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Clinical Ethics Consultation

Gender and Race in the Timing of Requests for Ethics Consultations: A Single-Center Study

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ABSTRACT

Background

Clinical ethics consultants are expected to "reduce disparities, discrimination, and inequities when providing consultations," but few studies about inequities in ethics consultation exist.¹ The objectives of this study were (1) to determine if there were racial or gender differences in the timing of requests for ethics consultations related to limiting treatment, and (2) if such differences were found, to identify factors associated with that difference and the role, if any, of ethics consultants in mitigating them.

Methods

The study was a mixed methods retrospective study of consultation summaries and hospital and ethics center data on 56

age-and gender-matched Caucasian and African American Medicare patients who received ethics consultations related to issues around limiting medical treatment in the period 2011 to 2014. The average age of patients was 70.9.

Results

Consultation requests for females were made significantly earlier in their stays in the hospital (6.57 days) than were consultation requests made for males (16.07 days). For African American patients, the differences in admission-to-request intervals for female patients (5.93 days) and male patients (18.64 days) were greater than for Caucasian male and female patients. Differences in the timing of a consultation were not significantly correlated with the presence of an advance directive, the specialty of the attending physician, or the reasons for the consult request. Ethics consultants may have mitigated problems that developed during the lag in request times for African American males by spending more time, on average, on those consultations (316 minutes), especially more time, on average, than on consultations with Caucasian females (195 minutes). Most consultations (40 of 56) did result in movement toward limiting treatment, but no statistically significant differences were found among the groups studied in the movement toward limiting treatment. The average number of days from consult to discharge or death were strongly correlated with the intervals between admission to the hospital and request for an ethics consultation.

Conclusion

Our findings suggest race and gender disparities in the timing of ethics consultations that consultants may have partially mitigated.

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INTRODUCTION

Clinical ethics consultants are called upon in healthcare settings when ethical uncertainty, conflict, or disagreement over the care of patients arise. Consultants are expected to address ethical and communication problems and to help to ensure that the values of patients and healthcare professionals are respected. Some literature suggests that ethics consultation may improve the quality of care by reducing treatment that does not benefit patients.² Ethics consultation may also ensure that treatment options are matched to patients' preferences, influence the timing and manner of death, and perhaps improve the quality of interpersonal aspects of other healthcare services.

In addition to providing these benefits to patients and healthcare professionals, ethics consultants may reduce disparities in a healthcare system that is marred by inequity. The ASBH "Code of Ethics and Professional Responsibilities for Healthcare Ethics Consultants" (hereafter, the ASBH "Code of Ethics") recommends that consultants "reduce disparities, discrimination, and inequities when providing consultations."³ While there is a massive literature on disparities in healthcare, the literature on the role of disparities and inequities in healthcare ethics consultation is scant. A 2014 literature review concluded that no empirical studies specifically addressed whether race/ethnicity is considered or documented in ethics consultations, and that no studies analyzed whether the same underlying factors that contribute to other racial/ethnic healthcare disparities influence ethics consultation.⁴ One study, however, did find that race was not a significant factor in access to ethics consultation at a trauma center.⁵ Another, more recent study found that race was not a significant factor in ethics committees' approval of unilateral do-not-resuscitate (DNR) orders.⁶ A third study, too small to draw definitive conclusions, did not find that race made a difference in dissatisfaction with ethics consultation.⁷ Responding to the thinness of the literature on ethics consultation and race, Silberman and colleagues called for "greatly expanded consideration of bias in the medical ethics literature, including rigorous studies to detect bias."⁸ Even more problematically, although there is a significant literature on gender disparities in healthcare,⁹ we are aware of no empirical study that focused on gender disparities and ethics consultation.

If ethics consultants are to "reduce disparities, discrimination, and inequities when providing consultations," as recommended by the ASBH "Code

of Ethics," then the factors that affect access to ethics consultation must be carefully examined. Access to ethics consultation is directly affected by several factors, including who can make a request,¹⁰ when requests for consultations are made, whether consultations can occur without a request (for example, as part of a hospital or research protocol),¹¹ whether physicians are permitted to block access or retaliate against requestors when a request is made,¹² and when ethics consultants are available.¹³

Our focus is on the second of these access factors: when requests for consultations are made. This factor is not well examined in the literature. Johnson and colleagues reported that consultations were made, on average, 25 days after admission, and that requests for "end-of-life" consultations occurred later after admission than requests for "shared decision-making" consultations, but the authors reported no racial difference in the timing of ethics consultation and did not examine gender.¹⁴ Nilson and colleagues reported a 10-day median interval from hospital admission to ethics consultation and did not examine race or gender.¹⁵ Gorka and colleagues' longitudinal study reported a reduction in the average interval from admission to request for consult, from 22 to seven days, and did not examine race or gender.¹⁶ No studies of which we are aware attempt to determine an optimal time for a consult, but one study reported that ethics consultations that were offered in the absence of ethical conflict, or without an underlying sense of ethical disquiet among participants, do not seem to be effective.¹⁷

The purpose of this retrospective case survey was to determine if there were racial or gender differences in the timing of requests for ethics consultation related to limiting treatment, and, if there were, to identify the factors associated with those differences, and the role, if any, of ethics consultants in mitigating them.

METHODS

Memorial Medical Center is a 500-bed tertiary care academic medical center with a Clinical Ethics Center that performs 400-500 ethics consultations annually. At Memorial Medical Center, ethics consultations are performed upon request. Consultations may be requested by healthcare professionals and trainees, patients, families, and others; a physician's consent is not required for a consult. Ethics consultations are available 24 hours a day, seven days a week. Three full-time ethics consultants were employed by the hospital at all times during the study period.

The Clinical Ethics Center receives requests, responds to them with consultation, and maintains a database that tracks its work. Data for this study were obtained retrospectively from the center's database, from consultation summaries written by the ethics consultants for the purpose of review by the hospital ethics committee, and from hospital data.

An exploratory quantitative study was conducted to evaluate the salience of race to requests for ethics consultation. The exploratory study analyzed data on 754 ethics consultations performed from 2011 through 2014 whose reason for request had been identified, at the time of the request, as one of several related to limiting treatment.¹⁸ The racial difference in the mean intervals between hospital admission and the date of a request for ethics consultation on Caucasian versus African American patients was 4.1 days (8.1 days for Caucasians and 12.2 days for African Americans). The two-tailed *P*-value was 0.0080, which indicates that it is unlikely the difference in mean intervals was caused by random chance. No statistically significant differences were found when comparing the mean admission-to-request interval for any other groups of patients identified by race or ethnicity (Hispanic, Asian, Pacific Islander, other), or by status of the payer (Medicaid, self-pay, commercial insurance).

After examining the results of the exploratory study, a mixed methods study on a smaller sample of these consultations was designed for in-depth investigation. The sample included 14 ethics consultations related to limiting treatment from 2011 to 2014 on African American male Medicare patients for whom data were complete, and 14 limiting treatment ethics consultations from 2011 to 2014 on age-matched Medicare patients from each of the following groups: Caucasian males, Caucasian females, and African American females (see table 1). Quantitative analysis and qualitative textual analysis were performed on the 56 matched consultation summaries and on additional data available in the Clinical Ethic Center's database and Memorial Medical Centers' database.¹⁹ Two investigators who performed none of the ethics consultations served as coders of the qualitative data. When required for further statistical analysis, tie breaking was performed by additional investigators, none of whom had performed any of the ethics consultations being studied.

RESULTS

Pre-Consultation

We examined several factors that occurred prior to the ethics consultants' direct involvement in the

cases: the admission-to-request interval, the specialization of the attending physician, the reason for consult request, and whether an advance directive was on file at the beginning of the consultation. Several additional factors that occur prior to a consultant's involvement, and which a consultant's summary may describe, were also investigated: whether the patient had expressed any treatment preferences prior to the consultation, and whether, prior to the request but during this hospital admission, a physician had had a conversation with the patient about limiting treatment, goals of treatment, or end-of-life issues. We report below our quantitative results, as well as qualitative results when moderate or better interrater reliability was achieved.

Admission-to-request intervals, measured in days. The average number of days ("interval") from hospital admission to request for ethics consult for the four groups was significantly different at the $p < 0.05$ level. Statistical significance was measured using ANOVA, and the *P* value calculated was 0.038. The shortest average interval from admission to consult request was for African American females (5.93 days); the longest was for African American males (18.64 days). Using a one-tailed hypothesis *t*-test, the difference in average intervals for African American females and African American males was statistically significant at $p < .05$, with a *p* <value of .024. The difference between the average for all females and all males was statistically significant at the $p < 0.05$ level (the *p* < value was .0033). Other observed differences between groups were not statistically significant at the $p < 0.05$ level (see table 2). This suggests that the observed differences in the average admission-to-request intervals for all women and all men in the 56 cases were not due merely to chance, and that the observed differences between African American women and African American men in the study were also not due merely to chance.

TABLE 1. Demographics

Patients' demographics	Number of consults	Mean age*	Standard deviation
African American males	14	70.86	9.93
African American females	14	70.93	9.93
All African Americans	28	70.89	9.93
Caucasian males	14	70.93	9.85
Caucasian females	14	70.86	9.96
All Caucasians	28	70.89	9.90

*Ages greater than 90 were reduced to 90 to protect patients' identity.

Requestor and the specialty of the attending. Most consultations were requested by nurses (24); physicians were the next most frequent requestors (16). Consultations with African American patients were, however, more frequently requested by physicians (11) than by nurses (10); this difference was not statistically significant.

Patients for whom a consult was requested were attended by 15 types of specialists.²⁰ Requests for ethics consultation were most frequently made for patients who were attended by hospitalists (14), pulmonologists (10), internal medicine specialists (10), critical care specialists (five), and family medicine physicians (three). (Critical care specialists were available in the hospital only in 2013 and 2014; prior to this time pulmonologists were the critical care specialists.) A *chi*-square “goodness-of-fit” test was done to determine whether the distribution of specialists was different from an equal distribution to a statistically significant degree. There were no statistically significant differences among the groups for distribution of the three highest attending specialists. This means that we did not see statistically significant trends regarding which specialties did or did not request ethics consultation.

The reasons for consult requests. There were 28 reasons for ethics consultation requests identified as potentially related to limiting treatment. Most consult requests included only one reason, but some included as many as three reasons. The top four stated reasons for consult requests were goals of care (17 consults), code status (13 consults), competency (six consults), and disagreement regarding treatment (five consults). All other reasons were listed for fewer than five consults. The two reasons with the highest frequency—goals of care and code status—were

analyzed using a *chi*-square test, and no significant differences were detected among the groups. That is, race and gender did not seem to determine which of the 56 consult requests were made for these reasons. Because the number of occurrences for any other reason was small, no other statistical tests were attempted on the reasons for the consult request.

Advance directives. For purposes of the study, advance directives included durable powers of attorney for healthcare, living wills, Department of Public Health DNR orders, physician orders for life sustaining treatment (POLST), and mental health treatment declarations. More advance directives were on file for Caucasian males (nine) and Caucasian females (nine) than for African American females (seven) or African American males (five), but the differences among those groups were not statistically significant. A lower percentage of African Americans who died in the hospital had durable powers of attorney for healthcare, but the differences among the groups in this study were not statistically significant. The average admission-to-request interval was not significantly correlated with the average percentage of advance directives on file for the four groups. Therefore this study did not detect evidence of a statistically significant relationship between having an advance directive and the number of days before the first consult after admission.

Physicians’ discussions of limiting treatment and patients’ preferences expressed during this admission. Raters achieved perfect agreement for the question “Did the summary indicate that, during this hospital admission, any physician had spoken with the patient or family or other surrogate about goals of care, possibly limiting care, end-of-life-care, etc., before ethics was involved?” with a Cohen’s *kappa*

TABLE 2. Pre-consult data

Patients’ demographics	Hospital admission to consult request interval in days [†]	Number of advance directives on file	Number of consults with prior limiting care conversation with MD this admission
African American males	18.64*	5	0
Caucasian males	13.50	9	3
Caucasian females	7.21	9	4
African American females	5.93*	7	2
All males	16.07**	14	3
All females	6.57**	16	6

* Denotes statistically significant difference at .05 level.

** Denotes statistically significant difference at .05 level.

† Denotes correlation with length of stay from consult to discharge or death.

of .931. In most ethics consultation summaries (47 of 56), no prior conversation with patients, family, or surrogates was noted. Using a *chi-square* “goodness-of-fit” test of $P < .05$, no statistically significant differences of race or gender were found. We note, however, that no indication of a discussion of this kind was found in summaries of any of the consultations with African American males; each of the other three groups of summaries noted several such discussions (see table 2).

In just under half of consults (27 of 56), the summary “note[d] that the patient has expressed . . . care preferences . . . prior to ethics consult during the hospital stay.” Raters achieved substantial agreement with a Cohen’s *kappa* of .712 for this question. Using a *chi-square* “goodness-of-fit” test of $P < .05$, no statistically significant differences for race or gender were found concerning who did and did not express preferences about care prior to the consult.

ETHICS CONSULTATIONS

To assess whether ethics consultations may have either mitigated or exacerbated the gender and race differences evident in the timing of requests, we examined the following features for each ethics consultation: how much time the consultant spent on the consultation, whether the consultant interacted more than once with the patient and/or family members or surrogates, and whether the consult summary reflected any movement toward limiting treatment during or after the ethicist’s involvement.

Consultants’ Time

The average number of minutes that ethics consultants spent on consults for African American males (316 minutes) was greater than for Caucasian males (284 minutes), African American females (268 minutes), and Caucasian females (195 minutes). Although there were no statistically significant differences among groups at the $p < .05$ level, there was nearly a statistically significant difference detected between the mean minutes for African American males and the mean minutes for Caucasian females, with $p = 0.050115$. The average for African American males scored 4 on a scale of 1 to 5 in Bruce’s time intensity scale for ethics consultation, while averages for other groups scored 3.²¹ (See table 3).

The Number of Consultants’ Interactions with Patient, Family, or Surrogate

Raters achieved substantial agreement for the question “Does the summary indicate that the ethicist interacted with the patient and/or family mem-

bers or surrogates more than one time?” with a Cohen’s *kappa* of 0.701. In 24 of 56 summaries, consultants said they interacted with these stakeholders more than once. Using a *chi-square* “goodness-of-fit” test at $p < .05$, no statistically significant differences for race or gender were found (see table 3). This does not mean that the groups had exactly the same percentage of consults reporting multiple family or surrogate visits. Although not statistically significant, a higher percentage of African American males than other groups had a surrogate decision maker who was a niece, nephew, grandchild, family guardian, or state appointed guardian, rather than a spouse or adult child. Because these more distant surrogates may have less information about a patient’s values than close family members do, consultation with them may have required more of the consultant’s time.

Limiting Treatment at the End of a Consult

In the majority of consult summaries (40 of 56), movement toward limiting treatment during or after an ethicist’s involvement was noted. Agreement between raters about movement toward limiting treatment was substantial, with a Cohen’s *kappa* of .616. Using a *chi-square* “goodness-of-fit” test at $p < .05$, no statistically significant differences among race or gender groups were found (see table 3). Of those patients who died in the hospital or were discharged to hospice following an ethics consult, a lower percentage of African Americans, particularly African American males, had DNR orders, but the difference was not statistically significant.

POST-CONSULTATION

We also examined several post-consultation issues: concerns about readmission reflected in the

TABLE 3. Consult data

Patients’ demographics	Consultant minutes	Number consults with patient/family interactions	Number consults with movement toward limiting care
African American males	316*	6	12
Caucasian males	284	6	10
Caucasian females	195**	5	9
African American females	268	7	9

* Denotes statistically significant difference at .10 level, $p = .50115$.

consult summary, days from consult to hospital discharge or death, the number of deaths that occurred in the hospital, and discharges to hospice.

Concern about Readmission

For the question, “Does the summary reflect any concern about/interest in discharge planning or ‘re-bounding’?” (that is, readmission shortly after being released), raters achieved moderate agreement with a Cohen’s *kappa* of .595. Using a *chi-square* “goodness-of-fit” test at $p < .05$, no statistically significant differences for race or gender were found in how many consults in each group included these concerns.

Days from Consult to Discharge or Death

The average number of days for each group from admission to consult request were paired with the average days from consult to discharge or death. These pairs showed a strong linear relationship, using Pearson’s linear correlation measure, $R = .718$. This means that if a patient had a relatively long interval between admission and a request for a consult, the patient was likely to have a relatively long interval between the consult and either discharge or death. Using a two-tailed value of P , the association between the two variables was statistically significant at the $p < 0.05$ level, $p = 0.01352$ (see table 2, column 1, and table 4, column 1). The difference in average days from consultation to discharge or death for African American males (18.21) and African American females (8.07) was statistically significant at $p < .10$, $p = .066518$ (see table 4).

Death in the Hospital, Discharge to Hospice, and DNR in Pre-Morbid Patients

Of the 56 patients with whom ethics consultations were conducted, 23 died in the hospital. Using a *chi-square* “goodness-of-fit” test, there was no statistical difference for the gender and race between

this distribution of death and an equal distribution of death (see table 4). Also, no differences among groups in the number of discharges to hospice were statistically significant. Among the subset of patients who either died in the hospital or who were discharged to a hospice, a higher percentage of Caucasian patients than African American patients had DNR orders, but the difference was not statistically significant (see table 4).

DISCUSSION

It is likely that some ethics consults in the 56 cases that were studied occurred too early and some too late to provide optimal care to patients. When the male/female difference in average days from admission to consult request was highly significant ($p = .0033$) and not explained by other factors, as was the case in our study, there is cause for concern that the difference represents a gender disparity that should be addressed by clinical ethicists.²² Because the gender difference for African American patients in our study was both significant ($p = .024$) and especially large (> 12 days), research and interventions should particularly focus on the interaction between race and gender in consult requests.

Future investigators could help determine which uncertainties, biases, and/or stereotypical thinking among requestors contribute to gender and race disparities in the timing of requests for consultation,²³ and to help design interventions that address disparities and yet are sensitive to requestors’ perceived need for help when a request is made (not earlier or later). Among the possibilities that should be explored are these: (1) that requests for “limiting care” consults for African American women may be occurring too early, and (2) that requests for consults for African American men may be occurring too late to provide optimal care. If requestors believe that females—especially African American females—are

TABLE 4. Post-consult data

Patients’ demographics	Length of stay from consult to discharge or death†	Number out of 14 discharged to hospice or death in hospital	Number discharged to hospice or death in hospital with DNR
African American males	18.21*	10	6
Caucasian males	12.57	6	6
Caucasian females	11.00	8	8
African American females	8.07*	6	3

* Denotes significance at $p < .10$.

† Denotes correlation with admission-to-request interval.

less rational than males, that belief may translate into premature requests for consults whose stated or implicit reasons include ascertaining female patients' capacity for healthcare decision making. If the stereotype that females are or should be more self-sacrificing, or prefer dying more "naturally" than others is operative among requestors, it may result in the expectation that females—especially African American females—will be more open to limiting treatment earlier in the course of a hospitalization than males.²⁴ Either perception related to gender could contribute to a shorter admission-to-request interval for females than for males and to potentially premature requests for consultations about limiting treatment.

Later-than-optimal consult requests are at least as problematic as earlier-than-optimal requests; a late ethics consultation cannot ensure that a patient or proxy decision maker can participate in shared decision making and have his or her preferences taken seriously.²⁵ When requests are made later for African American males than for others, investigators should determine which uncertainties, biases, and stereotypical thinking about African American males are operative among requestors, so that clinical ethicists and educators can address them. Late requests may be related to health professionals' reluctance to fully engage with African American males about their treatment preferences. This possibility is prompted by our findings that nurses, as a group, requested a lower percentage of consults for African Americans than for Caucasians, and that physicians' conversations with African American males or their family or surrogate prior to ethics consultation may not occur. Reluctance to fully engage with African American males would be consistent with other studies that suggest that African American patients receive lower quality interpersonal care than others in healthcare settings.²⁶ Further, if it can be determined that delays in requests for ethics consultation for African American males are the result of stereotypical thinking about the preferences of specific racial groups (for example, that African American males prefer aggressive treatment such as cardiopulmonary resuscitation or prefer not to discuss treatment preferences), the difference would clearly represent a disparity that should be investigated and addressed.

Ethics consultations have the potential to mitigate disparities, to exacerbate disparities, or to have no discernible effect on them. We found that ethics consultants spent the most time, on average, on consultations involving African American males (316 minutes). This amount of time could mitigate prob-

lems that may have developed during, or been exacerbated by, the significant lag in consultation requests for African American males. Because African American males in our study tended to be dependent on surrogates who were more socially distant from them (and likely less intimately knowledgeable about their values and treatment preferences), ethicists' time may have been spent ensuring that the surrogates were functioning well as surrogates (that is, mitigating disparities in family-social networks). Our study did not suggest that ethicists spent significantly more or less time on consults with African American females (268 minutes), who fell at the other extreme of average admission-to-consult intervals, but who had surrogates who were, on average, more closely related to them.

Because we did not find that ethics consultations more frequently resulted in movement toward limiting treatment for one group than for another, it is possible that the consultations mitigated the disparate admission-to-request intervals. That is, although requests for consults about limiting treatment were made earlier for females (especially African American females) than for males (especially African American males), consults with females did not more frequently or less frequently result in movement toward limiting treatment than consults with males.

Consultants did not mitigate all disparities. The significant difference in post-consult lengths of stay between African American males and African American females is worth further investigation and may be related to weak family/social supports for African American males. The difference in rates of DNR orders between dying African Americans and dying Caucasians, as well as the correlation between disparate admission-to-request intervals and disparate post-consultation lengths of stay, are also worth further investigation.

CONCLUSION

Our findings suggest that there are race and gender disparities in the timing of ethics consultations. A research and intervention agenda is necessary for ethics consultants to understand race/gender interactions in the organizations where they practice and to design informed interventions to "reduce disparities, discrimination, and inequities when providing consultations," as recommended by the ASBH "Code of Ethics." Ethicists have opportunities to mitigate or exacerbate disparities during consultations, and should conduct research on best practices for mitigation.

LIMITATIONS OF THE STUDY

Ethics consultation reports are somewhat subjective summaries of consultation contexts, issues, interventions, recommendations (sometimes), and follow up as reported by ethics consultants. The reports are limited in length. Lengthier, more comprehensive narratives of consultations might provide details that would suggest other interpretations of some results.

Some database entries were incomplete and were eliminated from the exploratory study. The database entries for all of the 56 cases in the more detailed study were sufficiently complete for analysis.

IRB

This project was reviewed by the Springfield Committee for Research Involving Human Subjects.

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NOTES

1. ASBH, "Code of Ethics and Professional Responsibilities for Healthcare Ethics Consultants," 2014, [asbh.org/uploads/publications/ASBH%20Code%20of%20Ethics.pdf](https://www.asbh.org/uploads/publications/ASBH%20Code%20of%20Ethics.pdf).

2. W.S. Andereck, "Seeking to Reduce Non-beneficial Treatment in the ICU: An Exploratory Trial of Proactive Ethics Intervention," *Critical Care Medicine* 42, no. 4 (2014): 1-7.

3. Ibid.

4. R.S.M. Angove, E.M. Ngui, and M. Repenshek, "Inclusion and Use of Race and Ethnicity in Ethics Consultation Research," Catholic Health Association of the United States, 2014, <https://www.chausa.org/docs/default-source/hceusa/race-and-ethnicity-in-ethics-consultation-research.pdf?sfvrsn=2>. Danis, Wilson, and White urged bioethicists, including clinical ethicists, to address racism in M. Danis, Y. Wilson, and A. White, "Bioethicists can and should contribute to addressing racism," *American Journal of Bioethics* 16, no. 4 (2016): 3-12.

5. L. Johnson, J. Lesandrini, and G. Rozycki, "Use of the Medical Ethics Consultation Service in a Busy Level I Trauma Center: Impact on Decision-Making and Patient Care," *American Surgeon* 78, no. 7 (2012): 735-40.

6. A. Courtwright, "Experience with a Hospital Policy on Not Offering Cardiopulmonary Resuscitation When Believed More Harmful than Beneficial," *Journal of Critical Care* 30, no. 1 (2015): 173-7.

7. L. Schneiderman, "Dissatisfaction with Ethics Consultations: The Anna Karenina Principle," *Cambridge Quarterly of Healthcare Ethics* 15, no. 1 (2006): 101-6.

8. J. Silberman, W. Morrison, and C. Feudtner, "Pride and Prejudice: How Might Ethics Consultation Services Minimize Bias?" *American Journal of Bioethics* 7, no. 2 (2007): 32-4.

9. R. Bugiardini, "Gender Bias in Acute Coronary Syndromes," *Current Vascular Pharmacology* 8, no. 2 (2010): 276-84; D.E. Hoffmann and A.J. Tarzian, "The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain," *Journal of Law, Medicine & Ethics* 29, no. 1 (2001): 13-27; A. Abufel, Y. Gidron, and Y. Henkin, "Physicians' Attitudes Toward Preventive Therapy for Coronary Artery Disease: Is There a Gender Bias?" *Clinical Cardiology* 28, no. 8 (2005): 389-93.

10. G. McGee, "A National Study of Ethics Committees," *American Journal of Bioethics* 1, no. 4 (2001): 60-4.

11. Several studies have focused on "proactive" ethics consultations, i.e., those undertaken so that researchers could investigate the effectiveness of a consultation at a particular point in the patient's stay in the hospital or stay in the intensive care unit, rather than wait to see if and when participants would make a request.

12. E.J. Gordon and A.B. Hamric, "The Courage to Stand Up: The Cultural Politics of Nurses' Access to Ethics Consultation," *The Journal of Clinical Ethics* 17, no. 3 (Fall 2006): 231-54; M. Danis, "Does Fear of Retaliation Deter Requests for Ethics Consultation?" *Medicine, Health Care and Philosophy* 11, no. 1 (2008): 27-34.

13. In some organizations, ethics consultants are not easily accessed; ethics consultants may be part-time or authorized to do only retrospective case reviews. We are unaware of any organization that makes the cost of ethics consultations a barrier for patients by billing for them.

14. E.G. Nilson, "Clinical Ethics and the Quality Initiative: A Pilot Study for the Empirical Evaluation of Ethics Case Consultation," *American Journal of Medical Quality* 23, no. 5 (2008): 356-64.

15. L.S. Johnson, J. Lesandrini, and G.S. Rozycki, "Use of the Medical Ethics Consultation Service in a Busy Level I Trauma Center: Impact on Decision-Making and Patient Care," *American Surgeon* 78, no. 7 (2012): 735-40.

16. C. Gorka, "Growing an Ethics Consultation Service," forthcoming in *American Journal of Bioethics Empirical Ethics*.

17. W.S. Andereck, "Seeking to Reduce Nonbeneficial Treatment in the ICU: An Exploratory Trial of Proactive Ethics Intervention," *Critical Care Medicine* 42, no. 4 (2014): 824-30, 828.

18. The following reasons for requests were included in reasons related to limiting treatment: goals of care, competency, code status, durable power of attorney for healthcare, Illinois Department of Public Health do-not-resuscitate order, physician orders for life-sustaining treatment (POLST), treatment refusal, treatment decision making, treatment disagreement, treatment withholding or withdrawing, discharge plans, counsel family, artificial nutrition and hydration, hospice, counsel patient/family, futility, and inappropriate treatment. A narrower definition

was considered for the in-depth study (“consults in which a key question was the appropriateness of interventions or care settings that may under some circumstances, extend life or delay death”). The broader definition proved more appropriate because it facilitated age matches close enough to eliminate male/female age differences as a reason for differences in timing of requests, and because more than 70 percent of the consults it captured ultimately resulted in movement toward limiting treatment.

19. Coders who were trained on a sample of consultation summaries that were selected randomly from ethics consults conducted during years not included in the study. After the initial draft codebook was developed, coding rounds were completed on multiple random samples of consultation summaries as the codebook was modified. Questions included: Does the summary reflect any concern about/interest in discharge planning or “rebounding”? Does the summary note that the patient has expressed any care preferences at any point prior to ethics consult during the hospital stay? Did the summary indicate that, during this hospital admission, any physician had spoken with the patient or family or other surrogate about goals of care, possibly limiting care, end-of-life care, etc., before ethics was involved? Does the summary indicate that religion influenced the patient or family or surrogate to limit or reduce the aggressiveness of treatment? Does the summary indicate that the ethicist interacted with the patient and/or family members or surrogates more than one time? Does the summary reflect any movement toward limiting any treatment during or after ethicist’s involvement?

20. Specialty areas included cardiology, critical care, colon-rectal surgery, family medicine, general surgery, hematology, hospitalist, internal medicine neurology, oncology, plastic surgery, psychiatry, pulmonology, and trauma surgery.

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