VOICE OVER:

Welcome to ASA's Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER (HOST):

Welcome back. This is central line, and I'm your editor and host, Dr. Adam Striker. With me today is Dr. James West, chair of the ASA Committee on Ethics, who also wrote the guest editorial for the February issue of the Monitor, which digs into the topic of ethics from various angles. We're going to do some of that on today's show, so we're happy to have you with us, Dr. West.

DR. JAMES WEST:

Well, thanks. I'm really happy to be here.

DR. STRIKER:

Let's start off with the committee itself. Do you mind telling our listeners a little bit about ASA's Committee on Ethics, how it came about, what role does it play, et cetera?

DR. WEST:

Well, first I have to say thanks to Dr. Stephen Jackson, one of my mentors, because he helped me find the history of all of this because it was just a little before my time. But it was in existence prior to 1992. But it had been dissolved because, according to Dr. Jackson, so many times that people try to use it for economic gain. But after that, it was reformed, and Dr. Bob Saltine was the original chair. But he asked Dr. Jackson to take it. And Dr. Jackson was chairman for 15 years. We've had several other chairs. I've been the chair for three years now.

But the first two things the committee did was it drafted guidelines for the treatment of patients with do not resuscitate and other orders that limit treatment. And then that was
followed by guidelines for the ethical practice of anesthesiology. The former is something that's still misunderstood today. In fact, we have an article this month in the Monitor that addresses that a little bit.

DR. STRIKER:

The Ethics Committee created the Guidelines for the Ethical Practice of Anesthesiology, which are updated by the committee and approved by the House of Delegates. As I understand it, they're the only ASA guidelines a member can be expelled for not following. Is that right? Can you talk about why the guidelines are different and what members should know in order to stay on the right side of those guidelines?

DR. WEST:

Well, yes, that is correct. They are the only guidelines that you can be removed from the society for not following. These guidelines, they may better have been named a code of conduct or a moral code than a just a guideline because that kind of like throws them in to being related to, or maybe people think of them in the same boat as, say, the guidelines for central line placement or things such as that. But that's completely different. This is a code of conduct, and they're important because we have a contract with patients and our colleagues and a society to be ethical. These guidelines support that. They promote truth telling, honoring patients right to choose, and many other things. If a member wants to be sure that they stay on the right side of all the guidelines, they certainly should be familiar with the guidelines.

My editorial this month actually has a link to those guidelines, as well as all the other ethics resources that we have.

DR. STRIKER:

We're going to talk a little bit later in the podcast about the guidelines you mentioned for treatment of patients with DNR and other orders that limit treatment. But aside from that--I know that one was the one that may be a little more misunderstood--but aside from that, what are some common ethical concerns anesthesiologists grapple with?

DR. WEST:

Well, I think the big concern and ethics that everybody gets involved in is that patients that come into the OR getting futile care or care a lot of times that we feel like may not be necessary. This is an everyday occurrence, and often patients don't understand that their surgery might be an ethical issue, and they may not understand all the implications
of their surgery because they may think surgery, a lot of times, is curative when maybe it's not. So in those situations, a lot of times when we talk with surgeons, we find that both clinical and ethical judgments overlap. Sometimes its clinical judgment because they might think that this is a surgery that's going to help somebody. But if we haven't talked to the patient about their goals and objectives or what they're trying to achieve, then maybe this surgery is not going to help the patient achieve what they want.

But there are a lot of other ethical concerns that just being a bioethicist or being on the ethics committee, there's transplant ethics. There is discussions about should we transplant alcoholic, donations after circulatory death, physician participation and lethal injection, the utilization of limited resources, environmental sustainability, and a host of others that we have addressed from time to time. So clinical ethics gets into a whole large number of things. Also, distributive justice, which is a very, I think, important thing, especially these days trying to make sure everyone, regardless of financial need and financial ability, can get the care that they need.

DR. STRIKER:

Well, obviously, this committee touches on pretty much every facet of care that we as anesthesiologists perform. But I do want to follow up a little bit, just get your take on the idea of delivering clinical care when you may not think it's in the best interest of the patient, you touched on it in the answer. What is your take on what role the anesthesiologists should play in that regard? How far should you go to object to care that you may feel is not in the best interest. You know, a lot of time, in the back of our minds, we think, yeah, I don't know if they need this, but you know, I'm here to make sure they get them through safely. How much should we be proactive in that regard? Kind of an ambiguous question, but I just want to hear your take on it.

DR. WEST:

Well, because you asked me an ambiguous question, I'm probably going to give you an ambiguous answer. That is very difficult. And, you know, because I'm in private practice and I have to deal with it every day, a lot myself. It is very difficult trying to be a patient advocate because in this day of production pressure and so many patients that come in for outpatient surgery, and a lot of times not meeting our patients until shortly before their surgery, it is hard to be able to have a long enough discussion to find out everything you need to know about a patient. But I think that if it becomes clear to us that the patient doesn't really understand the surgery or at least doesn't understand, thinks they're getting something that's curative when it's just palliative and maybe not even all that palliative, that's when it's at least time to have a discussion with the surgeon and the other caretakers before we proceed with the surgery. And from that
standpoint, we have to go. Fortunately, I've been, personally, I've been in practice so long and have enough gray hair that it's not that hard for me to do that now. But it hasn't always been that easy to question the surgeon's judgment on proceeding with a big surgery that may not be beneficial.

DR. STRIKER:

We certainly are living in tough times right now, still in the midst of COVID 19 pandemic, and that has triggered some ethical concerns around the allocation of limited resources. And that is obviously a huge issue right now across the health care spectrum. Not only were drugs and equipment considered limited resources, but anesthesiologists were too and now other health care personnel are as well. What approach should we be taking to resource allocation during difficult times? What are some touchstones that may guide us through this?

DR. WEST:

Well, one common approach to the limited resource allocation during a pandemic incorporates a utilitarian philosophy. That's where a limited community resources are allocated to minimize the harm, which in ethical terms is sometimes referred to as non maleficents, and maximize the benefit beneficence for the greatest number of patients. But also distributive justice generally requires prioritizing saving those most likely to survive in order to save as many lives as possible, which includes giving treatments to those who may benefit most while also enabling the continued functioning of society. That's part of the reason why in most people's policies have prioritized health care workers, not because health care workers lives per say are more valuable than anybody else's, but because that and there is a moral reciprocity for health care workers putting themselves in harm's way and by treating health care workers and giving them priority, it helps get them back to work and taking care of other patients.

Those two goals distributive justice and utilitarianism are usually, but not inevitably, mutually supportive of each other. This topic recently came up with the monoclonal antibodies in Tennessee. Of course, there's been a big shortage of Regen, the monoclonal antibody, and in Tennessee, they said that they should prioritize unvaccinated patients, which many people thought was rewarding bad behavior. But also unvaccinated patients were the ones that were most likely to benefit from the monoclonal antibody because they were the most likely patients to end up being hospitalized or on ventilators. Vaccinated patients, unless they had some other extenuating circumstances, like being immunosuppressed, we're not likely to need help avoiding hospitalization. So that was an ethical dilemma. I think what it calls is there is just a lot of gut reaction to that, but it really made a lot of sense. However, that policy
has recently been changed. It really just took out the language about whether patients were vaccinated or unvaccinated, but left in language that said whoever it would help the most.

Most importantly, I think for allocation of resources, it's important for hospitals to have policies in place before dilemmas occur when the pandemic first started. The Ethics Committee put suggestions and references on the ASA website that included one reference even with a sample policy to aid the membership. So if it should be a multidisciplinary committee, should help make those policies and have agreement on the front end in rather than, all of a sudden, in the middle of the night, you're trying to decide who gets a ventilator. One of the articles in this issue of the monitor also addresses this.

DR. STRIKER:

Going along with this theme of COVID 19. And there's obviously another issue which generates a lot of passion and controversy depending on who you talk to. But vaccine mandates are certainly something that involve ethics as well. What can you tell us about ethical issues involved in vaccine mandates?

DR. WEST:

Well, there are a number of ethical issues that supporting mandates.

There's a utilitarian theory supporting mandates that says the idea of setting the maximum community well-being is the goal. That's population centered and privileges the good of the whole community over individual autonomy. And that especially goes would be applicable to mandating vaccines for health care workers and trying to keep your health care force healthy to take care of patients that do get sick. The vaccine mandate is also ethically justified if it benefits the person being vaccinated and minimizes harms to vaccinated individuals. Vaccination benefits outweigh any potential burdens, and it's the most effective and least risky method to prevent disease spread, compared to other potential interventions. There's also a precautionary principle that asserts that public health professionals must protect populations against reasonably foreseeable threats, even under conditions of uncertainty. Even though it's never been clear how well people that were vaccinated could actually transmit the disease if they were asymptomatic, I think it has been shown that they probably were not contagious near as long as somebody that was unvaccinated, even with asymptomatic disease. So vaccinated health care workers not only has the potential to prevent us from spreading the disease, but helps keep the workforce strong during those viral surges. Once again, this is part of our compact with society.
Now refuting mandates, considerations should include number one. There's two predominantly refuting arguments. Some people have argued that mandates equate to compulsory research participation, and some object to the government forcing health care decisions on individuals. These mandates that are broadly applies may not always consider that risk may vary depending on different regions, occupations, etc. In very small communities where there's not a whole lot of population density, the COVID 19 coronavirus has not been the scourge that it has been in places like New York, so maybe it wouldn't necessarily be necessary to have vaccine mandates there. But one thing I can tell you is that I never imagined that vaccines would be so controversial. But in countries like the United States, where there is so much emphasis on personal autonomy, many people have pushed back not just on vaccines, but on mask and social distancing, because this is a country that was built on personal freedom.

DR. STRIKER:

That's certainly going to be an ongoing, complicated issue to grapple with for the country as we move forward. Now beyond the pandemic, many anesthesiologists deal with ethical dilemmas around resuscitation. There's some question as to whether full resuscitation should be the default go to in elderly patients, the quote, revisit and revise or required reconsideration, approach is useful. But what do we do with the vast majority of patients who present for surgery without DNR orders in place? If you don't mind, talk a little bit about ethics of resuscitation.

DR. WEST:

For those that aren't familiar with the terms you used, the required reconsideration is a term from the American College of Surgeon’s policy on do not resuscitate patients that come to surgery, where if someone has a DNR order and you are going to bring them to surgery, you should at least have required reconsideration of that approach. It doesn't mean that you would immediately rescind those orders just because they're in surgery and have an anesthesia, but you would at least have another discussion with the patient about what they want. And that's similar to what our policy for patients with DNR is, is that you should have another discussion to find out what the patient's goals are, to find out what they would like you to do if they did arrest during surgery. But like you said, not all patients have a DNR order in place, but they might be getting up in years and they might be very sick with cancer or a heart disease or a number of other diseases. First of all, I think that when we don't know what the patient wants, there's no doubt that I think everyone would agree that we have to err on the side of life, which I've had to do on more than one occasion. But in a production pressure environment like I talked about earlier, it's not always practical to have long conversations with patients and families,
but if we can anticipate and communicate so that we understand the patient's wishes and goals, that's obviously the best thing, whether they have a DNR or not.

The article, that's about whether that should be the full DNR if they don't have a advance directive or a do not resuscitate order, the full DNR, the article in this issue talks about whether that should be your go to, but it doesn't have to be if you have a discussion with the patient and find out that maybe that's not what they want. Depending on the surgery that they're having. But the most important thing, I think, is to have a multidisciplinary approach which brings in not just the surgeon and the anesthesiologist, but someone with a long-term relationship with the patient. Now that's a lot harder to do now with the hospitalist system. There are very few. For example, my own internist does not see patients in the hospital. He might see me because I'm a colleague, but if I go into hospital at the age of 70, I'm going to be taken care of by a hospitalist who may not even know me. So he's not going to have much better idea of what I want than the anesthesiologist. So all of these things are getting much harder to do in our current situation. But when possible, if we can have discussions with the patient to find out their desires, that's what we need to do.

DR. STRIKER:

Well, this might be a good time to ask about ethics committees in the hospital. One of my former colleagues heavily involved in my previous institution's ethics committee and has written about ethics and felt very passionately about the involvement of ethics committees, I'd be remiss not to ask about that, given everything you just stated. How do you feel the role of ethics committees in specific institutions can aid in this endeavor?

DR. WEST:

I think they can aid quite a bit. In fact, the way I first got involved in ethics was a flight was delayed and I bought this little paperback in the bookstore called First Do No Harm by Lisa Belkin, and it was about the Ethics Committee at Memorial Hospital in Houston, Texas. And after reading that book, I came back to my hospital and said, Do we have one of these committees? And we did, and I got myself appointed, and that was somewhere around 30 years ago. So I've been involved in that situation. But the ethics committees in hospitals, depending on how they're structured, are usually multidisciplinary that include chaplains and physicians and social workers, and they can be very helpful. Many of the ethics consults that we get our hospital are really communication consults. We really end up just facilitating communication between patients, family members and their caregivers. And most of the time, our recommendations are not binding, but they still go a long way to help patients.
understand what's going on and helping them make a decision about whether they want to continue with life sustaining care or proceed with surgery or not.

DR. STRIKER:

Yeah, certainly. Well, let's talk a little bit about clinical and ethical judgments when it comes to perioperative consent for high-risk patients. What are the best practices for consent when it comes to these patients? In other words, what principles should clinicians be following?

DR. WEST:

Well, certainly the best practices are a patient should demonstrate mental capacity. Now, we're not psychiatrist, but we make that determination without even thinking about it almost every day, whether a patient has the capacity. Do they understand the procedure that we're going to do? Do they understand what happens if they don't have the surgery? And do they understand what could happen if they do have the surgery? Preferably both the patient and the health care provider will demonstrate that they have mental capacity. But also, we want to ensure patients are given adequate information to make an informed decision. And it's really almost impossible for something very complicated for them to absorb all the information they need, just the first time you talk to them about it. But a lot of times we're the last ones to see a patient, and maybe it's the third or fourth discussion they've had about it. And maybe it's the time that the light goes on. It may or may not be. And we also have to assure when possible that the patient is not subject to coercion. Some other principles worth considering. You make sure the patient understands the procedure and the associated risks and the risk of doing nothing like I said before. And also, like I said before, we're often the second, third or fourth person to talk to them. So it helps us to reiterate things, but we may not always know, you know, as a as an anesthesiologist, I don't always know the chance of success or the patient's goals for treatment. In fact, honestly, sometimes the patient's goal for treatment might just be to live to see their daughter or son graduate from high school or to get married or something like that. And maybe this surgery will help them, even if it's not going to cure them. Without talking to a patient, we don't know that. So once again, communication is key.

DR. STRIKER:

Well, it highlights again the role anesthesiologists play in patient care and that we, you know, we have short times with our patients often, but we delve into so many facets of their care -- the medical aspects, the surgical aspects, the palliative aspects, their long
term care goals, ethical concerns. I just think it does highlight the unique role that we have to play in our patient's care.

One other thing I wanted to ask about, as we're talking about this, a lot of times when we learn these things in school or training, it seems like a common sense sort of thing that we're all more focused when we're learning about learning scientific principles, principles of anesthetic delivery, medical principles, et cetera. Do you feel that we should be doing a better job of teaching these things at some point in our curriculum, whether it's in medical school, whether it's in residency or afterward? Because I do feel like a lot of these kinds of things which are actually some of the most serious issues we grapple with, a lot of us are just learning on the fly, learning with experience. There's obviously no substitute for learning from experience. But do you feel like we, as a specialty and even beyond the specialty, I guess you should be getting a more foundational, a core teaching about these principles, about ethics, what really encompasses our obligations, what is necessary to get from a patient? What is necessary before you deliver a certain piece of medical care?

DR. WEST:

Well, the short answer to your question is yes. I think that to do that, there'd have to be a big change, I guess, in the curriculum for anesthesia residents to really get them to train. But you know, we have and we've had for a while some ethics resources with the ASA that, for example, in Memphis, I've offered on multiple occasions the program chairman and all that that we have now in Memphis at the University of Tennessee. It's a pretty new restarted program, but in the past I've offered it and they've usually been so focused on just trying to learn clinical that they haven't been interested in that. Yet at the same time, believe it or not, the surgeons were the ones that wanted me to give lectures to their residents about ethical concerns and ethical cases, which have been able to do over the years. But yes, we do need to do a better job of at least trying to give people an introduction and letting them know where the resources are to go when they do have ethical concerns.

DR. STRIKER:

Well, one last question before I let you go. I'd like to hear a little bit about the Monitor issue and your guest editorial. What surprises do you have in store for the readers in the ethics issue?

DR. WEST:
Well, I don't know if there'll be surprises or not, but I think that there may be many members that don't really know the function of the Ethics Committee, and we have a lot of things to offer. My editorial has a link to all the ethics resources, including the ethics handbook. Over the years, and that's something that Dr. Jackson started, used to be called the ethics syllabus, but now it's called the Ethics Handbook, which now contains twenty-six chapters on a wide variety of topics. And we add a chapter or two every year. There's a link to that. I mention it, and there's also a link to it.

We've also developed and had approved statements on many things like organ donation after circulatory death. It hasn't been very long since the member came across that for the very first time in a smaller hospital. We were able to point him to that statement. There's a statement on us participating in lethal injection and many others. We also give a history of the ethics committee, which I touched on it a little bit. Our two main statements--the ethical guidelines and the guidelines for how to manage patients that have DNR orders. We also have several exciting topics. Doctors Sween, Ekeoduru, and Mann have penned a great article on mandatory vaccination, which works very hard to present both sides of a very sticky issue. Dr. Matt Allen and Nick Sadovnikoff, I said, said his name wrong. I've known Nick for a long time. I'm still working on pronouncing his name correctly, but they give us a lot of food for thought and a good reminder of how important it is to talk to our patients. And it's a companion article to their November anesthesiology article, which talks about whether full DNR should always be what we do when we're talking with elderly patients. Resource allocation is always important, and especially so right now we're still getting surges of our COVID virus, and that's a great article that we have. And due to the length of this pandemic and the continuing surges, I think that it's important and kind of encompasses that and talks about the whole whole duty to be professional. Lastly, there's an article describing a very difficult case, something that I bet almost everybody can relate to. And it really emphasizes how the things we face on the ground every day can be really tricky and how clinical and ethical judgment do often overlap. So I think people are going to really enjoy these ethics articles in this issue.

DR. STRIKER:

It's an important topic, and I certainly want to thank you for your time and the information you've delivered and your insights, Dr. West. And just to let all our listeners know, to find the resources Dr. West has mentioned, please visit asamonitor.org and search ethics and then you can access the relevant articles there. I really appreciate you joining us.

DR. WEST:
Well, thanks. I appreciate you having me.

DR. STRIKER:

And please check out the February issue of the ASA Monitor, It's a very important topic. I certainly hope we've done some justice to it here in the short time we've had on the podcast. And thank you all for joining us on this episode of Central Line. Please don't forget to give us a review and subscribe to Central Line wherever you get your podcasts, and please join us again next time. Thanks.

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