Health Care Facility Ethics Committees: New Issues in the Age of Transparency

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Over fifteen years have passed since the 1992 mandate of the Joint Commission—then the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)—that American hospitals establish a “mechanism” for hospital personnel to consider and educate its constituents on ethical issues in patient care. The simple passage of time has not, however, delivered clear guidance on the most effective structures, methods, and models for implementing clinical ethics processes within hospital settings. Rather, the implementation of these programs remains ad hoc and lacks consistency in methods.

An article in the January 28, 2008, American Medical News, excerpting information from the February 2007 edition of the American Journal of Bioethics, indicates that by the year 2000 over 95 percent of community hospitals had established a clinical ethics committee. Forty-five percent of the participants in such committees, however, had no formal ethics training to support their role. Moreover, the article notes that to date no consistent standards of care have been developed for the methods or outcomes of ethics committee consultations. This lack of consistency in applying the principles and processes of bioethics consultation, coupled with an increasing call for using ethics consultation services, suggests that it is time that disciplined attention should be focused on the delivery of this health care service.
The Intended Benefits of Ethics Consultations

The Department of Veterans Affairs (VA) initiated its Integrated Ethics Initiative in 2007 with the intent to develop guidance to implement effective ethics programs. The VA identifies a number of organizational benefits intended to flow from a strong, consistent, and integrated ethics program. In its folio entitled *A Brief Case for Ethics*, these benefits are noted as (1) increasing patient satisfaction, (2) improving employee morale, (3) enhancing productivity, (4) conserving resources/avoiding costs, (5) improving accreditation reviews, (6) reducing ethics violations, (7) reducing risk of lawsuits, (8) sustaining corporate integrity, and (9) safeguarding the organization’s future.

In addition to these organizational benefits, applying a prescribed ethics process to an essentially idiosyncratic system of patient care enables health providers to address numerous ethical issues that may interfere with effective patient care. Thus, organized ethics processes may uncover conflicts of interest among health care providers or family members; prevent the undue influence of specific personalities that may occur in an unstructured setting; ensure that accurate information about a patient’s condition, interests, and goals are gathered and conveyed; provide a fair process for evaluation of competing interests; and help with risk management. Moreover, in a society that values clear rules for action, an effective ethics procedure may assist patient representatives and caregivers to understand and accept that true moral dilemmas may exist, i.e., that in some situations commonly accepted statements of moral obligations may appear to demand that a person take two or more alternative and inconsistent actions. See Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* 11 (5th ed., 2001).

The Genesis of Legal Ethics Committees

*In re Quinlan*, 355 A.2d 647 (N.J. 1976), was the first case to adopt the notion that a health care facility could establish an ethics committee to act as an alternative to the more traditional probate court process for determining a patient’s interests concerning end of life care. Karen Quinlan, in a “vegetative state” after an auto accident, was caught in life because her physicians could not in good conscience, or without risk to themselves, respond to her father’s request that life support systems be removed to allow her death. The court described the right of privacy in health care decision making and established that in New Jersey, Quinlan’s father had the right to act as her surrogate decision maker and direct the actions of her physicians. Moreover, the court recognized that it would be “impossibly cumbersome” for the courts to be some biographical information about the authors may no longer be accurate.

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involved in patient care decision making, especially in light of the limited expertise of most judges in medical matters. The court therefore proposed a new concept—that of a facility ethics committee—as a means for a care team to clarify proper action and for a facility to manage the risk that it would be liable for failure to provide necessary care.

This decision was not without its critics. In Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417 (Mass. 1977), for example, the court chastised the Quinlan decision and argued that the probate court system was the proper forum for response to the key issues of personal rights that arise at the end of life. Gradually, however, the notion became established that a facility ethics committee could provide a setting for competing ethical issues to be explored and, in many cases, resolved by consensus.

Concurrent with these judicial developments, the executive branch sought to address the ethical issues associated with increasing use of life-sustaining technologies for significantly impaired patients. The 1983 report of the President’s Commission for the Study of Ethical Problems in Biomedical and Behavioral Research entitled Deciding to Forgo Life-Sustaining Treatment, for example, strongly encouraged the creation of ethics committees to assist decision makers facing questions on the use of life-sustaining interventions. The report encouraged “administrative arrangements for review and consultation, such as ‘ethics committees,’ particularly for decisions that have life and death consequences,” deeming such arrangements “more rapid and sensitive than judicial review.” See page 5 at www.bioethics.gov/reports/past_commissions/deciding_to_forego_txt.pdf. The Office of Technology Assessment of the Congress prepared a 1987 report entitled Life-Sustaining Technologies and the Elderly, where an ethics committee was defined to provide consultation and education within a health care institution concerning ethical dilemmas.

In relatively rapid succession, these proposals were adopted and endorsed by professional organizations such as the American Society of Bioethics and Humanities, the American Medical Association, and the American Nurses Association. By 1992, the JCAHO had adopted its guidance that hospitals should establish its clinical ethics mechanism. By 1999, Medicare regulations, 64 Fed. Reg. 36060, required that Medicare-participating hospitals’ patients should be informed of the opportunities available within the institution for an ethics consultation. Current Joint Commission standards require that hospitals adhere to twenty-four guides on ethics implementation found in Sections RI.1 through RI.3.1, including standards relating to ethics committee activities.
Establishing Standards for Ethics Committees

The development of an expectation that health care facilities would offer bioethics consultations was not necessarily based upon empirical evidence of the efficacy of the processes. Such objective data has come more recently in an article by Mark P. Aulisio and his colleagues entitled Health Care Ethics Consultation: Nature Goals and Competencies and in another by Ellen Fox and her colleagues entitled Ethics Consultation in United States Hospitals: A National Survey.

Aulisio identified three key areas of competence for ethics committees: skills, knowledge, and character. Within the skill sets required of ethics committee members are ethical assessment skills, process skills, and interpersonal skills. In the core competencies of knowledge are moral reasoning and ethical theory, bioethical issues and concepts, health care systems knowledge, clinical contexts, knowledge of the applicable health care institution, knowledge of applicable institutional policies, knowledge of the beliefs and perspectives of the patient and staff population, knowledge of relevant codes of ethics for professional conduct and accrediting guidelines, and knowledge of relevant health law. Key character traits required for effective participation in an ethics committee process include tolerance, humility, patience, compassion, honesty, courage, prudence, and integrity. A facility should not presume that these characteristics are found in the members of its ethics committee but rather should take affirmative steps in training and assessment to ensure that the skill sets are developed and practiced.

Ethics Committee Functions

The American Hospital Association published a Handbook for Hospital Ethics Committees in 1986 that identified three primary functions for ethics committees. These functions include educating medical staff, hospital staff, and patients (and, in light of the increased emphasis on community benefit to tax exempt organizations since 1986, one would have to add community education as well); developing institutional policies and guidelines concerning bioethical issues; and consulting and reviewing cases. The content of educational activities is relatively self-explanatory, but a representative list of policies and guidelines may be helpful for those interested in ethics committee activities. Such a list appears below:

- advance directives,
- do not resuscitate processes,
- patient refusal of services,
- “Baby Doe” guidelines,
- withholding life sustaining treatment,
• ethics consult procedures,
• patient–caregiver confidentiality,
• medical futility,
• admission and discharge considerations,
• family communications,
• nutrition and hydration, and
• organ donation.

See P. Schneider, A Study of Twelve Hospital Ethics Committees in Eastern South Carolina, 96 J. S. Car. Med. Ass’n 409 (2000). The consistent development of ethics policies and guidelines may be of significant benefit to an institution in the articulation of the organization’s approach to ethics processes.

The case review function of ethics committees overlaps a number of organizational roles, including as an expression of organizational ethics, a method of compliance with accreditation standards, and a risk management tool. “Case consultation is perhaps the most useful role, easily the most controversial role, and possibly the most risky role a committee can play.” M.D. Jenkins, Ethics Committees: Creation and Purposes, Remarks Before the Am. Acad. Hosp. Attorneys, 25th Annual Meeting 1992. While “ethics committees can provide a multidisciplinary forum for discussing problematic issues; help frustrated health professionals uncover and analyze touchy questions about patient care; and suggest options to patients, family members and health professionals,” J. Fleetwood & S. Unger, Institutional Ethics Committees and the Shield of Immunity, 120 Annals Int. Med. 320 (1994), the committee also has the potential to interfere with patient privacy and autonomy, elevate cost containment over individual needs, and to unduly influence professional judgment. To protect the integrity of the ethics process therefore, it is critical that a clear written charge be developed for the committee, and that the committee members be trained upon and held accountable for adherence to the charge.

This adherence to excellence in process and clarity of charge is particularly important in states that have imbed ethics committees with decisional authority. Alabama, Georgia, and Texas, for example, all grant ethics committees the authority to make end of life decisions for patients who have no identified surrogate decision maker, if certain conditions are met. See Ala. Code § 22-8A-11 (2001); Ga. Code Ann. § 31-39-2 (2000); Tex. Health & Safety Code Ann. § 166.046 (Vernon 2000). Ethics committees who exercise such functions may face liability for battery or malpractice if life-sustaining treatment is provided over the patient’s objection, for wrongful death for withdrawal or withholding of life-sustaining treatment, or for breach of confidentiality and violation of privacy for unauthorized disclosure of patient confidences. If the committee members are particularly
persuasive and the care provider adapts his or her course of treatment, the committee and sponsoring institution should anticipate inclusion as a party in a malpractice lawsuit.

The choice of ethics committee function is therefore a key risk management decision for an institution. Committee review may be optional, with a patient’s option for acceptance of the committee’s comments, and in such a setting the institution is unlikely to carry significant risk. This level of review, however, may be least influential in developing either a course of action for an individual patient or an institutional expectation of ethical action. To increase the institutional expectation and utilization of the ethics committee process, the committee’s jurisdiction may be described as mandatory when certain types of referrals of cases are made. If the patient representative and physician retain an option about whether to follow the recommendation developed through the committee process, then once again the level of risk to the institution seems relatively low. Where an institution institutes a mandatory review process, however, and also institutes sanctions for a patient or care giver who acts against the recommendation of the committee, then the institution should anticipate that its actions will be subject to challenge in the judicial system.

Recognizing the risks associated with implementation of a decisional role for ethics committees, some states have provided immunity to ethics committee members and those who rely on or follow their advice. The model bill in the President’s Commission for the Study of Ethical Problems in Biomedical and Behavioral Research, for example, proposed a broad immunity for ethics committees activities except in instances of gross negligence or willful disregard of the patient’s interest. As ethics committee processes are distributed across the country and implemented by a mixture of trained and untrained personnel, however, there is some reason to question whether a grant of immunity provides sufficient prodding to encourage adequate committee member training and care. Thus, risk management personnel should be involved in developing the roles and monitoring the activities of the ethics committee, and the committee should make periodic substantive reports to the hospital’s governing board.

**Operational Issues**

As institutions resolve these key issues of role, charge, composition, and training, ethics committees should begin to play an influential role in the ethical life of the organization. With this increased competence and influence, however, it is key that institutions recognize that ethics committees have a different function than an institutional risk management tool. Thus, the governing board and key management should ensure that ethics
committees do not inadvertently or intentionally overlap with the functions of peer review committees and quality management committees, which may have separate confidentiality and immunity rights under state law. Ethics committees should not, for example, intervene in the process of sentinel event identification, investigation, and reporting, but rather must allow the risk management functions associated with these events to be fulfilled within the scope of the sentinel event reporting standards and regulations. Further, the role of the ethics committee should be recognized as a health care operation for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996, and the institution should determine whether records of the ethics consultation will be considered part of the medical record of that act’s designated record set.

Because an ethics committee does not primarily play a risk management function within the institution, risk management personnel should not play a role in the presentation of or deliberation on ethics issues. Counsel to the institution should limit his or her role to the procedural issues associated with the consulting process, and should not be a presenting witness nor provide counsel on the substantive law or the ethical precepts that may apply to a given situation. These roles should be left to outside counsel, an ethics consultant, or a trained member of the committee. Institutional counsel or risk management personnel who play too many roles in the committee process run the risk of becoming a witness if the process goes awry.

Participants in the ethics committee process should be provided a safe setting in which to address problems of information, communication, values, and actual misunderstandings. The salutary effects of physician truth-telling in the context of untoward medical outcomes are becoming well documented in recent years. See T. Gallagher et al., Patients’ and Physicians’ Attitudes Regarding Disclosure of Medical Errors, 280 JAMA 101, 107 (2003); T. Delbanco & S. Bell, Guilty, Afraid, and Alone—Struggling with Medical Error, 357 New Eng. J. Med. 1682, 1683 (2007). Some states have adopted “I’m sorry” laws, which prohibit the admission into evidence of statements of physicians that acknowledge the existence of a medical error or unintended consequence. In states in which such laws exist, they should be noted and described to the patient representative. In states that do not provide such protection, the principle of inadmissibility may be invoked as part of a contractual process of acknowledging the decision to enter into the ethics consultation process. A liability release relating to committee witnesses and members might also be warranted.

These matters, once resolved, should be documented and explained to the patient representatives in a clear informed
consent to the ethics consultation process. The patient and family should be provided with a written document outlining the scope of the proposed consultation. Any potential conflicts of interest, whether between individuals or in terms of any institutional values or religious directives that may interfere with patient autonomy, should be identified. The patient representative should be given clear notice that he or she may refuse to participate, and the alternative of a probate court proceeding should be clearly described. The patient representative should be informed about alternative options should the outcome of the consultation be unsatisfactory. The informed consent should meet the criteria established by state law for the delivery of or withholding of medical treatments. Thus, if the patient representative does not perceive that a real option to refuse the consultation conditions exists, the principles of informed consent may be compromised. Once obtained, a record of the informed consent should be included in the medical record.

Conclusion

In the last thirty years, ethics committee consultations have become a key component of the clarification of bioethical issues in patient care. The development of clear standards and goals of ethics committee development, however, is only now beginning to take shape as greater empirical evidence of best practices is developed. Organizations should adopt practices that will increase the efficacy of ethics committee consultations while preventing intrusion in the consultations by extraneous issues such as professional review and risk management.