advised that the most important concern was appropriate terminal care and that the patient's wishes about life-sustaining treatment should be sought. Once informed about his disease, the patient refused cardiopulmonary resuscitation. A do-not-resuscitate order was written and the patient died on the fourth hospital day.

In many cases, the consultant was able to help the referring physician identify other ethical issues not previously recognized. In case 17, for example, a resident and an attending physician disagreed about the appropriateness of a do-not-resuscitate order for a 68-year-old lethargic woman three weeks after she had suffered a middle cerebral artery embolism and massive stroke. She had worked in a nursing

- Question(s) asked, quoted
- Name and position of referring physician
- Summary of present illness and hospital course, with relevant consultant reports, patient disabilities and prognosis
- Present medications
- Family and personal history
  - Functional status and primary relationships, including "significant others" and caretakers if appropriate, before hospital admission
  - Family members' involvement in patient's care
  - Family interests, objectives and needs regarding patient and patient's illness and potential conflicts with patient's interests, objectives and needs
  - Patient's expressed preferences, with interests, objectives and needs regarding life processes, including present illness
  - Verifiable advance directives or proxy decision makers
  - Patient's religious views, if "religiously active"
- Physical examination, with special attention to
  - Mental state and competency to participate in health care decision making
  - Critical organ function—heart, lungs, kidneys and liver
  - Neurologic function
- Laboratory review, with special attention to
  - Reversible causes of depressed neurologic function or abnormal mental state
  - Critical organ function—heart, lungs, kidneys and liver
- Assessment of ethical issues, with discussion
  - Medical indications
  - Patient preferences
  - Socioeconomic considerations
  - Quality of life considerations
- Suggested answers to the clinical question(s) and approaches to the ethical issues identified
- Signature
- References

Figure 1.—Ethics consultation format.*

*Mark Stegler, MD, provided assistance in designing the format for the figure.

TABLE 1.—*Patients Referred for Ethics Consultation*

Patients, in Order of Consultation	Age, Years	Sex	Primary Diagnosis
1	72	♂	Probable lung cancer
2	60	♂	Squamous cell carcinoma, unknown primary
3	65	♀	Adenocarcinoma, breast
4	25	♂	Cirrhosis with encephalopathy
5	38	♂	Gram-negative endocarditis
6	55	♀	Squamous cell carcinoma, breast
7	73	♂	Meningioma, after resection
8	38	♂	Squamous cell carcinoma, penis
9	8	♂	Chronic postmeningitic state
10	58	♂	Acute nonlymphocytic leukemia
11	33	♂	Subarachnoid hemorrhage
12	33	♀	Thalamic hemorrhage
13	63	♀	End-stage renal disease, idiopathic
14	68	♀	Uterine sarcoma
15	60	♀	Anoxic encephalopathy
16	20	♀	Coma, after viral encephalitis
17	68	♀	Severe cerebrovascular accident
18	44	♀	Acute subarachnoid hemorrhage
19	58	♀	Progressive systemic sclerosis
20	27	♀	Spinal cord astrocytoma
21	55	♂	Hepatocellular carcinoma
22	26	♂	Idiopathic cardiomyopathy
23	10	♂	Anoxic encephalopathy
24	38	♂	Prosthetic valve endocarditis
25	83	♀	Anoxic encephalopathy
26	25	♀	Staphylococcal endocarditis; positive for human immunodeficiency virus
27	95	♀	Urosepsis

home and cared for many chronically ill patients. She had lived with her daughter and a sister with whom she had spoken only generally about various patients at work. Incompletely recognized ethical issues here included the appropriate role of the family in the care of an incompetent patient and the nature of advance directives for life-sustaining therapy. In this case, the consultant advised that the patient's prognosis for recovery be clearly documented before limiting any treatment. The physicians' goals of treatment should have been oriented towards alleviating symptoms, rather than curing disease, if there was no improvement within a reasonable and defined time period.

Reasons for Consultation

Assistance in decision making. Assistance in decision making was one of several reasons for consultation. In case 1, for example, a 72-year-old lethargic man with a large right apical mass and atelectasis of the right upper lobe was admitted to the ICU. Bronchoscopy showed an obstructing lesion of a segmental bronchus; cytology showed no acid-fast bacilli but findings were strongly suggestive of malignancy. In this case, the consultation was requested to analyze and affirm the physicians' judgment that a do-not-resuscitate order was appropriate for a patient who appeared to be terminally ill, but whose cytology results were nondiagnostic. The consultant suggested that futility of treatment was an ethically appropriate indication for a do-not-resuscitate order and, given the medical data, such an order was appropriate. The order was written, and the patient died three days later.

Assistance in case management. A second reason for consultation was assistance in case management. In case 13, a 63-year-old woman suffered idiopathic renal failure and severe neuropathy. Sural nerve and renal biopsies showed only "degeneration"; hemodialysis and every-two-hour turning were required. The patient, still competent five months after admission and diagnosis, requested hospital discharge despite inadequate home nursing care. Here physicians sought an independent analysis of the patient's competency and morally justifiable potential solutions to the question of hospital discharge. Several alternative solutions were provided (additional home health care, hospice support), and, after a week, the patient left the hospital in the care of her son.

Assistance in resolving disagreements. A third reason for consultation was to help resolve disagreements between patient and family, physicians and family and between two physicians. In case 14, for example, the physician and the patient's daughters disagreed about dialysis for a 68-year-old semicomatose woman with uterine sarcoma refractory to therapy. The consultant noted that the physician's overall treatment goals had changed from an attempted cure to comfort as it became clear that the patient was dying. The daughters had not previously been informed of their mother's terminal condition and insisted on dialysis. The consultant helped to resolve the physician-family disagreement by mediating a discussion between the daughters and the physician. The patient's prognosis and the changing goals of therapy were clarified for the family by the physician. The physician did not order hemodialysis, the family agreed and the patient died within 24 hours of the discussion.

Discussion

The referred cases involved a broad range of issues, most of which focused on questions of foregoing one or more life-sustaining therapies in seriously ill patients. The clinical eth-

TABLE 2.—*Questions Asked, Issues Perceived and Their Correlation*

Patients	Clinical Question Asked	Primary Ethical Issue Perceived
1	DNR order appropriate?	Indications for orders not to resuscitate
2	DNR order appropriate?	Indications for orders not to resuscitate
3	Patient competent to refuse chest tube removal?	Competency to refuse treatment
4	DNR order appropriate?	Indications for orders not to resuscitate
5	DNR order appropriate?	Role of cost in patient care
6	Withdrawal of treatment appropriate?	Withdrawal of life-sustaining therapy
7	Withdrawal of intensive care appropriate?	Allocation of scarce resources
8	Cost concerns appropriate?	Patient's refusal of treatment
9	DNR order appropriate?	Indications for orders not to resuscitate
10	DNR order appropriate?	Autonomy of a competent patient
11	Withholding feeding tube appropriate?	Indications for withholding life-sustaining therapy
12	Withholding feeding tube appropriate?	Indications for withholding life-sustaining therapy
13	Patient *v* family re: placement	Autonomy of a competent patient
14	Physician *v* family re: dialysis	Indications for withholding life-sustaining therapy
15	Withholding nutrition, resuscitation, mechanical ventilation appropriate?	Brain death *v* chronic vegetative state
16	Further aggressive treatment appropriate?	Roles of an acute-care institution
17	Attending MD *v* resident MD re: DNR order	Indications for orders not to resuscitate
18	Withdrawal of vasopressors, ventilator appropriate?	Indications for withholding life-sustaining therapy
19	Withholding of nutrition, withdrawing of hydration appropriate?	Recognition of a terminally ill state
20	Mechanical ventilation appropriate?	Autonomy of a competent patient
21	HMO obligated to pay for liver transplant?	Indications for experimental therapy
22	Psychosocial criteria valid for heart transplantation?	Allocation of scarce clinical resources
23	Withdrawal of ventilator appropriate?	Indications for withdrawing life-sustaining therapy
24	Responsibility for long-term care?	Principles of palliative medical care
25	Withdrawal of ventilator, TPN antibiotics appropriate?	Indications for withholding life-sustaining therapy
26	Responsibility to warn public contacts?	Confidentiality: when to breach
27	DNR order appropriate?	Indications for orders not to resuscitate

DNR=do not resuscitate, HMO=health maintenance organization, MD=physician, TPN=total parenteral nutrition

ical issues in these cases form the beginning of a basic curriculum in medical ethics; most have been identified as essential topics for medical school curricula.[11]

Three major reasons for consultation requests were identified. The first, assistance in decision making, was in some cases simple reassurance that a physician's own decision was morally justifiable; in other cases, physicians were genuinely puzzled by complex patient cases. In these latter cases, assistance in case management was requested. Here the consultant played an especially active role, suggesting the appropriateness of ventilator withdrawal or the institution of proper pain medication. Third and finally, assistance in resolving disagreements required the consultant to be a type of diplomatic liaison and help the disagreeing parties reach mutually acceptable conclusions.

Our consultations were practical, clinical and educational. During the consultative process, physicians were helped to think through difficult ethical issues and improve their decision-making skills. In each case, the consultant attempted to integrate the consultative process with the case synthesis. More instructive than the written report or citations from the medical literature were the interactions between the consultant and the health care team. It is one thing to didactically teach ethically appropriate indications for do-not-resuscitate orders or withdrawing life support. It is quite another to work alongside physicians on the wards and consider a particular patient at the bedside.

Experience as a clinician was invaluable in doing consultations. The ethics consultant's knowledge of patient care has been noted to promote his or her acceptance by referring physicians.[12] Clinicians, including some nonphysicians, understand nuances and dynamics of patient care and arrive at that understanding by bedside observation and experience.[13] Recognizing the uniqueness of an individual patient's problems and knowing that medical care is based on medical need are at the heart of being a consultant-ethicist.

It may seem to some that any wise and experienced clinician could do ethics consultations. Clinicians who are both wise and experienced know well the need to balance the technical and the moral aspects of patient care. Regardless of how wise an individual physician may be, however, most physicians in teaching hospitals have had relatively little experience in analyzing moral problems. Teaching practicing physicians to build their own conceptual framework for decision making is the duty of many consultants in medicine. A physician-ethicist can teach the relevant fundamental concepts and special language of ethics, while helping physicians develop a structured and coherent strategy for the analysis of ethical problems that arise daily in clinical practice.

Further, an ethics consultant has the specific task of bringing together disparate or incompletely known parts of a given patient's medical course and social history. With medicine's developing technologic capabilities, hospitals primarily provide technical services. Busy physicians, even those with an interest in ethics, may tend to marginalize patients' personal values and histories, with these data falling to the side, especially when a patient is critically ill. The ethics consultant has the special training and professional charge to help gather the relevant data and restore a central ethical focus to a given case.

Physicians obtained consultations by contacting in person the clinical ethics fellow or an attending physician. A Pediatrics Bioethics Committee, developed in response to federal "Baby Doe" regulations, exists at our institution, but there is no adult ethics committee. The pediatric consultations were not discussed with the Bioethics Committee. Hindered by variable standards of membership and uncertain legal liability, ethics committees generally have not been able to successfully assume active consultative roles.[14,15] Our consultation team was able to respond promptly to physician referrals and brought to the bedside both medical understanding and ethical insight. Few ethics committees have either the time or inclination to analyze a patient's chart or examine a patient and suggest recommendations for care. With their multidisciplinary membership and administrative orientation, many ethics committees are well equipped to consider problematic hospital policies and less well equipped to consult in individual patient cases.[16]

Ethicists in medicine are not new, although consultant physician-ethicists doing written consultations are. A National Institutes of Health-University of California, San Francisco, conference on ethics consultation was convened in October 1985.[17] It was attended by 53 ethicists, each having been identified by his or her institution as a consultant. The invited consultants were surveyed: 20 held PhDs, 6 MDs, 5 MAs, 4 JDs, 3 RNs and 6 held other degrees. Of 38 respondents, 20 kept records of their consultations. Only 15 wrote in patient charts; only 8 reported making medical rounds.

Physicians may express reservations about ethics consultation. They may fear possible legal liability in not following a consultant's written advice[15] or the loss of case-management autonomy. Many may doubt the actual usefulness of ethical analysis and advice. In this series of 27 cases, we received many positive comments for our clinical assistance and educational approach. Little data exist on the efficacy of ethics consultations or general medical consultation,[18] although Perkins and Saazthoff showed that ethics consultations "sometimes change patient management and almost always boost physician confidence in the final treatment plan."[4] Clearly, more research is needed to determine the usefulness of consultations, perhaps using follow-up evaluations from both consultant and referring physicians.

There are many important unanswered questions about ethics consultations: Who should do them? How should they be done? What skills should a consultant have? Perhaps the most important question is the most basic: What is the goal of an ethics consultation? Should ethics consultants become involved in issues of institutional policy making,[19] or do clinical work and teach clinical ethics to physicians at the bedside?[20]

Consultants in clinical ethics should be competent in both medicine and ethics and have strong interpersonal and communications abilities. Clinical ethicists should teach decision-making skills to practicing physicians during each consultation. Decision-making skills in clinical ethics are practical skills, as medicine is primarily patient care, distinguished from the humanities and the sciences by its practical purpose.[21] Clinical ethicists in a hospital can help physicians reach ethical solutions in a broad range of difficult cases.

REFERENCES

1. Jonsen AR: Can an ethicist be a consultant? *In* Abernathy V (Ed): Frontiers in Medical Ethics: Applications in a Medical Setting. Cambridge, Mass, Ballinger, 1980, pp 157-171

2. Rothenberg LS: Clinical ethicists and hospital ethics consultants: The nature and desirability of their clinical role. *In* Fletcher J, Jonsen AR (Eds): Proceedings of the Conference on Ethics Consultation at the National Institutes of Health. Ann Arbor, Mich, Health Administration Press, 1987, in press

3. Purtilo RB: Ethics consultations in the hospital. N Engl J Med 1984; 311:983-986

4. Perkins HS, Saazthoff BS: How do ethics consultations benefit clinicians? (Abstr). Clin Res 1986; 34:831A

5. Winkenwerder W Jr: Ethical dilemmas for housestaff physicians—The care of critically ill and dying patients. JAMA 1985; 254:3454-3457

6. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research: Deciding to Forego Life-Sustaining Treatment: Ethical, Medical and Legal Issues in Treatment Decisions. Government Printing Office, 1983

7. Cranford RE, Doudera AE: The emergence of institutional ethics committees, chap 1, Institutional Ethics Committees and Health Care Decision-Making. Ann Arbor, Mich, Health Administration Press, 1984, pp 5-21

8. Thomasma DC: Ethics committees in hospitals; Alternative structures and responsibilities. QRB 1984; 10:6-10

9. Jonsen AR, Siegler M, Winslade WJ: Clinical Ethics, 2nd Ed. New York, MacMillan, 1985

10. Glover JJ, Ozar DT, Thomasma DC: Teaching ethics on rounds: The ethicist as teacher, consultant and decision-maker. Theor Med 1986; 7:13-32

11. Culver CM, Clouser KD, Gert B, et al: Basic curricular goals in medical ethics. N Engl J Med 1985; 312:253-256

12. Volpintesta EJ, Schechter JP: Ethics consultants need doctors' support. Hastings Cent Rep 1986; 16:48

13. Tumulty PA: What is a clinician and what does he do? N Engl J Med 1970; 283:20-24

14. Siegler M: Ethics committees: Decisions by bureaucracy. Hastings Cent Rep 1986; 16:22-24

15. Wolf SM: Ethics committees in the courts. Hastings Cent Rep 1986; 16:12-15

16. Annas GJ: Refusal of lifesaving treatment for minors. J Fam Law 1984-1985; 23:218-240

17. Bermel J: Ethics consultants: A self-portrait of decision makers. Hastings Cent Rep 1985; 15:2

18. Ballard WP, Gold JP, Charlson ME: Compliance with the recommendations of medical consultants. J Gen Intern Med 1986; 1:220-224

19. Cassel CK: Doctors and allocation decisions: A new role in the new medicare. J Health Polit Policy Law 1985; 10:549-564

20. Siegler M: A legacy of Osler: Teaching clinical ethics at the bedside. JAMA 1978; 239:951-956

21. Pellegrino ED: Towards a definition: A philosophy of medicine. J Med Philos 1986; 11:9-16