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The Ethics of Ethics Committees

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THE ETHICS OF ETHICS COMMITTEES

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It is understood generally that proposals concerning life-sustaining medical care can be divided into two major classifications: substantive guidelines, that specify the kinds of patients from whom treatment either be withdrawn or withheld and for what stated reasons, and procedural guidelines, that emerge from hospital-based interdisciplinary groups that in turn classify health care issues, prognosticate, consult or even make final or ultimate decisions.[1] Termination of care decisions are not medical—but, rather, fundamentally ethical.[2]

> Sound judgments will obviously depend on accurate medical information—good ethics starts with good facts—but the crucial question is usually an ethical one: Is it right to deliberately shorten a patient's life by withholding or withdrawing life-sustaining treatment?[3]

Hospital or institutional ethics committees are still in their infancy. Their importance to patients and their families, health care providers and society, as a whole, cannot be underestimated.[4] Imprecision and lack of consistency in decisionmaking are often seen in the work of these committees. But with a more ready reliance upon ethical principles and constructs and a greater professionalization of the actual committees as but one element in a total hospital ethics *program*, there is every reason to expect a more focused and vital direction for them over the years ahead.

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1. Fost & Cranford, *Hospital Ethics Committees: Procedural Aspects*, in CONTEMPORARY ISSUES IN BIOETHICS 290 (T. Beauchamp & L. Walters eds. 3d ed. 1989).

2. *Id.* at 291.

3. *Id.*

4. Cranford & Doudera, *The Emergence of Institutional Ethics Committees*, in INSTITUTIONAL ETHICS COMMITTEES AND HEALTH CARE DECISION MAKING 15-21 (1984). *See* Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL'Y 23 (1986).

I. TRADITIONAL COMMITTEE RESPONSIBILITIES

In its 1983 Report, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research recommended strongly, as one way in which to review classical decisions within health facilities, the greater use of "ethics committees."[5] Such committees could not only review treatment decisions made on behalf of incompetent, terminally ill patients and conduct reviews of those medical decisions having ethical implications, but could also provide spiritual, psychological or social counseling for distressed family members, physicians and hospital staff members, work toward the establishment of guidelines regarding medical treatment, and sponsor educational programs designed to inform all concerned individuals and the public of the full scope of medical-ethical problem solving for contemporary health care providers.[6] In addition, ethics committees can serve as prognosis committees whose purpose "is to confirm the prognos[es] that no reasonable possibility exists of the patient[s'] return to a cognitive, sapient state."[7]

A. The Prognosis Committee

Generally, the work of the prognosis committee is treated separately from that of the ethics committee. The prognosis committee is potentially more crucial to validating decisions that withhold or withdraw life-sustaining treatment than normal considerations evaluated by the ethics committee. This premise is true, because unanimity amongst the prognosis committee minimizes the work of any other committee. Thus, when a disagreement arises between a personal physician and the family over the diagnosis and prognosis for an at-risk family member or between a court-appointed guardian when no family exists, the matter should be referred to a prognosis committee within the treating institution for a second opinion. Maintained on an *ad hoc* basis and constituted as need arises for each case on its own merit, the committee would be composed of the patient's personal physician and at least two other staff physicians. If a unanimous agreement was reached that no reasonable medical probability existed for the return of the patient to a

5. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE SUSTAINING TREATMENT 160 *passim* (1983).

6. *Id.* at 160-61. *See also* Broudeur, *Toward a Clear Definition of Ethics Committees*, 51 LINACRE Q. 233, 240-43 (1984).

7. Veatch, *Hospital Ethics Committees: Is There a Role?*, 7 HASTINGS CENTER REP. 22, 24 (June 1977). The improvement of intra-institutional public relations is listed as yet another reason for the formation of traditional ethics committees. Fost & Cranford, *supra* note 1, at 292.

rational or functioning state, then the prognosis would be entered in the patient's medical record.[8]

The only function, essentially, of such a committee would be to confirm the diagnosis and the prognosis. It would be this committee's responsibility, and not that of a court, to determine when there was no longer any reasonable hope for recovery for the terminally ill patient. If disagreement among the prognosis committee arose, then the matter would be then sent to a full multi-disciplinary ethics committee for possible resolution instead of being sent to a court for judicial determination. Even if it became necessary for the ethics review committee to review the case, the thorough and professional "preliminary" work of the prognosis committee, reflected in its prior unanimous opinion, would lighten the task of ethical reconsideration considerably.[9]

It has been suggested that the easiest way to avoid the cumbersome machinery of committee decisionmaking would be simply to relieve the physician of responsibility—civil and criminal—for those actions which he might undertake in *good faith* to relieve a terminally ill person.[10] This standard of reasonableness, or good faith, is a well tested and proven mechanism for assessing degrees of responsibility within the law. Although preeminently fair, the current disjointed state of legal, social and medical attitudes is such that a court of definite action, even though acting in good faith, would most surely subject the physician to professional censure as well as civil and criminal liability. To be sure, the indications are clear from a handful of cases and a significant legislative pattern among the states that terminating actions may be rendered by a physician acting in good faith *if* certain defined procedures are followed and approvals granted. But, swift preemptory, good faith actions of a unilateral order, lacking in an historical or evidentiary record of deliberation and consultation, have yet to be approved. Perhaps because of this state of affairs in the United States, Dutch physicians who participate regularly in efforts to assist terminally ill patients with acts of enlightened self-determination or what is commonly termed voluntary active euthanasia, regularly employ a "team" of doctors, nurses and a representative of the patient's faith or religion to counsel and evaluate the validity of requests made by terminally ill patients for relief. These teams also provide a level of protection and cover for the doctor's legal liability if he were ever to be

8. Smith, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?*, 22 U.C. DAVIS L. REV. 275, 412-13 (1989).

9. *Id.*

10. *Id.*

prosecuted.[11] This team has an obvious parallel in the prognosis committee or ethical review committee used in the United States. Of course, the similarity in this procedural mechanism here between the Netherlands and the United States is the only shared aspect—for the national attitude of the Dutch people regarding the right of enlightened self-determination creates an altogether more tolerant and accepting attitude toward death by this means than is evident in the United States.[12]

"What of the nonterminal yet severely suffering patient who can expect little more than years of suffering, incapacitation and personal degradation because of her Elizabeth Bouvia type of condition? Surely, she should have the same rights of self-determination as other less-afflicted citizens."[13] The physically and mentally distressed individual, after receiving a period of psychological counseling, should present his case to an ethics committee, to obtain the required permission and/or assistance in ending his life.[14] Composed of a wide sampling of independent individuals, representing legal, ethical, medical, social, religious and lay interests, the tribunal would be empowered—without interference, consultation or deference to any other interest group, family or otherwise—to decide the issue before it.[15] Ideally, the contrary or opposing position to that taken by the petitioner would be presented by an *amicus curiae*. Assistance should be provided to the person requesting it upon a favorable ruling by the committee.[16] Contrariwise, if the committee rules against the petitioner, the deliberative issue is whether he should be involuntarily committed to a state or other proper institution and retained; thereby hindered from obtaining his goal.[17]

If the individual still wishes to exercise his right of enlightened self-determination after a reasonable period of counseling, should he be enabled by

11. *Id.* at 414. *See* Appleyard, *The Last Appointment*, The Times (London), June 7, 1987, at 13, col. 4 (Sunday ed.).

12. Smith, *supra* note 8, at 414.

13. *Id.* Elizabeth Bouvia was born with severe cerebral palsy and her condition had deteriorated to the point where, at the age of 28, she was bedridden and completely dependant on others for her most basic needs. Her condition was complicated by degenerative arthritis. In spite of her physical disabilities, she was intelligent and competent. Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1135-36, 225 Cal. Rptr. 297, 299-300 (1986). Elizabeth Bouvia sought the removal of a nasogastric tube "inserted and maintained against her will and without her consent by physicians who so placed it for the purpose of keeping her alive through involuntary forced feeding." *Id.* at 1334, 225 Cal. Rptr. at 298.

14. Smith, *supra* note 8, at 414. *See generally* Dagi, *The Ethical Tribunal in Medicine*, in 1 ETHICAL, LEGAL AND SOCIAL CHALLENGES TO A BRAVE NEW WORLD 201 (G. Smith ed. 1982).

15. Smith, *supra* note 8, at 414.

16. *Id.*

17. *Id.*

assistance?[18] In other words, could he request another review by the same or another ethics committee or appeal to the courts for the assistance to actively or passively exercise his right?[19] One author has posited that, before consent is given, the proper authorities should investigate and satisfy themselves that it is "the patient's firm and well considered choice and not the desperate whim of a mood of melancholia and not under pressure from others."[20] In *Bouvia v. Superior Court*,[21] a California court addressed a patient's right of self-determination and reflects evidence of a developing wedge that would recognize the right of rational self-determination regardless of whether the applicant or petitioner is terminal.[22] Elizabeth Bouvia won the right not to be forced fed and to starve herself if she wished.[23] By the court's reasoning, the doctors who of necessity will have to assist her in carrying out her wish (or right to refuse treatment) by maintaining her morphine pump and directing her nursing care are directing the execution of her constitutionally protected right—not assisting in her demise.[24] "If more courts were to see the simple validity of this position, the current state of confusion would end."[25] This enlightenment cannot be expected realistically to evolve quickly, because traditional values about the preservation of "life"—no matter within a degenerative state or not—dictate a response that curtails those who wish to act otherwise and label them as irrational in their thinking.[26]

II. A Contemporary Response and Expansion

Between 1983 and 1985, a survey conducted by the American Hospital Association's National Society for Patient Representatives indicated "that 59% of the nation's hospitals had working ethics committees."[27] Interestingly, the growth of these committees was found to have occurred in those hospitals with over five-hundred beds.[28] In 1985, it was determined that

18. *Id.*

19. *Id.*

20. Smith, *supra* note 8, at 414 (quoting A. Toynbee, Man's Concern With Death 158 (1968)).

21. 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).

22. *Id.* at 1137-46, 225 Cal. Rptr. at 300-06. Smith, *supra* note 8, at 414.

23. *Bouvia*, 179 Cal. App. at 1146, 225 Cal. Rptr. at 307; Smith, *supra* note 8, at 414. *See generally* G. Smith, Final Choices: Autonomy in Health Care Decisions (1989).

24. Smith, *supra* note 8, at 414-15.

25. *Id.* at 415.

26. *Id.*

27. McCarrick & Adams, *Ethics Committees in Hospitals*, Scope Note at 1 (1989). This article was published by the National Reference Center for Bioethics Literature, Kennedy Institute of Ethics, Georgetown University, Washington, D.C. 20057. It was originally prepared in 1983 and has been revised to accommodate the changing face of ethics committees.

28. *Id.*

sixty-seven percent of all teaching hospitals actually utilized ethics committees. Eighty-six percent of these were considered as regular committees, rather than *ad hoc*, with meetings being conducted on an average of seven times during each year.[29]

The questions typically posed to the committees for their study and consideration were of six types: the need for no code or do-not-resuscitate policies; the allowance or the disallowance of life-support systems; the definition of brain death; informed consent; human experimentation research limitations; and the development of educational programs regarding the scope and complexity of ethical decisionmaking in medicine.[30] Interestingly, the vast majority of existing ethics committees view themselves *not* as primary decision makers, but rather as consultants, advisors, and informational and consensus developers.[31]

Committee membership is normally composed of a physician, nurse, social worker, attorney, member of the hospital administration, a clergyman, advocate for the handicapped, and a medical ethicist.[32] In certain individual cases, the committee can be expanded to include persons involved directly—family members or their proxies, the attending physician, primary nurse or perhaps a clergyman who best knows the at-risk patient.[33] It is considered wise to have at least one member of the committee be an uninterested member of the community at large who has no interest or ties to the hospital itself.[34]

III. FRAMEWORKS FOR PRINCIPLED DECISIONMAKING

Various constructs or models of ethical decisionmaking have been suggested as operational frameworks through which ethics committees may conduct their business.[35] One model, denominated the teleological model, seeks to focus decisionmaking processes on the specific goals of the particu-

29. *Id.* With the exception of several psychiatric hospitals, none of the regular hospitals in England have ethics committees. Apparently, among British medical circles, the prevailing attitude is that physicians should have complete clinical autonomy and their autonomy should not be diluted by the authority of ethics committees. Lloyd, *Ethics Committees in England*, 18 HASTINGS CENTER REP. 2 (Oct. 1988).

30. McCarrick & Adams, *supra* note 27, at 2.

31. Fost & Cranford, *supra* note 1, at 292. The authors note that, "[e]ven if a committee were consultative and had no decision-making authority, it needs to be legitimized by the hospital leadership." *Id.*

32. *Id.* at 293.

33. *Id.*

34. *Id.*

35. R. CRAIG, C. MIDDLETON & L. O'CONNELL, ETHICS COMMITTEES: A PRACTICAL APPROACH 42-51 (1986) [hereinafter A PRACTICAL APPROACH].

lar health care institution where the committee is in place.[36] After the patient problem has been identified, alternatives are listed for resolution of the problem according to the facility's goals.[37] For each alternative, a value is then assigned or a degree of completion charted to the goal achieved.[38] Then, a selection of the alternative(s), with the highest value for self-realization of patients and staff alike, is made.[39]

In the second type of approach to ethical problem solving, the formalistic or deontological construct, responses to ethical life are viewed primarily "in terms of laws, duties and obligations."[40] Here, principles—not goals—are determinative in analyzing the propriety of an action.[41] Accordingly, the correctness of an act is to be viewed as flowing from an individual's intention to do what, in principle, is right.[42] Under this ethical model, actions undertaken in conformity with a stated ethical principle (e.g., doing one's duty) are the linchpins to leading an ethical or good life.[43] Thus, for example, some physicians attending a dying patient might well perceive their primary duty as maintaining that patient's biological life at all costs.[44] Other similarly situated physicians could—contrariwise—perceive their duty as one to allow the patient to die with dignity.[45] Admittedly, scenarios of this type may well lead to a conflict of duty, with difficulty being encountered in discerning which principle has a given priority over another based on formalistic criteria.[46]

Another model is referred to as personalistic and is considered generally as complex and difficult to both explain *and* utilize.[47] Essentially it is concerned with assuring the personal development of each health care facility employee *as well as* each patient within a given health care community.[48] Utilizing this model forces a consideration of four assumptions concerning the human being: that all persons are not only unique, but should be viewed as relational beings (they are called to be in relationship with others); that

36. *Id.* at 42.
37. *Id.*
38. *Id.*
39. *Id.* at 42-43.
40. *Id.* at 43.
41. *Id.*
42. *Id.* at 44. "Thus formalist physicians who refuse to participate in direct abortion do so, not because of the consequences or the nature of the act itself are wrong, but because they would not be fulfilling their duty to uphold a certain principle." *Id.*
43. *Id.*
44. *Id.*
45. *Id.*
46. *Id.*
47. *Id.* at 46.
48. *Id.*

they are also unified and transcendent.[49] Accordingly, under this construct, an ethics committee would be concerned with the positive development of each person within the particular health care facility and emphasize those procedures that enhance this type of development.[50] Acknowledging the patient's right to be involved in treatment decisions, the medical staff would be viewed as but clinical resource individuals who aid the patient in the decisionmaking process.[51]

A fourth model, characterized as integrative, involves nine separate steps that an ethics committee would undertake.[52] The committee must focus narrowly on *real* problems presenting *significant* issues.[53] Policy decisions, to be reliable, must in turn be based on several alternatives. A tolerant attitude toward conflicting viewpoints must be engendered within the committee. The second step is the identification of alternatives; the third requires selection of the most relevant alternatives.[54] These alternatives are subsequently evaluated in consequence of the stated goals of the health care facility.[55] Restraint should be exercised in discounting alternatives because they are either unpopular or difficult.[56] The fourth step involves an examination and weighing of the value of each alternative in terms of universal ethical principles.[57] After consideration of the pertinent ethical principles comes an evaluation of ethical principles themselves.[58] Thus, in a Roman Catholic health care facility, for example, the controlling principles are evaluated according to three major sources of moral insight: sacred scripture and tradition, personal experience, and culture.[59] The sixth step in the integrative model posits a two-prong question to be asked by the committee: What will be the short-term consequence of a particular policy enunciated by it in one case and, what are the long-term consequences?[60]

The seventh step then forces the committee members to examine, in light of the health care facility's goal or goals, the long term and short term consequences of its actions.[61] A short-term effect may often have to be sacrificed

49. *Id.*
50. *Id.*
51. *Id.*
52. *Id.* at 47-50.
53. *Id.* at 47-48.
54. *Id.* at 48. "Alternatives are not always mutually exclusive. . . . Administrative harmony is derived through a consideration of conflict." *Id.*
55. *Id.*
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.* at 49.
60. *Id.*
61. *Id.*

because of its long-term consequence. "A policy that merely meets an immediate need may be deceiving since it may turn out to be a long-term disaster."[62] In the next step, the committee makes a determination of their best alternative to follow *vis-a-vis* not only the goal(s) at issue and the short term and the long term consequence of the policy determination, but the impact of this selection of *all* persons involved.[63] Finally, in implementing the decision, three more questions must be answered by the committee: who has to know about the decision, what actions must be followed in order to execute the decision, and who has to take the action?[64]

The fifth and final construct for consideration or, as the case might be, implementation by an institutional ethics committee, is recognized as the utilitarian model.[65] It is the most practical and straightforward of the other four constructs and the one most easily adopted by a committee for practical use. While imprecision and duplicitous steps are hallmarks of the other models, this final model does—to the degree any one can when dealing with ethical conundrums—solidify a very strong and basic principle of cost-benefit analysis.[66] And, of necessity, a qualitative measure of reasonableness is mandated in all considerations here. Thus, the quality-of-life result of any conclusion by the committee must be weighed against the economic costs of its actions.[67]

Cost-benefit analysis is, of course, situational and cannot be preordained by an unyielding *a priori* ethic.[68] Love, compassion and humaneness should perhaps be the primary constants in all deliberations of hospital ethics committee using this construct of ethical decision making or, for that matter, any of the other four. If these constants control, then the economic realities, consequences or impacts of committee decisions will be in equipoise with them because a humane and compassionate attitude that rejects, for example, the prolongation of life for a terminally ill patient is economically sound as well.

Under the utilitarian model, the controlling premise is that an act is good

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62. *Id.*

63. *Id.*

64. *Id.* This step is important since, once agreed upon, other persons will be responsible for implementing the policies. *Id.*

65. *Id.* at 44. "Utilitarianism is based on calculating the greatest good for the greatest number of persons. Thus acts that result in the greatest possible good for the most persons in a given situation are judged to be good actions." *Id.*

66. *Id.* at 44, 45.

67. Smith, *Quality of Life, Sanctity of Creation: Palliative or Apeotheosis?*, 63 NEB. L. REV. 709, 732 *passim* (1984).

68. Smith, *Death Be Not Proud: Medical, Ethical and Legal Dilemmas in Resource Allocation*, 3 J. CONTEMP. HEALTH L. & POL'Y 47, 59 (1987).

and meritorious if it promotes an increase of pleasure or good over pain for a majority of members in a defined community.[69] Accordingly, individual interests may be sacrificed if an act is seen as a benefit to the community as a whole.[70] Thus, if fetal research and experimentation are promotive of not only better health care but prevention of disease among children, then this action would be held to be morally justifiable simply because the consequence of its pursuit is taken as positive.[71]

A schematic, self-explanatory diagram illustrates the steps taken when an institutional ethics committee utilizes the utilitarian model as an aid to deliberations. Its integrity as a tool for decisionmaking is sustained by its relative simplicity of application.

The Utilitarian Model

1. Perceive the problem.
2. List Alternatives.
3. Make choice.
4. Frame an ethical statement.
   a. Conditions
   b. Who
   c. What
5. List consequences.
   a. Immediate
   b. Long range

For each consequence,

6. Scan list of personal values;
7. Compare consequences with values;
8. Examine this in light of the greatest good (that which increases pleasure over pain);
9. Make decision after possible consequences are decided.[72]

The seemingly complex, and overlapping textures and subtleties of all five of these ethical decisionmaking constructs ensure that the actions of the committee members will be measured and not careless. Careful thought and deliberation will attend every step in the evaluative process. Appraisal and reappraisal become the watch words. Given the heavy consequences that devolve from decisions made by hospital ethics committees, perhaps it is totally proper for these ethical models to be viewed as obscure and even obtuse by those *not* participating in the process, but understood as *guidelines* for those actually involved in the dynamics of committee decisionmaking.

69. A PRACTICAL APPROACH, *supra* note 35, at 44.
70. *Id.*
71. *Id.*
72. *Id.* at 45.

To the extent possible, ethics committee should employ a consensus model of decisionmaking.[73] Thus, policy recommendations should be committee decisions.[74] It will be of no assistance to the total decisionmaking process within the health care delivery system if the work of the ethics committee is avowed by some members and disavowed by others.[75] Indeed, in such cases, it will become useless and a needless burden to be avoided.[76]

IV. THE FLETCHER PROPOSAL

Dr. John C. Fletcher, Director of the Center for Biomedical Ethics and Professor of Religious Studies at the University of Virginia, views the ethics committee as but one forum designed not only for resolving first order medico-ethic dilemmas in clinical care, but, equally important, for serving as a core or magnet from which sophisticated, on-going educational and ethical consulting services may be provided.[77] Indeed, for ethics committee and consultation to be totally effective, it should be viewed as but one of four or five elements in a *total* hospital ethics *program*.[78] The first element in the program is an official, institutionally supported hospital ethics committee, with the second being a clinical ethics education program for not only members of the hospital's professional staff, but for students and members of the community at large as well.[79] The third programmatic element is provision for ethics consultations on request, for cases either of a prospective or retrospective nature, with the fourth providing for access to the resource persons having advanced education in biomedical ethics and health law.[80] Finally, for total program effectiveness, steps must be taken to assure that allowance is made for an adequate evaluation of the four preceding elements of the program.[81]

Under Dr. Fletcher's sound and creative proposal, the hospital ethics committees mandate is expanded by the provision for consultation delivery that allows the committee to act as consultant under chairmanic leadership

73. Broudeur, *supra* note 6, at 245.
74. *Id.*
75. *Id.*
76. *Id.*
77. J. Fletcher, How to Start or Strengthen Ethics Consultation Services. Paper presented at the Third National Conference on Ethics Consultation in Health Care, St. Louis, Missouri (Sept. 10, 1989) (available in the office of the Journal of Contemporary Health Law and Policy). This work will appear in the PROCEEDINGS OF THE SECOND NATIONAL CONFERENCE ON ETHICS CONSULTATION IN HEALTH CARE (1990) and appeared under the title, *Ethics Consultation Services: An Overview*, in 6 BIOLAW (Jan./Feb. 1990) (in press).
78. *Id.* at 2.
79. *Id.* at 8.
80. *Id.*
81. *Id.*

(who normally is, in actuality, the contact person for consultation) or utilize a sub-group of committee members specializing in consultation (and relying upon the whole committee when a forum is needed).[82] Additionally, the committee may delegate the availability of around-the-clock ethics consultation to a properly designated ethics consultation service with either totally different, or perhaps some overlapping, members from the primary hospital ethics committee, and with this service in turn acting on behalf of the hospital ethics committee and reporting fully to it.[83] Finally, the committee may delegate ethics consultation to one or more individuals.[84]

Since physicians, nurses and other clinicians in a health care facility are the major resources for the institution to not only identify but actually assist in routine ethical problems that arise daily in clinical care situations, an educational program in clinical ethics for the professional staff is vital.[85] Such a program would, of necessity, include study of the most frequent ethical issues in clinical care:

1. Major breakdown in communication.
2. Truth-telling and disclosures dilemmas.
3. Privacy/confidentiality.
4. Determining capacity of patients.
5. Informed consent to treatment.
6. Refusal of treatment.
7. Foregoing life-sustaining treatment.
8. Terminal illness.
9. Access to health care.
10. Controlling costs of health care.
11. Allocation of health care resources.[86]

In structuring an institutional policy that not only defines the goals, functions and responsibilities of the hospital ethics committee, care must also be given to achieving the same for ethics consultation.[87] Such an institutional policy or consultation should incorporate seven features: provide an unequivocal statement that supports an educational program for clinicians as the central, or front line, resource persons within the specific health care provider institution; encourage all clinical staff members to request ethics consultation under defined circumstances; fully protect from intimidation any and all who seek an ethics consultation; set forth an ethically and legally correct manner to receive request for ethics consultations; adopt a protocol

82. *Id.* at 9.
83. *Id.*
84. *Id.*
85. *Id.*
86. *Id.* at 10.
87. *Id.* at 11.

for ethics consultation; formalize an institutional policy of not billing patients directly for ethics consultations but instead factoring in salary and support facility costs into patient charges; and, finally, build into the policy a structure for maintaining accountability within the process of ethics consultation.[88]

Since an ethics consultation service (ECS) is a complement to the ethics committee, the service should report to the committee directly.[89] Clinicians should be encouraged to obtain assistance from the ECS when either the best efforts to resolve the particular problem have reached an impasse, the problem raises strong disagreement among the attending health care providers or the case is ethically very complex.[90] Ideally, the ECS would also be available for consultation on ethical problems arising from clinical research efforts.[91]

V. CONCLUSIONS

Generally, the traditional ethics committee will be forced primarily to evaluate terminal care clinical cases and should adhere to its central most ethical responsibility: the promotion of patient autonomy.[92] Other committee work may evaluate basic tenets of justice, of social ethics, and resource allocation.[93]

> Only in those rare cases where the patient is incompetent and the patient's agent appears to have exceeded the limits of reason will a committee possibly find for itself a limited role in making a decision to try to benefit the patient. Even here it will not be to directly overrule the patient's agent, but to determine whether the hospital should initiate a formal judicial review of that decision.[94]

A set of ethical principles or a more structured framework for principled decision making is a *sine qua non* for an effective (clinical) institutional ethics committee to work.[95] To this end, the five ethical constructs for decision making presented and evaluated in this essay allow ethics committees to work toward the goal of humane justice and measured efficiency. These models or constructs are often imprecise and duplicative in their various

88. *Id.* at 11-12.
89. *Id.* at 13.
90. *Id.*
91. *Id.* at 15.
92. Veatch, *An Ethical Framework for Hospital Committees*, in CONTEMPORARY ISSUES IN BIOETHICS 298, 300 (T. Beauchamp & L. Walters eds. 3d ed. 1989).
93. *Id.* at 301.
94. *Id.* at 303.
95. *Id.*

analytical steps. They nonetheless provide some structure or balance to stabilize the ethics of ethics committees.

The focus and stability of ethics committees would be enhanced greatly if they were to be recognized as but one element in a total hospital ethics *program*. Posited as such by Fletcher,[96] a program of this nature would operate around the central ethics committee and thereby have a far greater outreach and on-going educational component than ethics committee can now, as presently utilized, either aspire to or achieve.

In the final analysis, one hopes that ethics committees can provide a meaningful way for patients and families to resist manipulation from health care providers in critical areas regarding treatment or nontreatment as the case may be,[97] and thereby afford them real choices to their dilemmas. If this result is achieved, the committees will have indeed provided a meaningful avenue for exercising informed rights of consent, autonomy[98] and self-determination for patients and families alike[99]—with the entire health care community made stronger and more compassionate as a consequence of the noble work of ethics committees and ethics consultation services.

96. *See supra* note 77. *See generally* ETHICS CONSULTATION IN HEALTH CARE (J. Fletcher, N. Quist & A. Jonsen eds. 1989); Fletcher, *Goals and Process of Ethics Consultation*, 2 BIOLAW S37 (1986).

97. J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 214 *passim* (1984).

98. Pellegrino & Thomasma, *The Conflict Between Autonomy and Beneficence in Medical Ethics: Proposal for a Resolution*, 3 J. CONTEMP. HEALTH L. & POL'Y 23 (1987).

99. Levine, *Hospital Ethics Committees: A Guarded Prognosis*, 7 HASTINGS CENTER REP. 25, 27 (1977).