Education of Ethics Committees

by David C. Thomasma

The education of ethics committee is explored as a process of gradual "education" from the experience of the committee members and the institution. In addition to updating oneself in ethical theory and practice, the committee must institute activities that help it ascertain what ethical issues occur in the institution and assist it in developing procedures for analyzing and resolving these issues. Sometimes these additional requirements lead the ethics committee down paths it did not anticipate.

Education is a word stemming from *educare*, that is, "to draw out of" or educe. Nowhere is the meaning of the word more pertinent than when considering the education of ethics committees. The reason is that experience in the hospital or other health care setting is essential both for the self-education of staff and the public education roles of the committee. I will explore the meaning of *educing* and its implications for ethics committees in this essay.

Original Mission of Ethics Committees

For the most part, ethics committees in hospitals and other health care institutions grew out of a perceived need by those institutions. Individuals lobbied for the creation of ethics committees on the strength of concerns about ethical dilemmas arising in the practices of the institution and the widespread interest in exploring and resolving those dilemmas on the part of the staff and administration. Patients and clients, too, saw a need for such committees, and the public's growing awareness of medical ethical problems further underscored the importance of creating such committees.

Nonetheless, institutions did not readily adopt this concept. Medical staff in particular often perceived ethics committees as needless and even harmful interlopers between doctors and patients. In recent years this concern has abated somewhat. Physician-ethicists, such as Mark Siegler, reluctantly accept this "external interference" as a part of modern-day medical care, although some remain unhappy about it (Siegler 1992).

Once established, virtually every committee designed itself. This design was constructed around a three-fold task: education, policy development and consultation. The design went through a number of drafts and committee discussions and was eventually approved by hospital administrators. Although three tasks were enumerated, policy development and consultation were the important ones in most members' minds and education was seen as a means to those ends. Furthermore, the focus of education was external, particularly directed toward the medical staff.

Often new ethics committees focused primarily on developing or refining treatment guidelines, usually DNR policies. Yet almost every committee with which I have been associated rapidly became distressed that more physicians did not turn to it for advice. Thus, ethics committees soon began to understand the enormity of the task before them, a task that involved not only providing educational programs for staff and patients, but also educating themselves.

Inductive Nature of Ethics Committees

Ethics committees originally evolved as a response to activities and interests generated by professional staff and employees within an institution. They took shape

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from the warp and woof of daily practices and concerns. In short, they were educed.

Thus, the creation of ethics committees was already a process of widespread education within an institution. In some health care organizations, professional staff and administration gathered on retreat and developed the need, scope, design and even membership of the new ethics committee. The process by which these committees originated contributed to a growing awareness of the nature of a clinical ethical dilemma and procedures by which such dilemmas could both be resolved and could contribute to an institutional conscience, a concept I will explore below.

Levels of Education

There are at least five levels of education that should occupy an ethics committee. I will explore them in order of increasing committee-consciousness.

The first level involves updating oneself regarding the fundamental theories and axioms of medical ethics, a study which also includes a review of the thirty-year history of medical ethics (*Hastings Center Report* 1993; Thomasma 1993). The second has to do with developing clinical ethics skills. The third level is conducting ethics consults. The fourth is developing practice guidelines from these consults that can be adopted as hospital policy by other committees and boards of the institution. The fifth level is contributing to the institutional conscience and developing a public education program.

The role of ethics committees in each of these areas of education is examined in more detail below.

Theories and Axioms

A study of bioethics involves not only ethical theories, but also axioms, the clinical ethics rules by which principles are adjucated. For example, it is common knowledge that the four principles of bioethics are autonomy, beneficence, nonmaleficence and justice. But how are these four principles balanced in individual cases?

Sometimes patient autonomy might predominate; at other times beneficence may be the leading principle, especially when dealing with patients with limited or uncertain competence. In other cases, we may think that social justice should assist us in stopping expensive, high technology care when it has limited benefit to the patient, for example, a severely neurologically damaged newborn.

Learning the fundamental ethical theories alone does not guarantee good clinical judgments by ethics committees. A committee composed of Ph.D.'s in ethics could run the risk of acrimonious and stifled debate over theory to the detriment of prudential judgment (Lachs 1994). Indeed, one of the most interesting debates in the bioethics literature occurred when Beauchamp and Childress published their basic text on the principles of bioethics (Beauchamp and Childress 1994). Beauchamp is a well-known utilitarian ethicist and Childress is a deontologist, yet they agree in general on the shape of bioethics and the priority of autonomy among its principles. The debate, however, centered on whether or not theory matters. If people start with different ethical theories but can still reach consensus on issues, then what is the use of theory? The answer, of course, is that each person or group needs a template or process for analyzing ethical dilemmas. Theories assist us in this task, especially if we view them as the residuum of past experience with analogous dilemmas, a kind of precipitate of moral character we can then bring to new situations.

Hence, the focus of this level of education is directed less at the committee members becoming humanities scholars, and more at updating members about the history of ethics and bioethics. Despite its being just thirty years old, bioethics already has a developmental history of its own. Indeed, we are now beginning to question the hard-won foundations of the discipline, especially the primacy of the principle of autonomy. This questioning has now given rise to alternative ethical theories, theories such as narrative ethics, consensus ethics, casuistry, virtue theory, caring ethics, phenomenological ethics (Benner 1994), and feminist ethics (Gilligan 1993). Further, there is mounting concern

about cultural assumptions in bioethics (Marshall, Thomasma, and Bergsma 1994). Increasingly, bioethics has acquired an international tone (Holm 1994 and ten Have 1994). This questioning is true of the "applied ethics" model of ethics as well (Hoffmaster 1992), one in which too much attention is paid to the current decision and not enough to long-term consequences of the decision.

In reviewing the history of bioethics and ethical theories, it is important that the committee members have a common background of such knowledge. This kind of "make-up" ethics is best done in the context of cases so that members can assess the strengths and weaknesses of different approaches by constant reference to reality. Evidence exists that teaching ethics to medical students does little to change already-formed attitudes and values (*Hospital Ethics* 1994, 10:16). This is probably true of adult practitioners to an even greater degree. Only refinements can be expected, and then only with reference to experience.

Although I have stressed the importance of experience and reality over theory and abstract thought, the latter are not belittled by this emphasis. In other contexts they might be more important (*Journal of Clinical Ethics* 1994, 13-15). At this level of ethics committee education, however, the development of moral integrity in whatever way is tactically most effective, is more important than a thorough understanding of ethical theories.

Clinical Ethics and Mediation Skills

Ethics committee members must begin to trust their own experience in order to move beyond theories. This process can be enhanced through institutional retreats during which different services—medical, nursing, social work and others—bring for discussion and analysis dilemmas they face, and which ethics committee members then analyze inductively. For example, rehabilitation might propose the problem of a non-compliant, post-operative, cardiac patient; nursing services might bring up difficulties in implementing an advance directive (Silverman, Fry and Armistead 1994) or the

changing character of nurses' roles from one of obedience to good nursing practice (May 1993; Pence 1994); oncologists may discuss the problem of a dysfunctional family making decisions for an incompetent patient, and emergency and critical care services might ask about their duty to treat a transfer patient (Fox 1994).

Efforts should be made to formulate initial practice guidelines from these discussions. For example, consider that two problems emerge from the retreat: the

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duty of physicians to treat certain patients and the problem of interpreting advance directives that don't cover a certain contingency. When practice guidelines are formulated, the committee tries to influence the conduct of the institution itself, anticipating from its past experiences certain repetitions in behaviors that could be altered in the future by guidelines and by, perforce, education. From this highly complex process, the committee begins to realize the difficulties inherent in changing institutional behavior.

While dealing with actual cases and formulating policies from these discussions, committee members learn the need for a kind of prudence, that ability to make practical judgments in the midst of uncertainty and disagreement. Reaching a consensus is also an important, albeit controversial, method of arriving at ethical resolutions. Robert Wagener has developed the Center for Medical Ethics and Mediation, which also publishes a quarterly bulletin.[1] A recent book demonstrates the level of sophistication this training has reached with respect to bioethical disputes (Dubler and Marcus 1994).

Ethics committee can participate with other departments in ethics grand rounds, during which difficult

cases from different services are discussed. If there are no actual cases to discuss, these can be provided by a number of sources in the literature.[2] Ideally grand rounds would occur once a month and be open to everyone in the institution. Through the rounds, open discussion of cases with ethical ramifications is encouraged in a non-threatening way. Like a stone tossed in water, the ripples spread throughout the institution.

Ethics Consults

Armed now with training in ethical theory and practice in examining its own experience, the committee can offer ethics consults. If there are no skilled personnel in this field, it is wise to send some of the committee members to an academic center where consults are done for a fellowship (Hill 1994). Members of the committee may also function as a "committee of the whole," and develop rotations for an ethics consult service, and then ask the committee to conduct a retrospective case review. When cases are reported to the committee by the consult service, there is time to analyze in detail the assumptions and principles used to resolve the case, along with the other practices in the institution. This can lead to very concrete problem-solving for the future, as well as to formulation of important practice guidelines proposals.

All ethics consults are recommendations to physicians and patients, not directives. Ethics consults and reviews by the committee are all ancillary activities to the primary doctor-patient relationship. Both patients and doctors are free to accept or reject the advice. A physician who has called upon a committee for help may fear legal liability if he or she refuses to follow the committee's advice. This question about the role and scope of ethics committee deliberation about a case is still in its infancy. Some states have laws that grant immunity from prosecution for decisions made with consultation of an ethics committee (Fleetwood and Unger 1994). Usually, however, consults are requested to gain a second opinion about hunches both the doctor and the patient or family already have. Sometimes there is an authentic conflict that cannot be resolved. The guiding principle is to resolve ethical dilemmas as

close to the bedside as possible (Thomasma,*Cambridge Quarterly* 1992). Rarely do patients and/or families request a review by the whole committee.

One of the disputes about ethics consults revolves around whether or not the medical model of consulta-

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tion should be used. John LaPuma and David Schiedermayer have recently published the best book on ethics consults in the field, but fall victim to the notion that ethics consults should be offered by physicians in the context of making an independent assessment of the medical diagnosis and treatment (1994). In a review of the book, Robert Nelson writes

> One weakness of the "medical" model of ethics consultation is its tendency to reinforce the impression that ethics is predominantly a technical enterprise in the application of knowledge and skills to practical problems. It is debatable whether the ethical knowledge available to the clinical consultant can be applied in this manner, as opposed to a model which would emphasize the consultant's ability to interpret and perhaps negotiate conflicting values (Nelson 1994).

Another, more ancient, dispute concerns the role of an ethicist at the bedside. Is there a social warrant for such activity (Thomasma 1987)? How can philosophy help in practice (Thomasma, *Clinical Med Ethics* 1991)? Still another has to do with reimbursement for clinical ethics consults (LaPuma 1993). Should payment be made? If so, should the patient have to make it, or should the hospital pay for what may, in the end, improve its patient care and perhaps even save it money? Research on this issue is plentiful (Day 1994; Fry-Revere 1994).

In addition to the goal of helping physicians and patients make decisions, the goal of ethics consults is to gain clinical prudence, a quality of reasoned and sensitive decision making that the whole committee can share (Stevens and McCormick 1994). This prudential judgment grows in sophistication with experience. It is discerned in the quality of setting priorities; immediacy in detecting the important from the unimportant, sensitive and empathetic concern for families, patients and their caregivers; and the honesty and probity of the analysis itself. We often wish things were different in our institution and can be embarrassed by actions that seem to contradict what we value. Yet we cannot progress by denying a problem or failing to confront its causes.

Inductive Policy Development

Perhaps the most revealing inductive experience of ethics committees is the growing awareness of how medical technology has a life of its own (Hewa 1994). Even though committee members have more than likely affirmed the twentieth century mantra: "We don't care as persons anymore; our technology gets in the way," the clinical experience puts flesh on the concept. Members come to understand how interconnected our technological prowess is to our failings to properly care for persons at the bedside, particularly those who are dying. As Eric Cassell argues, this problem is actually one of misplaced power and domination (1993).

The Baby K case in Virginia is a good example of the extreme forms such technological capacity takes. The Virginia courts gave this anencephalic baby, at the mother's demands, the right to be on a respirator, despite the fact that the baby will eventually die of its neurological deficits. Most of the journals and bulletins for ethics committees carried accounts of the case (*Hospital Ethics* 1994; Norris 1994). An argument for the court's decision pointed out that the baby's apnea was potentially reversible, and that she could come on and off the respirator as a result. Many other issues entered the case, including the rights of the disabled, the EMTALA law requiring hospitals to provide stabilizing care, and anti-discrimination laws (Michel 1994).

Robert Veatch argued that although he would never recommend putting such an infant on a respirator, the mother had a right to request it based on her autonomous, surrogate decision-making powers By contrast, most ethics committee members, having experienced cases in which technological futility ruled over calmer and better judgments at patients' bedsides, would be cautious about offering such care to a dying child. Formulating a practice guideline for anencephalic treatment would facilitate similar, future cases.

Earlier I mentioned research on consultation models and activities. Ethics committees should conduct research on the issues they face as well as on their own effectiveness (Day et al. 1994). An example of an issue in need of research is the enduring problems with the concept of patient self-determination, especially when it conflicts with traditional medical beneficence (White, Siner and Siegler 1993; Pellegrino and Thomasma 1988). The ethics committee needs to examine the role of the professional's needs and wants in making ethical judgments. Are these legitimate, or should such professionals be self-effacing (Dagi 1992)?

Institutional Conscience and Public Education

A conscience is an internal aid in discerning right from wrong. It impels us to act in one way rather than in another. By inductive learning processes, the conscience of the institution is formed. This conscience is not embodied in the ethics committee so much as in all the employees and staff who try to improve their practice guidelines and patient satisfaction.

The wariness of physicians toward ethics committees led them early on to think the committees should go out of business; Mark Siegler made this argument often. But this is not the case (Thomasma, *APA Newsletter* 1991). The refinement of practices within an institution is an ongoing process. New challenges continuously arise; a "conscience" is never fully formed. The ethics committee should continually examine the nature of different models of the doctor-patient relationship and its impact on institutional practices, as well as assumptions about ethical interactions and about the

nature of the health care enterprise itself (Thomasma 1992; Thomasma 1993; Thomasma and Pellegrino 1994; Loewy, E.H. 1994; Loewy, R.S. 1994).

Furthermore, there is an ongoing need for ethics committees to develop staff and public education programs. Prevention and self-care are highlighted in health care changes. Hospitals and other institutions must begin a thorough public education program directed toward these issues and others. Ethical issues that can be included in on-going programs already in place in eldercare programs, fitness and rehabilitation programs, outcomes research (*Medical Guidelines and Outcome Research* 1994), and the like are the development and completion of advance directives (Emanuel 1993; Emanuel, L.L. 1994). Committees can ask former patients, as well as the current medical and nursing staff, to assist them in developing ethical practice guidelines on particular issues, such as neurological bleeds in the NICU, requests by patients for physician assistance in dying, the allocation of intensive care unit beds, medically futile treatment (Gregory and Cotler 1994), and the like.

Ethics committees should explore the role of the institution in carrying out health care in the community and the role of managed care. Committees need to explore the role of the paying patient in the managed care environment, as well as the institution's policy toward such patients. Is it ethical for institutions to compete with others for such patients (Braithwaite 1993)? Should economic restraints and allocation of health care have a direct impact on clinical decisions (Brody et al. 1991)? What will happen to the concept of medical futility and how will health care reform change the traditional roles of health providers in the institutions (Hadley 1994; Schneiderman, Faber-Langendoen and Jecker 1994)? Discussion of such ethical dilemmas is a good place to begin a public education program by ethics committees (Nairne 1993; Wildes 1993).

Conclusion

An examination of the need for education of the ethics committee reveals many profound and complex processes. These are ongoing, and sometimes exceed expectations of committee members. In all cases, while continuing reading and attending professional meetings, committees do best by examining their own experiences and analyzing them according to some structured reasoning process. This is especially important today since the Joint Commission for the Accreditation of Health Organizations has decreed that each institution must have mechanisms in place to protect patient rights. New standards must be set for ethics committees, particularly since their original design did not include the patient's rights mandate (Mirvis 1994; Iglehart 1994). This challenge alone could determine the design of ethics committee education for many years to come.

Notes

1. Essentially mediation is a formal process in which a neutral party helps conflicting ones resolve disputes. See *Pontis*, published by the Center for Medical Ethics and Mediation.

2. *The Hastings Center Report* contains case discussions; there are also many case discussions embodied in articles published in medical journals. Some journals, like *Cambridge Quarterly of Health Care Ethics* have case analyses and patient stories aimed directly at ethics committees, and others, like *Journal of Clinical Oncology* have just inaugurated "Ethics Rounds" that appear quarterly.

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