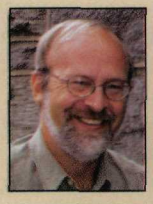
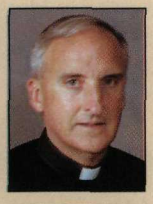
Ethics Committees in Catholic Hospitals

A NEW STUDY ASSESSES THEIR ROLE, IMPACT, AND FUTURE IN CHA-MEMBER HOSPITALS





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As recently as the early 1980s, hospital ethics committees (HECs) were a relatively rare phenomenon; national surveys estimated that such groups were present in fewer than 1 percent of U.S. hospitals.[1] Ethical considerations in hospitals were then largely a private affair between doctor and patient, taking place behind closed doors. "Ethics discussions" were limited to ethics in research. The bioethics movement, which arguably had its roots in kidney-dialysis selection committees in the 1960s and in abortion review committees in the 1970s, began to grow rapidly during the 1980s in response to such cases as those involving Karen Quinlan, Nancy Cruzan, and Baby Doe, as well as to the 1983 report of the President's Commission for the Study of Ethical Problems in Medicine, and the 1990 Patient Self-Determination Act.[2] As a result, the number of hospitals with HECs jumped, in less than a decade, to more than 60 percent.[3] Nowadays, every health care institution has at least one, and often several, ethics committees, largely the result of the Joint Commission on the Accreditation of Healthcare Organizations's (JCAHO's) 1992 mandate.

Throughout its 25-year history, the ethics committee movement has been a topic of controversy. On one hand, proponents have seen such committees as a promising means of enhancing ethical decision making, improving the quality of patient care, and protecting patients' rights. On the other hand, critics have argued that such committees threaten to bureaucratize medical practice, that they constitute an obstacle to the physician-patient relationship, and that they are little more

than a shield to protect hospitals from litigation.[4] Until recently, no one had conducted a careful empirical evaluation of HECs and their effectiveness. Thus the question has remained: Do HECs "work"?

The HEC Phenomenon

Over the past 20 years, a number of writers have studied the HEC phenomenon.[5] Most of these studies have focused upon the HEC's structure, scope, and functions and have been primarily descriptive in nature. Findings have generally converged upon several points of agreement:

- Most U.S. hospitals now have HECs.
- Physicians and nurses dominate HECs' composition.
- HECs spent most of their time concentrating on a combination of case consultation, education, and policy formation and evaluation.
- Important aspects of HEC consultation services are similar across many institutions.
- Differences in scope of HECs among consultation services are associated with differences in committee power, committee focus, and institutional goals.
- Some HECs are involved in financial matters.
- All HECs in these studies spent at least some time formulating or evaluating hospital policies; most spent substantial amounts of their time on this activity.

Several studies focusing upon HECs in member hospitals of the Catholic Health Association (CHA) have yielded similar findings. For example, a 1993 article in this journal by Sr. Joanne Lappetito, RSM, and Paula Thompson provided a detailed profile of the structure and function of HECs (including a history of HECs in Catholic hospitals before and after the President's Commission Report); their size and composition, the frequency of their meetings, and the nature of their governance; and issues addressed in case consultations.[6] It is not completely clear from those authors' description of their methodology who responded to their questionnaire (inquiring whether respondents were committee chairs, whether multiple responses were received from the same HEC, etc.)

Factors for Success

In response to the JCAHO mandate, several writers began calling for more accountability and ongoing assessment in HECs.[7] In 2000, a writer issued a similar challenge to Catholic hospitals, urging their HECs to "engage in a more vigorous evaluation of their work and the contributions they make within their health care organizations."[8] Some hospitals have responded to these calls; many have not. A 1993 study, examining factors that contributed to self-evaluation by HECs, was successful in identifying which types of HECs were more likely to self-evaluate than others.[9] Unfortunately, although that study provided valuable information concerning the likelihood of HEC self-evaluation, it provided none about the self-evaluations' outcomes.

In another study, the researchers conducted a focus group interview of members and leaders of HECs in southwestern Ohio, northern Kentucky, and southeastern Indiana.[10] The results indicated four primary factors critical to the success of hospital ethics committees: support from administration; committee composition; committee leadership; and committee structure, function, and process.

SUMMARY

The role, effectiveness, and even existence of hospital ethics committees (HECs) are not universally agreed upon. Over the past 20 years, the study of HECs has focused mainly on their structure, scope, and function, making the results more descriptive than anything.

In an effort to present study results that could help HECs better serve the needs of their organizations, the authors of this article recently set out to survey HEC chairs at CHA-member hospitals, asking questions about four key areas: 1) primary functions of an HEC, 2) selection criteria of HEC members, 3) strategies for success, and 4) the importance of HEC member training. The results of this survey provide some important food for thought.

A Survey of CHA Members

For our own study, we surveyed HEC chairs at CHA-member hospitals about their perceptions and attitudes concerning HECs. Given the chairs' perspectives, we tried to determine:

- What an HEC's primary functions are and should be
- Who should serve on an HEC and how they should be selected
- What strategies contribute to HEC efforts? What obstacles hinder those efforts?
- Whether HECs should require their members to receive training

Of the chairs invited, 113 responded to at least some items; 98 responded to all of them.

The survey questions were developed by means of a series of semi-structured interviews with eight Philadelphia-area health care professionals who were either chairs or senior members of HECs. Two graduate assistants conducted and transcribed the interviews. A survey consisting of 37 items was generated from interviewee responses and from items appearing in previous HEC surveys. Chairs of 261 CHA-member HECs were invited to participate via e-mail; they were provided with a password and directed to a website where an electronic version of the survey could be completed online. Of the 261 chairs invited, 113 responded to at least some of the items; 98 responded to all of them. We must warn readers that our response rate was low and that some of those who did respond had difficulty navigating the survey, so some data was lost. Even so, the results provide food for thought.

The hospitals represented in our survey were 98 percent not-for-profit and 99 percent Catholic. Forty percent were in urban areas, 28 percent in suburban areas, and 32 percent in rural areas. For survey purposes, they were categorized as large (300 or more beds), medium (200 to 299 beds), and small (fewer than 200 beds). (See **Table 1**.)

Table 1

CHA Member Hospitals in Survey

Size	Number	Percentage of Those Surveyed
Less than 200	44	39
200-299	36	32
300-399	18	16
400-499	7	6
Over 500	7	6

The sizes of the HECs represented varied widely, ranging from eight members to 50 members. Only 10 percent had 25 or more members, whereas nearly 60 percent had memberships ranging from 12 to 20. As would be expected, larger hospitals tended to have larger HECs; thus large facilities had a mean 21.88 HEC members, medium facilities had a mean 18.51 members, and small facilities had a mean 14.89 members.

Women constituted more than half the membership of 82 percent of the HECS represented. They constituted more than two-thirds of the membership of 30 percent of HECs. On only 6 percent of the committees did women make up less than a third of the membership. With regard to race, 49 percent of respondents indicated that their HECs were all white; 75 percent said that at least 90 percent of their HEC members were white. Thirty-two HECs (32 percent) reported having at least one Asian committee member, 27 (17 percent) reported having at least one African-American member, 22 (14 percent) reported having at least one Hispanic member; and 9 (6 percent) reported having at least one member from an unidentified minority group.

Physicians and nurses constituted approximately half of each HEC's membership. These percentages did not vary significantly among the different hospital and HEC sizes.

HEC Functioning

Nearly half (45 percent) of CHA-member HECs reported meeting on a monthly basis; 31 percent meet every other month, 23 percent meet quarterly, and 2 percent meet semiannually. The vast majority of them (89 percent) said they meet for either an hour (44 percent) or an hour and a half (45 percent) for each session.

Respondents were asked to indicate the approximate percentage of meeting time spent on each of the three principal functions of ethics committees as identified in the literature: policy formation and review, staff and public education, and case consultation.

Although it seems, at first blush, that the HECs devote, on average, about one-third of their time and energy to each of the three functions, a closer examination reveals a good deal of variability, with half of all HECs falling either above the highest or below the lowest value. For example, although the actual mean percentage of time spent on case consultation was approximately 31 percent, nearly 25 percent of the HEC chairs reported devoting 10 percent or less of their committees' time to case consultation.

Table 2

Chairs' Satisfaction with Ethics Committee Functions

Function	More Time Needed	About Right*	Less Time Needed
Policy formation and review	15%	58%	27%
Education of staff and public	40%	45%	15%
Case consultation	22%	53%	25%

*Includes the respondents who said they would like to have either a 5 percent increase or a 5 percent reduction in the time spent on HEC duties.

Table 2 shows HEC chairs' satisfaction with their committees' functions. Of the three functions, case consultation seems to be the most balanced; about equal numbers indicate a preference for increasing or reducing the proportion of time spent on it. Interestingly, about the same percentage indicated a need for more time spent in staff and public education (40 percent) as indicated that they were satisfied with the present amount (45 percent).

Although a large majority of respondents reported receiving five or fewer consultations during the preceding year, more than half (57 percent) felt that the number of consults was "just right" or "somewhat higher" than optimal. Surprisingly, HECs at medium-sized hospitals reported more consultations than those at either smaller or larger hospitals.

HEC Visibility

We evaluated HEC visibility by asking respondents to indicate, first, how aware their hospital's staff was of the committee's activities and function and, second, the extent to which the hospital used it as a resource in ethical decision making. Approximately 17 percent of respondents indicated that hospital staff was "very much unaware" and 10 percent indicated that it was "very much aware"; the remaining 73 percent described their staffs as between "somewhat unaware" and "somewhat aware." When asked to compare present levels of staff awareness to those of three years ago, 36 percent of respondents said that levels had stayed about the same or dropped; 49 percent said they had improved somewhat.

Eighty-one percent of HEC chairs said their committees were underutilized, either somewhat (66 percent) or very much so (15 percent). Although very few (6 percent) reported a decrease in utilization, 40 percent indicated no significant change over the past three years; 42 percent indicated that utilization had increased somewhat.

Respondents who reported less than optimal utilization of their HEC were asked to rate the extent to which several different factors contributed to that underutilization (see **Table 3**). Inadequate outreach was seen as responsible, especially outreach to staff; 75 percent of respondents rated this as a moderate or major factor in underutilization (outreach to patients was second, with 68 percent). Misperception of HECs was also seen as contributing to underutilization, especially among medical staffs. Respondents were nearly equally split regarding the impact of resistance to HECs on the part of medical staff. Very few respondents indicated that HECs being a low priority among hospital administrators was a factor in underutilization.

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The principal reason for underutilization seems to be a lack of educational outreach, both to patients and to staff (particularly to medical staff). When we asked HEC chairs about the educational methods they used, nearly half said they distributed brochures about their committees.

Table 3

Factors Contributing to Underutilization of HECs

Factor	None/Minimal	Moderate	Major
Inadequate Educational Outreach			
To staff	25	48	27
To patients	32	44	24
Misperceptions of HEC Function			
By medical staff	39	35	26
By auxiliary staff	54	32	14
By patients	52	33	15
By families	49	30	20
Other Factors			
Resisted by medical staff	46	30	24
Not highly valued by administration	81	16	3

Other methods—making formal presentations at meetings, posting information on bulletin boards, among others—were reported much less frequently. Whether these other methods had not been tried or, rather, had been tried but found to be ineffective and dropped as a consequence, was not clear. What is clear is that no clear strategy for tackling the visibility/utilization challenge has been found.

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Perhaps HECs have been too reactive in their approach to case referral. As a result, numerous ethical issues may have slipped through the cracks or, on the other hand, were allowed to intensify until they were been blown out of proportion and turned into actual conflicts. If the latter is the case, that is unfortunate and unnecessary. In such situations, which usually occur between family members and physicians, it is the patient who ultimately suffers the consequences.

One strategy that could be implemented to enhance visibility and utilization of HECs would be implementation of a "Proactive Bioethics Screening Policy" like that developed by Cedars-Sinai Medical Center, Los Angeles.[11] The policy's major objective is to "transform the process of requesting bioethical consultations from a completely passive process to one in which the bioethics program is actively involved."[12] This is done by creating a process that identifies patients who are "ethically vulnerable" and might accordingly benefit from an ethics consultation. An example would be a patient of advanced age who suffers severe organic dementia and possessing one or more of the following conditions: has spent the past 15 days in an intensive care unit; has been ventilator dependent for more than 10 days; has had multiple readmissions; or has a profound neurological deficit, terminal illness, or recurrent aspiration pneumonia.

Under this policy, a medical staff member believing that his or her patient would benefit from an ethics consultation would so inform the HEC chair by filling out a Proactive Bioethics Screening Data Sheet giving the patient's name, location, diagnosis, and other relevant information. The chair would then evaluate the data and, if agreeing that an ethics consultation was warranted, would attach a note suggesting a consultation to the patient's chart.

To date, this policy has been "modestly successful in increasing the number of consultations leads to an ethical benefit for the patient, family, and health care team."[13] If HECs were to become proactive with ethical consults, they would not only increase their committees' visibility and utilization but also help patients and family members better understand the full nature of the patient's condition.

Another promising strategy involves instituting an interdisciplinary ethics teaching round in hospitals with residency programs. Such programs have helped to raise physicians' awareness that an ethics committee exists and can be of assistance when medical-ethical issues arise. These programs have also helped defuse potential conflicts between patients or surrogates and physicians. Mercy Health System, Philadelphia, has had such a program in place for the past two years, and it has been quite successful in reducing formal ethics consults by dealing with potential ethical dilemmas before they become major problems. This success has gained the respect of physicians and nurses for the HECs involved. It has also encouraged interns and residents to look to HECs for guidance and support.

Training and Credentials

In response to our survey question "Should prerequisites be required for HEC membership?" the overwhelming response was no (86 percent). CHA-member HECs vary greatly in the educational programs they require of members and in the programs they sometimes offer to them. For the most part, training for HECs is an "invitational" affair; there are no specific requirements for participation (although 8 percent do screen applicants). Such openness is not surprising, given that most committee members participate because of personal interest and despite the fact that HEC work is done in addition to existing job responsibilities (i.e., it is something done "in one's spare time").

Respondents were also asked to indicate the number of years they have served on HECs; the number of years they have served as chair (if they have so served); and the training, if any, they received to prepare them to serve as chair. The mean number of years respondents served on ethics committees was slightly less than eight. The mean number of years they served as chair was slightly less than four.

Table 4 (p. 23) shows respondents' answers

to the question about their preparation to chair an HEC. Nearly a third of the chairs who answered all the survey questions (34) indicated either a graduate degree in bioethics or the completion of a certificate program in bioethics.

Our analysis of the responses produced no significant findings concerning a possible correlation between training, on one hand, and, on the other, experience as an HEC member or chair.

Most respondents felt that requiring some form of certification as a prerequisite to HEC membership would be ill-advised. Indeed, they said that requiring certification might cause problems, rather than solve them: It could undermine disciplinary diversity, increase the risk of displacing clinicians and patients as primary moral problem solvers, and add to the bureaucratization of health care (certification would necessitate a test to measure the competencies in question and engaging specialists to manage the process). Certification would, moreover, disenfranchise large numbers of people who might want to serve on an ethics committee but lacked the credentials to do so.

At the same time, although certification for HEC membership might be undesirable or impractical (or both), that membership should be more than merely a matter of invitation or self-selection. The American Academy of Pediatrics has recommended that "when asked to be a member of an IEC [institutional ethics committee], [the invited person] should assess his or her commitment to acquiring and then maintaining a sufficient level of knowledge in bioethics appropriate to the tasks of the IEC."[14] Moreover, "IEC membership requires a commitment to acquire, and then maintain, the knowledge sufficient to address the complex issues faced by an IEC. Each IEC should establish a continuing education program designed to assist IEC members in fulfilling the stated mission of the IEC, especially as new issues emerge."

Given the paucity of ethics consultants among HECs in CHA-member hospitals (only two-thirds of committees include one), as well as the wide range of formal training backgrounds among committee chairs, it would seem fruitful for those facilities to take a more vigorous stance in encouraging HEC members to undergo formal training of some sort. There currently exist a number of online certificate programs—for example, that offered by the Neiswanger Institute for Bioethics and Health Policy at Loyola University Chicago—which could be recommended to HEC members who wish to take such courses. Or CHA-member organizations might adopt a model similar to the one that the National Institutes of Health offer to members of institutional review boards: an online, self-instruction module that provides a certificate electronically on completion of the program. At the very least, HEC chairs should receive some training. Responsibility for seeing that such training is encouraged and adequately resourced may fall to hospital administrations, rather than being left for HECs to handle themselves.

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Two essential skills are required for ethics consultations: ethical assessment skills and process and interpersonal skills. Besides encouraging training for HEC members, hospital administrators should develop a process through which they can evaluate how effectively these two skills have been implemented by individual members and by the committee as a whole. One step toward such assessment might be a flexible but standardized approach to committee procedures. For example, all committees might be evaluated regarding the degree to which they follow CHA criteria in performing case consultations:

- Gather information

Table 4

Training

Background in Medical Ethics	Percentage of Respondents
Graduate degree in medical ethics/bioethics	2
Graduate degree in ethics	8
Related graduate degree	11
Graduate science or medical/clinical degree	14
Certificate program in bioethics	11
Isolated course work/workshops/seminars	21
On-the-job training	3
Appeal to position, experience	16
Undergraduate/college course work	8
Other	6

(Some survey respondents did not answer this question.)

- Carefully identify the issue
- Review core commitments
- Identify alternatives
- Make a decision
- Evaluate the decision.

Other procedures and policies might also be standardized in the HECs of CHA-member organizations.

Credentialing HEC members is probably not immediately feasible or even desirable. But HECs should commit themselves to providing some level of training for all members and to recruit trained ethicists as members. Training might involve initiating monthly meetings in which committee members hear presentations by invited speakers to or, in seminar fashion, discuss articles they have read on some pertinent topic (e.g., tube feeding, extraordinary/ordinary means distinction, use of restraints). Universities are increasingly offering certificate programs in health care ethics, such as that at St. Joseph's University, Philadelphia. CHA-member facilities might encourage HEC participants to enroll in such a program.

HEC Composition

When we compared the composition of current HECs with those reported in 1993, we found little change. Physicians and nurses still constituted at least half of all HEC memberships and women still predominated. Nearly all HECs included a chaplain (or at least a person in pastoral care) and an administrator. Community representation had increased, although only half of responding HECs reported having at least one member from an ethnic or racial minority. A majority of HECs had board members, risk managers, or lawyers as members.

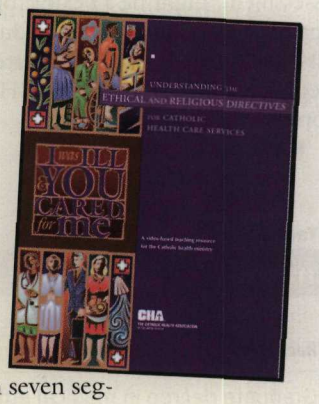
It is particularly interesting that very few HECs reported including psychologists, physical or occupational therapists, or nutritionists as members. It would seem beneficial to include psychologists or psychiatrists, since many of the issues that HECs deal with have to do with patients' competency to make medical decisions. Physical therapists and occupational therapists have also been found beneficial, especially in cases where issues of wound care arise (particularly in elderly patients). Therapists' input would be valuable in decisions regarding pain management, which is a major concern in hospitals today.

A similar argument could be made for including nutritionists on HECs. Since feeding-tube issues now constitute a majority of the ethical dilemmas involving elderly patients, an HEC should have someone aboard with that area of expertise. And including such a person or persons would greatly enhance the interdisciplinary character and decision-making capacity of the committee.

Achieving ethnic and racial diversity on HECs remains a challenge. Including representatives of different racial and ethnic backgrounds would help hospitals identify and eliminate disparities in the care they provide. Diversity on the HEC would also increase other members' sensitivity to the cultural and racial needs of the various populations the hospital serves.

Educational Resource for Ethics Committees

THE EDUCATION of ethics committee members is challenging. Time is limited and finding easy-to-use, accessible resources can be difficult. CHA has developed a tool kit that is perfectly suited for conducting short educational sessions at ethics committee meetings. Titled "Understanding the *Ethical and Religious Directives for Catholic Health Care Services,*" this video-based resource delivers the insights of experts in the ministry, as well as materials for generating rich, educational discussions about the *Directives.*



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The HEC's Future

Survey respondents were generally positive about member commitment, chair leadership, and support from the hospital administration and board of directors. However, they were less satisfied with the resources provided to HECs, members' ethical training, the racial and ethnic diversity of committee composition, and support from the medical staff. These problems—especially the lack of medical staff support—suggest that HECs are "supported in principle" but perhaps generally not taken seriously enough to "move to the next level." On one hand, HEC members are seen as committed; apathy is not a problem. On the other hand, time demands and scheduling conflicts are perceived as obstacles to HEC effectiveness. Training for HEC participation tends to be available but not required.

In short, participation on HECs is generally perceived as a voluntary "add-on," rather than as "important enough" to require serious training and resources.

The good news is that our study has identified several avenues that HECs can travel in their efforts to improve their effectiveness. As the Catholic health ministry begins to discuss "next generations" of HECs, it should, we think, pay particular attention to HEC composition and function issues. In addition, as our study points out, the ministry should also develop and implement strategies to increase the visibility and utilization of HECs. Doing so will necessarily go hand in hand with committing more institutional resources and energy to the education and training of HEC members. Such challenges, though daunting, can certainly be met. Although substantial, the obstacles to success are certainly not insurmountable. ■

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NOTES

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