CENTER FOR PRACTICAL BIOETHICS

GUIDANCE AT THE CROSSROADS OF DECISION

Recommendations for the Development of Policies and Procedures for Ethics Committees

Kansas City Area Ethics Committee Consortium
Center for Practical Bioethics

1111 Main Street, Suite 500
Kansas City, Missouri 64105-2116
816 221-1100
816 221-2002, fax
bioethic@practicalbioethics.org

Reviewed and Revised May 2015

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Kansas City Area Ethics Committee Consortium of the Center for Practical Bioethics

Prologue

Consortium members believe that having written policies and procedures benefits their committees. Among these important benefits are several that relate to the development of the committee itself. Written policies can help the committee develop a sense of identity and purpose. In addition, written policies and procedures help the committee delineate and clarify its role within the institution, address basic issues of committee organization and function, and establish guidelines for committee activities.

Consortium members also believe that developing written policies can educate others about the committee's role in the institution. Whether ethics committees are new to healthcare providing institutions or simply in need of revitalization, Consortium members believe that written policies and procedures regarding the committee's work will facilitate acceptance of the committee and maximize its benefit to the institution.

Additional reasons for undertaking this project on written policies and procedures for ethics committees are that written policies enable committees to compare and contrast their development, assess their effectiveness, and evolve within broadly accepted parameters. It will also allow more mature committees within the Consortium to assist newer committees.

Consortium members identified a number of concerns that should be addressed when developing written policies and procedures. An obvious concern is that committees for small rural institutions or agencies may confront special issues not addressed in this document as a result of their size and the resources available to them. The development of written policies and procedures should be understood as a means to facilitate the work of the committee, not as an end in itself. The focus of the written document should be on the structure and general operations of the committee and should avoid consideration of specific ethical issues or topics.

Consortium members feel that it is important to avoid an excessively rigid or formalistic "cookbook" approach. Policies and procedures should not become a list of “have tos” that can impede the work of the committee. A final concern is that such documents must include provisions for periodic reevaluation and revision.

Elements of Ethics Committee Policies and Procedures

I. Mission and Purpose

The first section of a committee's written policy document will reflect the committees's mission and purpose. The specific language and items selected for expressing its philosophy and purpose will be a reflection of the unique character of a particular organization. However, this section will likely include the following items:

A. Name: forum, committee, study group, interest group.

B. History: a brief description of the way the committee came into being.

C. Organizational placement: medical staff committee, administrative or board committee; governance; accountability.

D. Charge: a brief description of the formal charge given to the committee.

E. Philosophy: a general statement of the ethical principles that provide the foundation for the committee's work.

F. Mission statement: a broad pronouncement about the committee's reasons for existing: the committee's general mandate.

G. Purpose: a clarification regarding the committee's role in "doing ethics" within the institution. This purpose should be worded in a way that will not jeopardize the potential protections afforded by professional peer review committees.

H. Goals: a listing of specific benefits the committee hopes to provide to the institution.

II. Jurisdiction

Once the committee's mission has been clarified, its jurisdiction should be spelled out, including its relationship to other review committees (e.g., other ethics committees, institutional review boards, quality assurance committees, patient care committees.) Defining the committee's jurisdiction will also help clarify the kinds of problems appropriately referred to an ethics committee. Examples of inappropriate referrals may include billing problems, matters of professional discipline, staff or patient grievances, human experimentation issues, and animal care policies.

Further, this section on jurisdiction will help explicate the issue of the relationship between the committee and the rights and authority of competent patients, legal guardians, designated healthcare surrogates, and family members, specifically regarding issues of prior consent and notification for case consultation by the ethics committee.

Finally, this section will also deal with the question of mandatory vs. optional case review. With the exception of case consultation undertaken in response to allegations of "medical neglect" of an infant or child (so-called Baby Doe Cases), consultation with an ethics committee is usually optional (i.e., undertaken only upon request) and committee recommendations are usually advisory in nature.

III. Function (Roles)

A committee's policies and procedures document should contain a brief description of each of the committee's proper functions as well as other functions the committee may have within a particular organization. The proper functions are those specific to the committee's mission and purpose. The Consortium recommends the following core functions or roles, which, taken collectively, are an apt expression of the committee's mission and goals.

A. Forum: Ethics committees shall be a"place" and an opportunity for individuals within institutions to express a broad range of concerns, questions, and problems about clinical and organizational ethics.

The term "clinical ethics" refers to a concept of ethics that includes the ethical beliefs of individuals and traditional professional ethics — for example, medical ethics, nursing ethics, social work ethics and applied ethics. Clinical ethics also refers to ethical questions or problems that arise at the "bedside" (i.e., in a clinical context).

The term "organizational ethics" refers to those areas of applied ethics ordinarily referred to as "business ethics." Such areas would include conflicts of interest and policies regarding admission, transfer and discharge, and marketing.

B. Education: Ethics committees shall engage in self-education. They will also develop or help others develop lectures, seminars, workshops, rounds, in-service programs, and similar offerings in the area of clinical or organizational ethics.

C. Policy review and development: Ethics committees will help their institutions review and develop policies and guidelines regarding recurrent ethical issues, questions, or problems that arise in the care of patients.

D. Case review (consultation, discussion): Ethics committees shall provide consultation and advice to healthcare providers, patients, surrogates, and members of the patient's family regarding complex ethical issues involved in the provision of care.

IV. Membership Criteria

A. Size and number of members: The size of ethics committees will depend on the scope of committee activities. Ordinarily, committees will have more than seven but fewer than fifteen members. Small institutions or agencies may need to consider a different system; however, even small institutions must have an appropriate minimum number to function as a committee.

B. Appointments: The policy and procedures document should clarify the mechanism by which individuals are selected, nominated or appointed to ethics committees. Special consideration should be given to the appointment and reappointment procedures for the chair and vice chair.

C. Composition: Ethics committees should consider whether and to what extent the committee should be representational and multidisciplinary, and whether limitations should be placed on membership from any discipline. Categories or disciplines to be considered for membership include the following:

- board members
- institutional administrators
- medicine, medical specialties
- psychiatry, psychology, mental health professionals
- nursing: staff, administrative, nurse clinicians/practitioners, special nursing units
- social service: supervisory personnel, case workers, clinical units
- pastoral care/clergy: chaplains, ministers, theologians
- ethicists: (persons trained in philosophy)
- financial officers
- librarians
- community members/lay persons: representatives from community advocacy groups
- lawyers: private practice, academic, institutional
- patient representatives

Committees may also consider appointing some ex-officio nonvoting members. Such appointments may include persons with potential conflicts of interest (e.g., hospital attorneys, hospital administrators, or board members). Special purpose or ad hoc members could also be appointed to provide expertise to the committee as needed.

Selection criteria for ethics committee membership may also include issues of diversity such as gender, minority representation, and religion.

D. Members' Terms: Ethics committee policies and procedures should set the length of members' terms and the procedure for changing members, for example, rotating or staggered terms, eligibility for renewal, and time-off. Mechanisms by which a member can be removed from the committee should also be documented.

E. Chair/Vice-chair: An ethics committee's policies and procedures document should specify the qualifications for these positions and the committee's role in the selection process. Term limits and special responsibilities should be noted.

V. Procedures

A. Forum functions: To function as a safe forum, committees should determine in advance their meeting place, frequency of meetings, and communications (i.e., how people are invited or notified). Rules for the conduct of the meeting and who may attend should also be clarified.

B. Educational functions: Committees should clarify their mechanisms for continuing self-education (e.g., journal review, film review, mock case analysis, retreats, and educational resources). Consideration should be given to networking with regional ethics committees and other institutions and participating in consortia.

Ethics committees should coordinate their educational offerings with existing educational programming within the institution. Planning and funding mechanisms will be needed for providing programs. In addition, the role of committee members in providing education about the committee, the institution's policies, and important bioethical issues to the larger community should be clarified.

C. Policy review and development functions: Committee procedures should include the way policies come before the committee for review and to what purpose. They should also determine how the committee will be involved in developing policies that involve significant ethical questions or problems. A mechanism for recommending new policies or policy modifications should also be discussed.

D. Case consultation

1. Access to the committee: Consideration should be given to how cases will come before the committee; who may request that the committee review a case (e.g., the attending physician, physician consultants, nursing staff, social workers, therapists, pastoral care providers, competent patients, guardians, and families). Committee policies and procedures should also specify on what grounds the chair will determine the appropriateness of the request, and what is to be done if the chair determines a case should not be brought before the committee? These tasks may also be undertaken by a small subcommittee (i.e., a screening or preconsultation review committee).

2. Preparation for consultation: Procedures for consultations should be well thought out. Consider for example the following questions. How will issues of consent, permission, and notification regarding consultation be handled? Is consent of a competent patient required? Should guardians or family be required to give consent or permission or merely be notified of the meeting? Is permission of the attending physician required, or is notification sufficient? How should medical records be reviewed? Who should have access

to them? Who should be invited to attend the meeting (e.g., the attending physician, physician consultants, nursing staff, social workers, therapists, pastoral care providers, competent patients, surrogates and families)?

3. Expedited review: Procedures for convening an ad hoc committee should be in place in the event the emergent nature of a case precludes formal review by the entire committee. For example, how many committee members should participate in an expedited review and from what disciplines? How will the results of an expedited review be reported to the entire committee?

   Note that the Consortium distinguishes between an ethics committee expedited review and an ethics consultation provided by a clinical ethicist or member of the committee. Care should be taken that such consultation only be undertaken by members with appropriate expertise and experience.

4. Conduct of the consultation: Cogent consideration should be given to how a consultation will be conducted. For example, what instructions should be given to all nonmembers concerning the role of the committee, the committee's advisory nature, and the need for confidentiality? How and to whom should the committee report? Who should be asked to present information about the case, and what kind of material does the committee need (e.g., the medical history of the patient, the present condition of the patient, the prognosis of the patient, information about the patient's goals and decision-making capacity)? And, finally, does the the committee need a "closed" or for-members-only portion of the meeting?

5. Committee report: Committee policies and procedures should specify the appropriate result of the consultation or case review (e.g., recommendations, a list of options, and a description of the ethical considerations discussed). To whom and how should the results be reported (e.g., to the person who requested the consultation, the attending physician, the nursing staff, the patient, surrogate, or family)? Should the report be verbal and written and should personal identifiers be deleted? Should recommendations be recorded in the patient's medical record? How will committee approval be secured?

VI. Meetings

Consortium members agree that committees should meet at least monthly and that committees that meet "as needed" are problematic. Considerations should be given to frequency and regularity of meetings; attendance requirements; how members are notified of meetings; attendance by non-members, and how the agenda is to be determined.

VII. Record Keeping

Although Consortium members expressed concern about keeping written records and maintaining the confidentiality of patient information, they adamently believe that the minutes of committee meetings should be kept. Ethics committee procedures should specify who the recordkeeper will be and who will formally prepare the minutes. Guidance should be included concerning the inclusion or deletion of personal identifiers and how

the confidentiality of patient information will be protected. The process for approving the minutes should be clarified along with a process for their maintenance and a specification of who shall have access to them.

VIII. Indemnification

A mechanism providing liability protection for committee members who do not have such protection by virtue of their office should be available to ethics committee members.

IX. Adoption, Approval, and Modification

Once the policies and procedures are in written form, consideration should be given to how they will be approved by the committee and accepted by the institution. Approval should include a method by which the policies and procedures can be updated and modified, for example, an annual review is possible, or perhaps there should be a "sunset" clause.

This document was completed in 1992 and 1997 with revisions in 2015.

For additional copies, contact

Center for Practical Bioethics
Harzfeld Building
1111 Main Street, Suite 500
Kansas City, Missouri 64105-2116
816 221-1100
816 221-2002, fax
bioethic@practicalbioethics.org