Ethics Committees

PURSUING ENHANCED EFFECTIVENESS

After their approximately 25 years in existence, it can safely be said of health care ethics committees (HECs) that they have a mixed track record. This is evident from the experience of those who serve on them, as well as from a fairly extensive literature examining their effectiveness.

Some committees have been very successful and have made a difference in patient care and within their organizations. Other committees have succeeded in some areas, but languished in others. Yet other committees have simply languished. And of even those that have been "successful," one must ask whether their success has been case specific or whether they have also effected institutional change. It is one thing to resolve *this* conflict over a do-not-resuscitate (DNR) order; it is another to affect the way DNR orders are sometimes addressed by clinicians in order to minimize or avoid conflicts.

In 1999, Jack Glaser and David Blake from the Center for Healthcare Ethics at St. Joseph Health System, Orange, CA, proposed a new conceptualization of ethics committees, which they called "the next generation health care ethics committee." Their proposal evolved from their observation of the challenges that ethics committees across the country were encountering, especially committees' seeming inability to effect change in practice patterns relating to patient care. In contrast, Glaser and Blake believed that HECs should be agents of organizational change in a proactive rather than a reactive manner.

Six years later, Glaser and Blake's reconceptualization of HECs still has not taken hold, though inroads are being made in some places. Many HECs are still struggling to survive, to function, to be effective, and to make a difference. And most are still focused primarily or solely on clinical cases and issues.

The articles in this special section offer innovative strategies for addressing the effectiveness or the roles and responsibilities of HECs. The article by Francis Bernt, PhD, and his colleagues takes the pulse of ethics committees. It reports on a survey of ethics committee chairs in Catholic hospitals. The results confirm what is known anecdotally and reported in the literature—there is much room for improvement! The authors, while reporting on the results of the survey, also offer suggestions for dealing with "areas of opportunity."

In another article, Fr. John Tuohey, PhD, describes his efforts to enhance the quality of and preparation for doing ethics consultation in the committees in the Portland Service Area of the Providence Health System Oregon Region. Mary Beth Foglia, RN, and Robert Pearlman, MD, describe how HECs, even with their existing structures, can broaden their analysis of cases to address organizational dimensions, thereby integrating clinical and organizational ethics and effecting organizational change.

In a similar vein, Kevin Murphy, PhD, explains how St. Joseph Health System has attempted to integrate ethics with quality improvement, that is, organizational change. However, this endeavor has involved the reconceptualizing and restructuring of the system's ethics committees. Murphy focuses on the successes and challenges of this endeavor, tools that assisted in the transition to the "Next Generation Model," and opportunities for future development and growth. Finally, Brian O'Toole, PhD, describes efforts by the Sisters of Mercy Health System, St. Louis, to integrate ethics into operations in the form of an organizational ethics committee. ■

BY RON HAMEL, PhD
Dr. Hamel is senior director, ethics, Catholic Health Association, St. Louis.