



# TODAY'S ETHICS COMMITTEES FACE VARIED ISSUES

**D**uring the spring of 1993, the Catholic Health Association (CHA) distributed a questionnaire to all its member hospitals to gather information about the roles and structures that ethics committees have assumed within Catholic healthcare. The purpose of the survey was twofold: to assess the status of ethics committees and to provide direction for future education programs offered by CHA.

CHA distributed 600 ethics committee surveys; 329 responses (55 percent) were returned. This large response provided information on how a majority of committees function and raised questions about their future roles.

A large majority (92 percent of the 326 persons who responded to the question) indicated that they have formal ethics committees at their institutions. Nineteen (6 percent) said their healthcare institutions address ethical issues through an informal, ad hoc method of consulting, whereas six (2 percent) said they have no formal or ad hoc means of dealing with ethical issues within their hospitals.

The institutions that reported an ad hoc method of consulting are hospitals whose bed capacity, on average, is under 200; the six hospitals that said they had no formal way of dealing

## *A CHA Survey Reveals Committees' Functions, Authority, and Structure*

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with ethical issues are small rural hospitals averaging less than 80 beds.

### **THE FIRST GENERATION**

Ten years have passed since the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research recommended that hospitals establish institutional ethics committees (*Deciding to*

### **Summary**

In a survey of Catholic Health Association member hospitals, 92 percent indicated they have formal ethics committees at their institutions. Sixty-two percent said their ethics committees were formed between 1983 and 1989.

The survey found that current ethics committees are still committed to their traditional roles—education, policy development, and case review—but the education is directed to more diverse audiences than in the past. Support for medical and nursing staffs may be emerging as another possible function of ethics committees.

The issues that precipitated the formation of institutional ethics committees have become more complex. In particular, questions involving the appropriate use of technology, the renewed awareness of patients' rights, changing relationships among healthcare providers, and conflicting social values have continued to require the intervention of ethics committees. However, the frequency with which respondents said their committees provide case consultations seems lower than it should be if committees were used to their full advantage.

*The institutional ethics committee can play a part in enlarging the current healthcare reform debate and promoting moral values. It can address such important questions as, Should the well-being of individuals take precedence over the well-being of communities?*



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*Forego Life-sustaining Treatment*, U.S. Government Printing Office, Washington, DC). Since the commission published its report in 1983, this date has become an important point of reference for analyzing the effects of established ethics committees within hospitals.

The growth of ethics committees in Catholic hospitals is reflected in **Figure 1**. Of 254 respondents, 62 percent reported that their ethics committees were formed between 1983 and 1989. These dates seem to suggest that the president's commission helped foster the development of ethics committees or legitimized the efforts of mission leaders who were attempting to integrate ethical reflection into the practice of medicine.

Landmark cases, especially those involving Karen Ann Quinlan and Paul Brophy, as well as the inappropriate research studies undertaken with mentally retarded children at Willowbrook State School and with poor African-American men in Tuskegee, AL, underlined the need for ethical reflection on medical practices. These abuses and urgent issues provided the impetus for hospitals to develop what is generally referred to as the first generation of institutional ethics committees.

However, many ethics committees within Catholic hospitals were initiated well before the commission's report. Thirty-six percent of respondents reported that their ethics committees began before 1984, some as early as 1969. The 12 percent of ethics committees founded between 1969 and 1979 may actually have been

**Respondents expressed concern over their inability to provide more extensive physician and community education.**

medical-moral committees, which were established within Catholic hospitals to review the moral appropriateness of specific procedures related to reproductive issues. Many of these committees expanded their responsibilities and evolved into institutional ethics committees.

The fact that the ethics committees at a number of CHA's member hospitals have such a long history suggests they may provide significant insight into what action can facilitate the development of a second generation of institutional ethics committees.

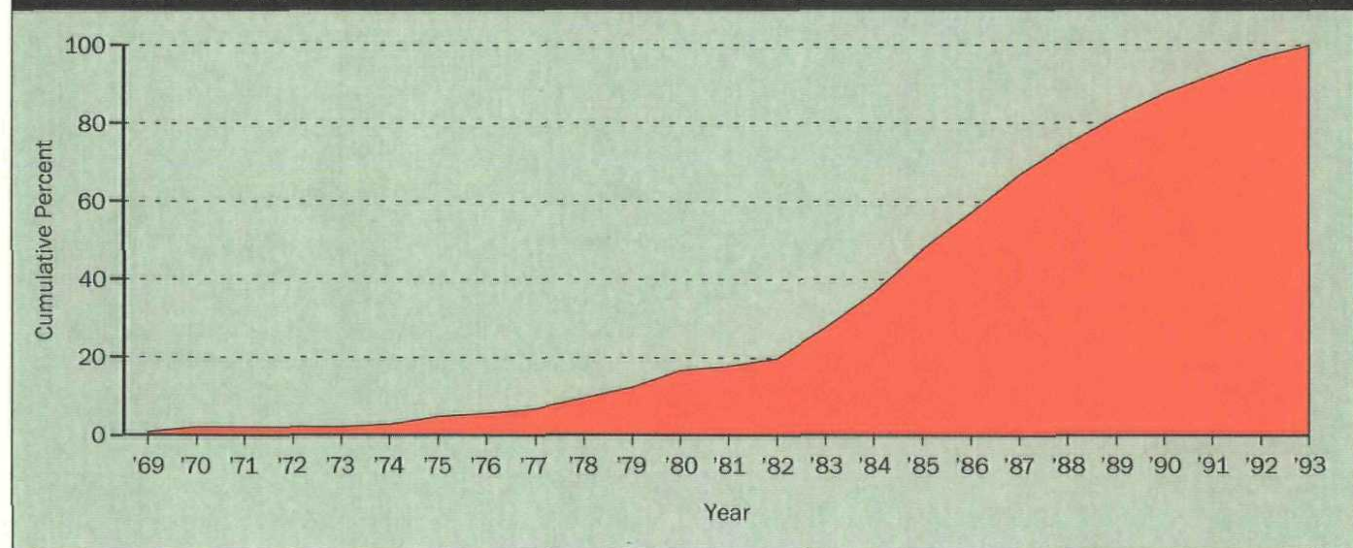
#### COMMITTEE FUNCTIONS

Traditionally the three functions of institutional ethics committees are education, policy development, and case review. The survey found that current committees are still committed to these traditional roles, but the education is directed to more diverse audiences than in the past (see **Figure 2**, p. 36).

Respondents' written comments reflected their concern over their inability to provide more extensive physician and community education. Many respondents noted the difficulties encountered in these areas and requested information about resources and programs developed specifically for these audiences.

Thus support for the medical and nursing staffs may be emerging as another possible function of ethics committees. The staff ethicist or members of the ethics committee often assist a physician or nurse by tactfully asking questions to sort out the

**FIGURE 1: GROWTH IN CATHOLIC HOSPITAL ETHICS COMMITTEES (N = 254)**







clinical data and delineate the values at risk. This does not mean that the ethicist avoids asking the right or hard question. It does mean that an open dialogue is carried out within a professional relationship that is rooted in trust and respect for all the persons engaged in the discussion on the patient's behalf.

### COMMITTEES' AUTHORITY

Because physician and nurse support may be considered a new and emerging role, this function may be understood more clearly in relationship to the committee's authority. In the survey, a question about hospital ethics committees' degree of authority was answered by 315 people. The percentages were as follows:

Advises and makes recommendations	69%
Advises only (consultative)	24
Makes decisions (deliberative)	6
Other	1

If a committee's decision-making authority is deliberative, as six percent of respondents indicated, physicians in particular may view the ethics committee as an adversary, interfering in their professional responsibilities. But if the committee's decision-making authority is consultative and advisory, as indicated by 24 percent of respondents, or if the committee advises and makes recommendations, as in the majority of cases, the interpersonal interactions are likely to be more productive. A committee's conciliatory manner

Questions involving the effects of changing relationships among healthcare providers have continued to require the intervention of ethics committees.

will invite amiable interaction with physicians and nurses, enhance the level of discussion, and contribute to the quality of the decision made on the patient's behalf.

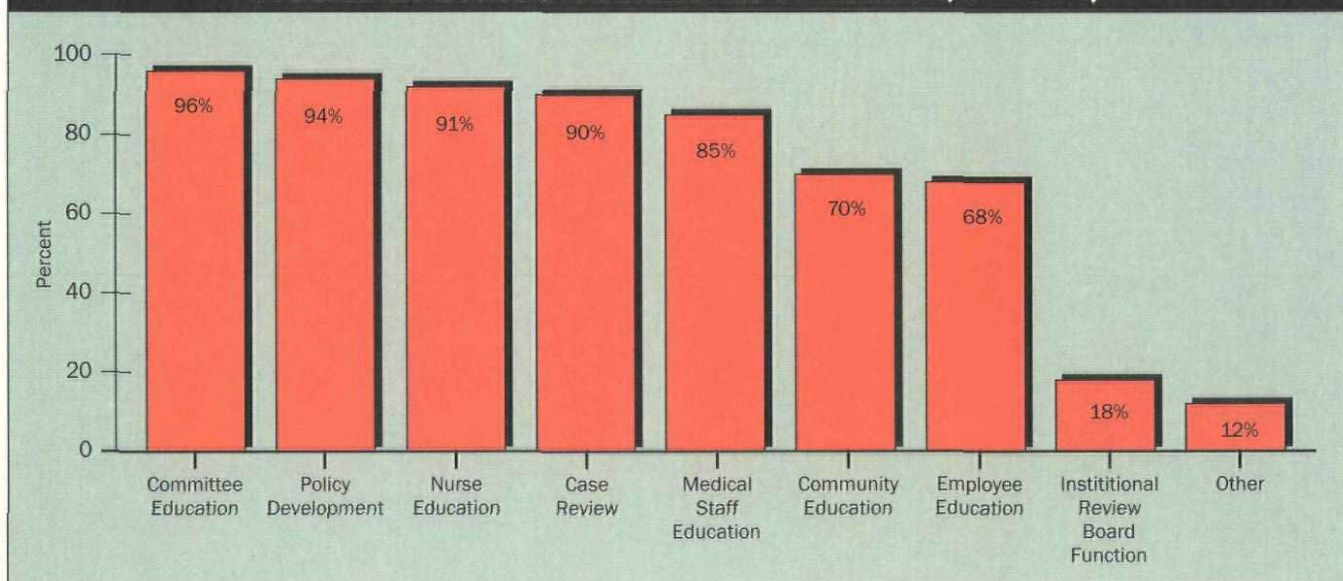
Another result of this supportive relationship is a deepening trust between committee members and care givers, with optimal conditions for dialogue. In such an atmosphere, members of the ethics committee are able to facilitate a case conference by bringing together the appropriate physicians and others with family members in a timely fashion. Furthermore, when an ethics committee achieves this degree of competence, physicians, nurses and hospital staff usually want to serve on the ethics committee, further strengthening its influence in the facility.

### CLINICAL ETHICS AND CASE CONSULTATIONS

The issues that precipitated the formation of institutional ethics committees have not only persisted over the past 10 years, they have become more complex. In particular, questions involving the appropriate use of technology, the renewed awareness of patients' rights, the effects of changing relationships among healthcare providers, and conflicting social values have continued to require the intervention of ethics committees.

The survey responses explicitly demonstrate which issues lay claim to a committee's time and attention. The Table represents both a range of clinical issues and the frequency with which ethics

**FIGURE 2: ETHICS COMMITTEES' ROLES (N = 301)**







committees provide case consultations.

The frequency with which respondents said their committees provide case consultations seems lower than it should be if committees were used to their full advantage. For instance, despite a growing respect for patient autonomy, anecdotal information suggests that treatment decisions regularly disregard patient wishes. Medical technology is often used aggressively and uncritically, especially toward the end of life, when patient benefit is marginal or virtually absent.

At what point are cases brought before the ethics committees? Are the medical and nursing staffs so ethically sensitive and sophisticated that the ethical questions become nonissues in some Catholic healthcare institutions?

### ETHICS AND HEALTHCARE REFORM

The traditional role of the ethics committee as educator and case consultant raises much larger questions in this turbulent time of healthcare reform. Ethics committees are asked to respond to biomedical issues that emerge from within the current healthcare system. The basic assumptions and values that drive our present delivery of American healthcare are themselves in need of reform. The orientation is toward the treatment of episodic disease; the incentives are economic, unduly endorsing healthcare as a profit-making business. In a reformed delivery system based on capitation, overtreatment will decrease physician

may be reduced. But new economic incentives will dictate the direction of new abuses. Are ethics committees prepared for these emergent issues?

The debate on healthcare reform, which concentrates primarily on reforming the delivery system and containing costs, ignores crucial issues. To achieve real reform, we must address the larger questions. The institutional ethics committee can play a part in enlarging the current debate and promoting moral values. It can address the important questions: What is the meaning of health? Of aging and death? What is the role of personal responsibility in one's own healthcare? Can the American appetite for high-technology treatment be curbed? Should the well-being of individuals take precedence over the well-being of communities?

### EUTHANASIA

Although euthanasia and physician-assisted suicide are being increasingly debated in the public forum, it is not surprising that CHA members

**TABLE: ISSUES DEALT WITH BY ETHICS COMMITTEES**

Issue	Never or Rarely	Monthly	Weekly or Daily
Withholding or withdrawing life-sustaining treatment (N = 302)	42%	45%	13%
Patient autonomy issues (N = 305)	38	41	21
Relations among patients, physicians, and family (N = 303)	59	31	10
Obstetric issues (N = 301)	75	20	5
Cost-effective use of expensive technology; futile treatment (N = 303)	74	18	8
Euthanasia and physician-assisted suicide (N = 304)	97	3	<1
AIDS and HIV-related care (N = 302)	82	14	4
Corporate ethics (N = 302)	90	10	<1
Social issues (N = 302)	89	8	3

noted that these issues infrequently require the

The institutional ethics committee can play a part in enlarging the current healthcare reform debate.

tal (see Table). Seventy percent of the respondents reported that their ethics committee is never asked to address these issues.

One reason for this may be public perception regarding Catholic religious beliefs and moral practices. Catholic resistance to legalizing euthanasia and physician-assisted suicide, together with the prohibition of any form of euthanasia within Catholic hospitals, may prevent patients or healthcare providers from raising the issues. Only 3 percent of respondents noted that they address the issues on a monthly basis, although growing public debate and awareness may increase the pressure on providers.

### COMMITTEE STRUCTURES

**Size** Forty-three percent of 284 respondents to the question about size said their ethics committees had between 11 and 15 members. The mean was 15 members, with a range from 1 to 38. Twenty-four percent of respondents' committees have less than 11 members, 22 percent between 16 and 20, and 11 percent over 20.





## CONFIDENTIALITY AND LIABILITY



A major concern of an ethics committee is the confidentiality of the information it receives and of

the committee's deliberations and conclusions. Certainly, one reason a situation is brought to the attention of an ethics committee is the sensitive nature of the issues involved. An ethics committee would be constrained in fairly discerning and addressing the issues unless both participants and committee members were reasonably assured confidentiality would be maintained.

There are few cases in which courts have considered protection from disclosure of an ethics committee's gathered information, record of deliberations, and conclusions or recommendations. A recent case, *Estate of Behringer, M.D. v. Medical Center at Princeton* [592 A.2d 1251 (Superior Court of New Jersey, 1991)], discusses similar con-

cerns and the legal principles that might be applied by healthcare institutions as policies for their ethics committees.

The *Behringer* case involved an otolaryngologist and plastic surgeon on the medical center's staff who was diagnosed as suffering from AIDS. Apparently, medical records concerning the testing and diagnosis of this surgeon were not stored in a manner which would limit access to those with a need to know. The hospital and its laboratory director were found liable for having breached a duty to keep the surgeon's medical records confidential.

The case demonstrates that legal liability can result when the healthcare institution fails to adhere to a policy of strict confidentiality. The hospital in the *Behringer* controversy was found to be not only responsible for institutional fault in failing to maintain adequate

control of its medical records; it was also found to be responsible for the fault of its agent or employee, the laboratory director.

Similarly, a healthcare institution could face liability for failing to establish and follow strict confidentiality controls over the information gathered by its ethics committee and the deliberations and conclusions of that committee. Additionally, the institution could face liability for failing to instruct committee members and the participants in its proceedings on their responsibility to maintain full confidentiality of all information obtained in the ethics committee review, in the ensuing deliberations, and in the conclusions reached by the committee.

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**Interdisciplinary Membership** Three hundred and one persons responded to a survey question asking the occupation of ethics committees members. The percentages listing particular positions were as follows:

Physician	98%
Nurse	98
Hospital administration representative	98
Pastoral care giver	98
Social worker	80
Mission integration personnel	68
Risk management personnel	62
Community representative	58
Ethicist	58
Attorney	52
Board member	50
Patient advocate	30
Diocesan representative	25

**Governance** Although almost a third of ethics committees are committees of the board, they are more likely to report to another body. Of 303 respondents, the percentages were as follows:

Board	31%
Administration	19
Hospital or system	17
Medical staff	15

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Interdisciplinary body	8
Other	10

**Meeting Frequency** A question on the frequency of meetings garnered 310 responses. Forty-five percent of respondents indicated their ethics committees meet monthly. Others meet as follows: bimonthly, 19 percent; as needed, 9 percent; quarterly and as needed, 7 percent; quarterly, 7 percent; monthly and as needed, 7 percent; and bimonthly and as needed, 5 percent.

**Selection of Members and Terms of Office** Although 40 percent of 324 respondents indicated their committees have term limits for their members, 60 percent do not. Only 138 and 139 persons, respectively, indicated the length of the term of the chairperson and the members-at-large. They indicated that the average chairperson term is 2.3 years, whereas members-at-large serve for slightly longer terms—2.6 years.

The majority of hospitals appoint committee members (90 percent of 311 responses) and chairpersons (80 percent of 309 responses). Other methods of choosing members and chairpersons include volunteering (members, 4 percent; chairpersons, 3 percent) and election (members, 2 percent; chairpersons, 11 percent).





**Minutes** The survey asked a number of questions about the distribution and retention of committee meeting minutes, an issue related to confidentiality (see **Box**, p. 38). Respondents indicated that, outside the ethics committee, the following persons receive copies of the minutes:

Board	27%
CEO/president	21
Administration	13
Medical executive committee	11

Chief of staff/medical director	6
Vice president	4
Diocese	3
Ethics consultant	3
Corporate or system representative	3

When hospitals send copies of their meeting minutes to someone outside the committee, 80 percent of the responding hospitals allow these individuals to retain their copy, and 20 percent

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## RESOURCES FOR ETHICS COMMITTEES

### NEWSLETTERS

#### **Ethical Currents**

Center for Healthcare Ethics, St. Joseph Health System, 440 S. Batavia St., Orange, CA 92668-3995

#### **Health Care Ethics USA**

Center for Health Care Ethics, Saint Louis University Health Sciences Center, 1402 S. Grand, St. Louis, MO 63104

#### **Issues**

SSM Healthcare System, 477 N. Lindbergh Blvd., St. Louis, MO 63141

#### **Bioethics Forum**

Midwest Bioethics Center, 410 Archibald, Suite 200, Kansas City, MO 64111

#### **Medical Ethics Advisor**

American Health Consultants, 3525 Piedmont Rd. NE, Building Six, Suite 400, Atlanta, GA 30305

### JOURNAL

#### **Hastings Center Report**

225 Elm Rd., Briarcliff Manor, NY 10510

### BOOKS

#### **Medical Ethics**

##### **Principles of Medical Ethics**

Tom L. Beauchamp and James Childress, Oxford University Press, New York City, 1989

#### **Healthcare Ethics: A Theological Analysis, 3d ed.**

Benedict Ashley and Kevin O'Rourke, Catholic Health Association, St. Louis, 1989

#### **Dimensions of the Healing Ministry**

James E. Hug, ed., Center of Concern, Washington, DC, 1989

#### **Care of the Dying: A Catholic Perspective**

Catholic Health Association, St. Louis, 1993

#### **Guidelines on the Termination of Life-sustaining Treatment and the Care of the Dying**

Hastings Center, Indiana University Press, Bloomington, 1987

#### **On Moral Medicine: Theological Perspectives in Medical Ethics**

Stephen E. Lammers and Allen Verhey, William B. Eerdmans, Grand Rapids, MI, 1987

#### **Medical Ethics: Sources of Catholic Teachings**

Kevin O'Rourke and Phillip Boyle, Georgetown University Press, Washington, DC (in press)

#### **A Primer of Healthcare Ethics**

Kevin O'Rourke, Jean deBlois, and Patrick Norris, Georgetown University Press, Washington, DC (in press)

#### **Bioethics: Basic Writings on Key Ethical Questions**

Thomas A. Shannon, Paulist Press, Mahwah, NJ, 1987

#### **Ethics Committee Development**

**Ethics Committees: Core Resources**  
Hastings Center, Briarcliff Manor, NY

#### **Health Care Ethics Committees: The Next Generation**

Judith Wilson Ross et al., American Hospital Association, Chicago, 1993

#### **Handbook for Hospital Ethics Committees**

Judith Wilson Ross et al., American Hospital Association, Chicago, 1986

### EDUCATION PROGRAMS

#### **Decisions Near the End of Life**

Hastings Center and Education Development Center, 55 Chapel St., Newton, MA 02160

#### **Caring for Persons at the End of Life**

Catholic Health Association, St. Louis, 1993

### PAMPHLETS

#### **AIDS: Ethical Guidelines for Healthcare Providers**

Diana Bader and Elizabeth McMillan, Catholic Health Association, St. Louis

#### **Development of Church Teaching on Prolonging Life**

Kevin O'Rourke, Catholic Health Association, St. Louis



## LEARNING TO PAY ATTENTION

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### GOOD INSTITUTIONS

Institutions are socially organized forms of paying attention. If a good institution is one that encourages attention rather than distraction, SCHCS eldercare facilities are moving in that direction. A group of people have come to appreciate the importance—and the challenge—of paying attention. Having become conscious of new ethical horizons, they are emboldened by the words of anthropologist Margaret Meade: "Never doubt that a small group of thoughtful citizens can change the world. Indeed, it is the only thing that ever has."

Changing a small corner of the world would satisfy this group. They have taken steps to bring their experiences back to their respective facilities and share them with staff. With approval from senior management, the group is currently developing an in-service program on ethics education and training. Designed in four modules, the program will focus on protecting and enhancing resident rights, staff issues and professionalism, talking about death and dying, and staff-physician issues.

The program's goal is to sensitize staff to what it is like to be a resident. A number of staff from SCHCS facilities are actively involved in both the design and development of these modules, two of which are near completion (see **Box**, p. 43). Each includes a video, a leader's guide, participant materials, and relevant resource materials. All indications are that the process of developing these modules has been as educative for those involved as the finished products will be for target audiences.

The project is scheduled for completion in December. At that point, the four modules will be exchanged between facilities involved in their development and, eventually, with other SCHCS eldercare facilities. The ultimate objective of the group—development of ethics structures—will be addressed in concert with implementation of this education program. □

## VARIED ISSUES

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require that these individuals return their copy. Seventy-two percent of hospitals allow their committee members to retain a copy of their own minutes from the meetings, whereas 28 percent do not. Whether minutes are retained or broadly distributed, 95 percent of the respondents are satisfied that their patients' confidentiality is sufficiently protected.

### FUTURE DIRECTIONS

Although respondents on average rated their ethics committees as effective, in open-ended comments respondents indicated services and programs provided by CHA that might enhance their committees' effectiveness.

The 52 comments related to medical-ethical issues indicated the need for further education on end-of-life decisions (19 percent), technology-versus-cost decisions (14 percent), and euthanasia/physician-assisted suicide (14 percent). Issues related to obstetrics and reproduction were mentioned in 12 percent of the comments. Also, 25 percent of the comments indicated a desire for advice on how to deal with these issues.

Respondents expressed interest in attending seminars, conferences, and workshops. They were also interested in short videos and printed resources. They requested information about newsletters that provided a Catholic perspective on issues, and they also need books to help ethics committee members understand various medical-moral issues and strengthen their programs for medical staff and the community (see **Box**, p. 39). CHA's Division of Theology, Mission, and Ethics will incorporate member needs and interests, as expressed in the survey, in planning its future activities. □

*The authors thank Edwin Fonner, Jr., director of Research and Information, and Lartivia Hammond, research associate, Catholic Health Association, for their assistance in preparing the survey instrument.*

## GROWTH

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wellness focus, and science versus humanism, the authors suggested.

They said that the ethical foundation embodied in the SMHS vision and mission can provide a framework to ensure that the system's philosophy and values inform its actions. SMHS and its members are committed to developing a worldview that enables them to see patterns of organizational and system behavior; to grasp the root causes of illness, disease, and other health-related problems; and to understand why the poor and other disadvantaged groups suffer disproportionately. A mature CEC will become an advocate for a more just healthcare system by carrying that analysis outside the system and into communities, Congress, courtrooms, and corporate boardrooms.

**Continue to Grow** According to the report, comments from members indicate that confronting contemporary ethical issues will require the committee to:

- Perform in-depth analyses of current healthcare issues
- Continue work on defined goals
- Assist in policy formation
- Help realize the SMHS Vision 2000, strategic plan, and articulated core values
- Educate current and new members
- Network, internally and externally

### CURRENT CEC ACTIVITIES

The CEC has already reflected on its growth, renewed its commitment, and formed a task force to develop an ethical framework that can be used systemwide to translate the SMHS mission and values into just action. Although the evaluation of the system's CEC has some limitations, the results clearly demonstrate that the committee has achieved real growth. Committee members also believe that the process used to evaluate the CEC can be easily adapted for evaluating other ethics committees. □