

Rovenstine Lecture

Patient Values, Hippocrates, Science, and Technology: What We (Physicians) Can Do versus What We Should Do for the Patient

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FIRST of all, I want to thank Dr. Feeley for the article in the July issue of the American Society of Anesthesiologists Newsletter, which provides some overview of my own values and priorities in life. I would like to add another thought directed to those in the audience who are faculty members and those who are considering a faculty appointment. I'll start by showing this picture of my wife of 43 years, Marilyn, and me surrounded by our five children and their spouses, and 10 grandchildren to comment about endings and legacies.

Endings and Legacies

When it is all said and done, what of meaningful value do you have to look back on? When you retire or leave your career for any reason, you may receive a nice gift, some accolades, and a party. But then where do you go? To whom do you turn, especially when you become ill? As Morrie Schwartz points out in *Tuesdays with Morrie*,¹ it is your family and friends who come to the



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forefront of your life. Be sure to give them time and attention now as you scurry about your life.

Also, keep in mind that there are two unending legacies that exist in perpetuity. As a parent, you have offspring extending over an unforeseeable number of generations. As a teacher, you have an unending succession of students extending far into the future. That is what Emery A. Rovenstine has, and before him Dr. Ralph M. Waters, who was Dr. Rovenstine's teacher. Although I never had the good fortune to meet either man, I have had the benefits of knowing and learning from many of their direct descendents. The Water's tree (fig. 1) shows only the trainees who became chairpersons of anesthesiology departments and does not depict the many others who were successful practitioners of anesthesiology in academic medicine and in private practice. The second major branch of the main trunk represents Dr. Rovenstine and his progeny.

My goal for the 38th Rovenstine Lecture is to make your investment of time as worthwhile as I can by giving you something to think about that affects both the professional and the personal aspects of your lives. By doing so, I hope to extend just a bit of the Rovenstine legacy to all of you. I would like to dedicate this lecture to my parents, Carl and Aimee Hug, whose end-of-life experiences initially focused my attention on the issues I am addressing today.

As I see it, the Rovenstine Lecturer is given the opportunity, indeed is invited and encouraged, to project some aspect of his or her experience onto challenges and opportunities in medicine and anesthesiology. In my practice of anesthesia and intensive care of patients undergoing cardiac, thoracic, and vascular surgery, I recognize a recurring number of ethical conundrums that beg for answers. They revolve around the questions, What can we do to the patient? *versus* What should we do for the patient? I am motivated today, more by observation than by special expertise, to discuss these questions, particularly as they relate to the patient near

medical indications for surgical interventions. Raising legitimate questions in a realistic and honest manner with our surgeons may make everyone a bit uncomfortable at first, but over time, it will gain the respect and support of surgeons who will value an ally in fending off inappropriate requests for interventions from family members and referring physicians.

Anesthesiologists and End-of-life Issues

Why should anesthesiologists be concerned about end-of-life issues? I see at least five reasons. First of all, we are members of the medical profession and of society-at-large, and we should take our place as informed participants and leaders.

Second, anesthesiologists have made questions about surgical interventions more difficult to answer. It used to be that patients were too sick to tolerate an anesthetic, and there was no need to consider an operation. Now however, anesthesia and perioperative life-support are so effective and safe that virtually any patient, no matter how sick, is eligible to be considered for an operation. We have eliminated the "anesthesia barrier."

Third, we have direct responsibilities to patients in balancing the benefits, risks, and burdens of different anesthetic techniques, pain control procedures and therapies, critical care interventions, and clinical research. Anesthesiology has been expanding its sphere of influence to the broad realm of perioperative medicine. In this role, we have a responsibility to identify and to discuss ethical issues, particularly as they relate to informed consent. Only the physician has the training, knowledge, and experience to frame the benefits, risks, and burdens of disease and of interventions for the patient so that well informed decisions can be made.

Fourth, physicians must confront outside pressures and mandates, which create new ethical conflicts. For example, some are beginning to talk about the optimal way to go about assisted suicide. They suggest a "triple-play combination" of general physician to psychiatrist to anesthesiologist. Anesthesiologists are seen as having the knowledge and skill to maintain comfort, to devise lethal doses, and to treat the failures. And we may encounter conundrums such as organ donors who have not fully met the accepted criteria for "brain death."²

Fifth, we are moral agents, autonomous professionals, who are free to choose to whom we offer or refuse to offer services. We are not just technicians nor indentured servants. We should be aware of our patient's understand-

ing of and goals for the proposed procedure, and if those do not seem to be reasonable expectations, then I believe we are obliged to raise questions with the surgeon and to encourage further discussion with the patient about the balance of benefits and burdens of the proposed operation. If we believe the discrepancy between benefits and burdens and the patient's goals to be so great that we find it unacceptable to participate as a facilitator of the operation, then I believe we have an obligation to withdraw from the care of the patient on the basis of conscientious objection. Otherwise, we are guilty of complicity!

Informed Consent in the United States Today

Now, let's consider informed consent. The mindset of the typical United States citizen today is "identify the problem and fix it," and physicians, especially interventionalists, are being characterized by the public as being treated by HMOs more like mechanics or technocrats than doctors.

Many patients, family members, and friends have unrealistic expectations based on the marvels of the science and technology of modern medicine. These expectations are reinforced by the physician who focuses on "the problem" and "the fix." A scenario might sound like this. "You have chest pain due to blockages in your heart's blood vessels, which we can bypass. Our success rate in correcting the problem is 98%; only 2% of patients in your risk category die." Thereby, the patient is presented with a simple binary choice and a "no brainer" decision.

Of course, the consent form has a list of possible complications, often in fine print and hurriedly summarized by the physician. Few pay attention to such lists until something bad happens. Indeed, in most cases, the operation is a success, and the patient resumes daily activities feeling better than he or she has for some time.

But what about those patients and families faced with less than satisfactory outcomes? They were expecting the patient either to die or to be "normal." With the heart "fixed," they were not expecting lingering illness and disability in the form of stroke or lung or kidney failure, which may mandate long-term support in an extended care facility (read "nursing home"), a fearful prospect to many in our society. Or, with the heart "fixed," they were shocked to be faced with considerations of DNR [do not resuscitate orders] and withdrawal of life-support because of multiple organ system failure, sepsis, and no reasonable prospect for recovery of independent function.

I think we as anesthesiologists can help change things for the better. We can prospectively monitor the patient's understanding of the proposed intervention and its possible outcomes. Where the patient's understanding is deficient, we can signal the surgeon of the need to review the situation with the patient so that the conditions of informed consent are fully met and the patient's autonomy is respected. Where indicated, advanced planning for management of a bad outcome short of death can be accomplished.

Prospective planning has the potential benefits of providing more thorough understanding and well-informed consent; achieving better physician-patient relationships; reducing the risks of complaints, legal claims, and lawsuits; limiting suffering and anguish on the part of patients, families, and friends; and reducing the enormous expenditures for acute care at the end-of-life, which in 1998 represented approximately 50% of the total costs for medical care in the United States. More than \$500 billion of \$1.1 trillion were spent caring for patients in the last 6 months of life.³

Ethical Analysis

A number of clinical ethicists have suggested schemes for conducting an ethical analysis, analogous to a medical workup, to facilitate medical decision-making. One popular scheme, widely utilized as the basis of teaching ethics to medical students today, is that proposed by Jonsen *et al.* and presented in their textbook entitled *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*.⁴

They base ethical analysis on four main topics: medical indications, quality of life, patient preferences, and contextual features (e.g., religious, cultural, economic). They have developed a checklist for each of these four topics, which might be useful in focusing discussions with the patient. For example, in regard to medical indications: What are the specific, realistic goals achievable with the proposed operation? How do they compare with alternative treatments? What are the risks of complications? Perhaps more importantly, What are the burdens? How does the elderly patient feel about amputation of a leg? The demands of rehabilitation? Confinement to a wheelchair? What will be done if serious, long-term disability results?

Many patients are not able to make such decisions after they experience the complications of an operation—hence, the advisability of making plans prospectively for

dealing with therapeutic failure. The development of such plans takes time and focuses on the patient's own assessment of their quality of life, with the physician's counsel as free as possible of personal biases. Such planning includes respect for autonomy, which is the ethical principle underlying the physician's acceptance of the patient's preferences, expressed directly or through advanced directives and a proxy, and taking into account extenuating circumstances and other contextual features. Physicians are ethically obligated to abide by the patient's decision to refuse treatment and to respect the patient's autonomy, no matter how strongly they disagree with the decision. This obligation is reinforced by the law, which protects the patient from abuse and battery.

In regard to medical indications, it is useful to keep in mind the seven goals of medicine⁴:

1. the promotion of health and prevention of disease
2. relief of symptoms, especially pain and suffering
3. cure of disease
4. improvement of functional status
5. extension of "real" or "meaningful" life, from the patient's perspective
6. education and counseling of the patient regarding his or her condition and its prognosis with and without treatment
7. the avoidance of harm in the course of care

At least one of these goals must be achievable by the treatment proposed. Otherwise, there is no medical indication for the treatment and no benefit to justify any risk or burden. The physician is not ethically obligated to provide treatment that is not medically indicated, even if it is requested by the patient, proxy, family member, or referring physician.

Consider the case of a cardiac surgical operation for which I had questions about the balance of benefits and burdens. Some time ago, I faced a 37-yr-old juvenile diabetic with virtually all the ravages of diabetes mellitus. She was scheduled to undergo her third coronary artery bypass operation, a single saphenous vein graft to an obtuse marginal coronary artery less than 1 mm in diameter. Two years earlier she had spent almost 6 months in the hospital recovering from her second coronary operation, which was complicated by mediastinal infection and compromised renal function.

In my mind, I questioned the notion that limited improvement in regional blood flow was justification for

what was undoubtedly another long course of hospitalization, pain, and suffering. I expressed my concerns to the surgeon as well as my reluctance to participate as her anesthesiologist. His response was that he shared the same concerns. Would I talk to the cardiologist?

Again I expressed my concerns to the cardiologist who responded that this was the "only thing that could be done" to reduce her angina. He agreed that the proposed operation was not likely to relieve it completely, or for very long. I suggested that we both go and talk to the patient and her family.

Without going into all of the details of the conversation, the conclusion of the patient was best expressed as, "Well, no one gave us the option of no surgery!" She chose to modify her medical regimen, avoid the high risk of a stormy postoperative period of convalescence, and add that time to the limited time she had left to spend with her family and friends.

Patients and physicians do not realize that sometimes, no surgery is the best medicine.

It should be noted that extension of biological life is not a primary goal of medicine. The patient facing an acute illness and possible intervention near the end of life has to consider carefully what benefits are to be realized in terms of improvement of quality of life. Few patients will opt for an extension of biological life if they cannot realize some improvement in their condition. For patients near the end of life, the focus should be on

- relieving pain and suffering,
- improving physical and mental quality of life,
- maintaining or restoring function to a level acceptable to the patient with minimal additional burdens,
- facilitating realistic decision-making by the patient given the prospects for limited recovery and longevity.

The primary goal of an ethical analysis is not what, but how. How to identify, characterize, and deliberate issues so that a truly informed decision can be made. It is not dictating what the decision should be. In other words, it is a process, an "ethical workup." It provides a map to goals, but the individuals involved have to use their own ethical compasses (*i.e.*, personal and professional conscience, a set of moral values) to navigate their way to an appropriate decision.

What is the role of the physician? Remember, it is the patient or the patient's proxy who decides, not the physician. The physician's role is to inform, counsel, and support to the best of his or her ability, free of bias, prejudice, and self-interest.

The Surgical Trial

Another approach to the patient with an intolerable health problem is to consider an intervention, even if it is high risk, on a try-and-see basis.⁵ A "surgical trial" may offer an intervention that has the possibility of a better existence, but also may have a risk of long-term dependence on life-support measures, or even death.

A surgical trial is appropriate, however, if the intended goal is relief of intolerable symptoms and not assisted suicide. The trial invokes the ethical principle of double effect, in which the good consequences are intended and the bad consequences are not intended but may have to be accepted.^{6(p206-11),7} It would be reasonable, indeed essential, that the period of trial be limited in some manner (*e.g.*, to a certain number of days without improvement or the appearance of deterioration).⁵

Two examples might provide an effective means of conveying an understanding of a "therapeutic trial" as it relates to surgical patients.

Mr. KK, 52 yr of age, was to undergo a palliative procedure. He had an unresectable tracheal cancer which did not respond to radiation and chemotherapy. He developed progressive shortness of breath and labored breathing, even at complete bed rest, due to upper airway obstruction. He was miserable and said that he would rather be dead. With the patient well sedated, an attempt was made to insert a percutaneous endotracheal catheter as a palliative measure to reduce his symptoms. However, a tracheal tear occurred and pneumothorax resulted. The surgeons summoned me and requested tracheal intubation so that the tracheal hole could be closed *via* a right thoracotomy.

Is there an ethical requirement to treat iatrogenic complications of a palliative procedure, especially when it adds substantial pain and suffering to the patient's already ready miserable state? Is there a medicolegal requirement? The answer to the ethical question is no. And, in my opinion, the need for compassion requires the physicians to take the small risk (if there is any at all) of a malpractice claim for failing to treat such a complication. In fact, an article on the topic of treating iatrogenic complications of palliative procedures appeared 1 week after I had refused to perform intubation in Mr. KK or to participate in the thoracotomy, and it supported my decision.⁸

Another example was Mr. RT, a 74-yr-old diabetic with mild renal insufficiency who underwent successful coronary artery bypass surgery. Early in the postoperative period he developed mediastinitis and sepsis, which

were treated with antibiotics, debridement, and a muscle flap. Then renal failure occurred. The nephrologist recommended hemodialysis to reduce his BUN [blood urea nitrogen] and edema and to give his kidneys a chance to recover. He had a living will and had clearly indicated previously that he did not want to become dependent on any kind of machine. The physicians and family agreed that dialysis would be started and if there was no improvement in his condition after four or five treatments over 8–10 days, dialysis would be discontinued. During the next week, Mr. RT awakened after dialysis had reduced his blood urea nitrogen, which was his only “sedation.” He clearly indicated his desire to have the endotracheal tube removed, and that no further hemodialysis be done. In fact, after four dialysis treatments, his kidneys had shown no recovery. His requests were granted. He lapsed into coma the next day and died 3 days later.

Is this euthanasia? Assisted suicide? I am a practicing Catholic. What would a Catholic priest say? My pastor said, “If God is going to work a miracle, He doesn’t need a machine to do so.”

Along the same lines, therapeutic trials of cardiac assist devices, mechanical ventilation, antibiotics, etc., can be undertaken with agreed-upon, realistic limitations of time to determine failure to recover or deterioration.^{6(p197–202)} There is no ethical distinction between withdrawing and withholding life-sustaining treatment.⁹

Another circumstance for which a surgical trial may be an option, is the person who has been living a satisfactory life, until she or he is suddenly incapacitated by an acute, potentially reversible condition (e.g., disabling angina pectoris). Even though a definitive operation may have substantial risks of complications, the patient may opt for surgical intervention with the understanding that, if recovery toward the presymptomatic level of function fails to progress or deterioration becomes apparent, then DNR status would be established, and life-support measures would be withdrawn.

In other words, the high-risk patient is given one shot, and lives or dies without additional, prolonged intervention. So far, I have not had one ethicist raise an objection to this approach to a fully informed patient. Many to whom I have raised the question actually support the approach as humane, practical, and ethical, and it has been accepted by three patients for whom I provided care. Of course, understanding of the plan for the surgical trial has to be explicit among the patient, proxy, family members, and the physicians, and sufficient time

has to be allowed for recovery from the acute impairment of the surgical operation *per se*.

Automatic Medicine

Now, let’s talk about automatic medicine. A disabled, and especially a demented patient, languishing in a nursing home waiting to meet their maker (e.g., my mother) develops an acute problem such as pneumonia or urinary tract infection, falls out of bed and fractures hip, or develops angina pectoris. What should be done? I can tell you from my personal experiences with both of my parents, that without intimate knowledge of how the particular nursing home operates and very specific orders written in advance on the particular patient’s chart, it is virtually impossible to stop an immediate transfer to a hospital where the physicians receiving the patient in the emergency room have no knowledge of the patient’s wishes and values and are left with no choice but to treat the problem and most likely to admit the patient. Thus, the patient enters the acute care hospital and is subjected to the marvels of drugs and medical technology that cannot fix their dementia or disability or improve their existence even if the infection is cured or the hip is replaced, and their biological life is extended. Is that what we want for ourselves? For our loved ones? For our patients?

At the moment, there is no simple recipe for preventing inappropriate “automatic medicine.” DNR orders apply only to cardiopulmonary arrest.⁹ DNR does not limit increased treatment of worsening disease or of new acute problems (e.g., pneumonia) for which it is appropriate to allow nature to take its course in accordance with the wishes of the patient. Advance directives are usually not sufficient in detail to cover all circumstances and they are often open to different interpretations. Physicians receiving the patient may not have timely access to advance directives, the patient’s charts from other institutions, the primary care physician, or the patient’s proxy for healthcare decisions.

However, once such information becomes available, the physician caring for the patient is advised from both the ethical and legal points of view to respect the patient’s wishes. If the intervention is contrary to the patient’s wishes, it should not be undertaken, or if already in progress, it should be discontinued. Discontinuation of a surgical operation in progress will require careful consideration of the options by the surgeon (e.g., convert a “curative” to a palliative operation). But, if the

surgical incision has not been made, the anesthesiologist would be correct in stopping the anesthetic and allowing the patient to awaken without undergoing any surgical intervention.

Postoperative Dilemmas

Complex and difficult decisions involving surgical patients also arise after an operation, which has a less-than-satisfactory outcome, especially when there are complications that will require long-term life-support measures and prolonged or permanent disability of the patient. Often the patient is unable to participate in the decision-making because of the severity of the illness and incapacity to understand what is going on. The decisions then are left to the patient's proxy or next of kin, surrounded by family members and friends. It is in this situation that one appreciates the value of advance directives by the patient and, more importantly, prior expressions of values, wishes, and preferences about how such circumstances should be handled. Some knowledge of the patient's preferences can go a long way in relieving the burdens of decision-making for the healthcare proxy, next of kin, family, and friends. Advanced planning can also reduce the chances of controversy and recrimination among the patient's survivors. In addition to considerations of expanding, maintaining, or withdrawing life-support measures, the question of what should be done in the event of a sudden deterioration of the patient's condition, particularly respiratory and cardiac arrest, needs to be addressed.

Do Not Resuscitate or Relax

Concerning DNR orders, two important points should be kept in mind. First of all, DNR stipulates only that the patient will not be resuscitated from a sudden life-ending event, such as cardiac or respiratory arrest.⁹ The family should be assured and reassured that the wishes of the patient or the proxy will be followed in terms of the level of care decided upon. It is especially important for physicians and nurses to tell the family that the patient will not be allowed to experience pain. Suffering (*e.g.*, due to restraints, which would terrorize my father) should be minimized to the greatest extent possible. These are important messages to get across to nurses and others caring for the patient, because surveys have found that care givers relax their vigilance and attentiveness to the patient's needs when DNR status is estab-

lished.^{10,11} Another meaning of DNR is Do Not Relax! Families easily detect lowered levels of vigilance, attentiveness, and caring. In my experience, this has been a reason for family members to refuse an appropriate DNR status. They simply fear that their loved one will be abandoned.

Second, under all circumstances, it is extremely important that all involved in the care of the patient have a common understanding of what is and what is not to be done. Explicit and detailed orders should be in the chart and have attention called to them. All of this can get very confusing as the care of the patient is passed from one nurse to another, or one physician to another, over time. If the patient has a written directive stipulating limits on life-support measures, these must be respected by the care givers on the basis of the ethical principle of autonomy and the law prohibiting battery. However, problems may arise when the family insists that everything possible be done and the patient is unable to reaffirm his or her wishes. In such circumstances it is advisable to follow a conflict resolution algorithm.

Conflict Resolution

Practical approaches to conflict resolution, including one discussed in the March 10, 1999, issue of *JAMA*, define a series of steps to be taken toward reconciling differences in futile cases.¹² As noted previously, conflict resolution is greatly facilitated by knowledge of the patient's values and wishes expressed while the patient was able to do so prior to the present critical state.

The procedural steps are usually taken in the following order, going to the next succeeding step when disagreements remain unresolved.

Steps to Conflict Resolution

1. The ideal is to have joint decision-making by the physician or physicians and the patient's proxy using outcome data and value judgments based on knowledge of the patient's wishes.
2. If there is no consensus, then it is advisable to request a consultant or a patient representative (*e.g.*, minister, counselor) to facilitate advancement of the discussions toward a decision.
3. The next step is to involve the institutional ethics committee by requesting a detailed review of the situation, including a bedside examination of the pa-

tient by at least one of the physician members of the committee.

4. Failing a consensus resolution, the physician may attempt to transfer the care of the patient to another physician within the same institution or at another institution.
5. Last and least desirable, it may be necessary to appeal to the legal system.

When Death Occurs in the Operating Room

Before concluding, I would like to tell you about another way I have found to be helpful in supporting the surgeon and the family and friends of a patient. It involves the patient who dies in the operating room.

With my focus on surgery and bad outcomes at the end of life, you might get the impression that Emory University Hospitals have unusually large morgues. Not so. We take pride in our outcome results, which are among the very best in the United States.¹³

But, on occasion a patient dies in the OR. When that happens, I make every effort to accompany the surgeon when she or he goes to meet with the family. Although, I may have little to say (quite uncharacteristic for me) I see five major benefits of doing so.

1. The anesthesiologist can assure the family members and friends that the patient did not experience pain or suffer at any time. You certainly should be able to make that statement! This is an important point, because some people have the notion from the medical literature, popular press, and especially television that the doses of anesthetic drugs may be limited or reduced as part of a resuscitation effort.
2. By listening carefully to the conversation and watching the facial expressions and other reactions of the people present, you may detect points of confusion and uncertainty, which you can correct with clarifying comments. Some physicians are better than others in communicating clearly with people outside the world of medicine, especially when they have to deliver bad news.
3. I believe it is part of the anesthesiologist's professional duty to speak to the family and friends at some point after a death in the OR, and the chances of mixed or conflicting messages are greatly reduced when the surgeon and anesthesiologist deliver their messages together.
4. There are obvious benefits of clear and consistent messages in terms of legal risk management. You may

also want to consider this combined approach to the patient and family members when there is a serious, nonfatal complication.

5. The anesthesiologist and surgeon together can share the impact of the reactions to bad news, demonstrate that they function as a team, and show their mutual respect for each other.

I strongly recommend that you participate in these difficult and sad experiences as a way to help your patients and your surgical colleagues. I hope such experiences will be few in your practice. In addition to that last recommendation, I offer the following additional recommendations

All of us are human beings with a limited natural life span. Sooner or later, each of us will likely face difficult medical questions about what to do, or not to do, in relation to our family members, our friends, and ourselves. Often these questions arise suddenly and unexpectedly, and there is an urgent need to find answers. The burdens of making decisions, and living with their consequences, can be lightened by devoting a relatively small amount of time and effort to identifying our values and discussing our priorities in advance. We consult lawyers, estate planners, and tax advisors and make prospective decisions about the disposition of our assets after our death. Should we not put forth a modicum of thought and effort to inform ourselves and our loved ones about our wishes and priorities should we become incapacitated and decisions have to be made about medical or surgical interventions?

Of course, I am referring to interventions that may prolong biological life but carry a substantial risk of pain, suffering, and lingering disability that are threats to the quality of life. Perhaps the investment of time and effort now can be looked upon as an insurance policy mitigating the emotional suffering, and even the physical pain of a life-threatening illness, which can strike at any time and at any age.

Incidentally, when choosing our own physicians and surgeons, the questions sometimes posed include, Who is the smartest or most knowledgeable? Who has the best pair of hands? Who is most skillful? I think we should also ask, Who is compassionate?

My second recommendation is to support as strongly as possible the mandates of the American Board of Anesthesiology¹⁴ and the Anesthesiology Residency Review Committee that anesthesiology residents spend at least 2 months caring for critically ill patients, preferably in the postsurgical ICU [intensive care unit], so they can begin

to appreciate the impact of the surgical operation on the whole patient and on the patient's family members and friends. They also can observe how experienced physicians, sensitive to the worries and concerns of family members and friends of the patient, handle discussions of end-of-life options and reactions to them.

I urge incorporation of ethical discussions and problem-solving in anesthesiology residency training and in continuing medical education programs. Sooner or later, virtually every physician who interacts with patients directly will be faced with questions and conundrums for which ethical know-how will provide a pathway to a solution. The chances for such encounters are increasing with the aging of our citizens, the expectations of baby boomers, and the continuing advances in the science and technology of medicine. Sooner or later, everyone of us will be "overmastered by disease," to use Hippocrates' words.¹⁵ Or as Morrie Schwartz said, "Everyone knows they're going to die; but nobody believes it. If we did, we would do things differently."^{1(p81)}

Finally, we should be prepared to help patients, surgeons, and other physicians to assess the appropriateness of proposed interventions in light of the patient's values and goals. This is a particularly difficult and sometimes time-consuming task because of the need to strike an appropriate balance in providing information that is sufficient to learn the patient's values and wishes and yet not so frightening as to cause undue anxiety and fear.

You may be interested to know that there are efforts to increase the public's awareness of the need for advanced thought and discussion of values and preferences. Lacrosse, Wisconsin, has an ongoing program called "Respecting Your Choices." The Georgia Health Decisions Project is developing and testing promotional and educational programs in various communities across the state and have established an information base available by telephone (1-877-6 DECIDE) or *via* the World Wide Web at <http://www.critical-conditions.org>

Thank you for this opportunity to share my thoughts with you. I would sincerely appreciate receiving your comments, criticisms and other ideas.

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