Maryland Law Review

Volume 50 | Issue 3 Article 9

Institutional Ethics Committees: Proceed with Caution

Jonathan D. Moreno

INSTITUTIONAL ETHICS COMMITTEES: PROCEED WITH CAUTION

JONATHAN D. MORENO*

INTRODUCTION

I come as a friendly critic of ethics committees. Indeed, as one who has been a member of several ethics committees and has consulted for a number of others, I am in no position now to disassociate myself from this fascinating phenomenon, nor do I wish to do so. But I do want to introduce a series of cautionary notes. In general I hold the following to be the case about ethics committees: They are poorly understood; their historical precursors should give us pause; they are subject to the usual problems of bureaucratic entities called committees; and if mandated by legislation, their strengths are likely to be undermined.

I. UNDERSTANDING ETHICS COMMITTEES

Ethics committees are poorly understood in two senses: there is widespread misunderstanding about them, and it is not clear what it would mean to understand them correctly. Partly this is because ethics committees were born in ambiguity. The term "ethics committee" was first used in its current meaning by a doctor in an article that attracted little attention at the time.[1] It was picked up and applied erroneously by the justices in *In re Quinlan*[2] who were evidently referring to prognosis review.[3] Conversely, when promulgating its "Baby Doe" guidelines in the early 1980s, the Department of Health and Human Services piggy-backed on the concept, eschewed "quality of life decision-making," and changed the name, preferring the more innocuous "infant care review committee."[4] With this history

---

* Ph.D., Professor of Pediatrics and Medicine and Director of the Division of Humanities in Medicine, State University of New York Health Science Center at Brooklyn, New York. I am grateful to Gail Povar, M.D., for comments on a previous draft.

1. *See* Teel, *The Physician's Dilemma: A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6 (1975).

2. 70 N.J. 10, 49-51, 355 A.2d 647, 688-69, *cert. denied*, 429 U.S. 922 (1976).

3. *See id.* at 51, 355 A.2d 647, 649; *see also* J. ROSS, HANDBOOK FOR HOSPITAL ETHICS COMMITTEES 6 (1986).

4. *See* Procedures Relating to Health Care for Handicapped Infants, 45 C.F.R. § 84.55 (1984). For an overview of the issues related to the "Baby Doe Rule," see generally Moreno, *Ethical and Legal Issues in the Care of the Imperiled Newborn*, 14 CLINICS IN PERINATOLOGY 345 (1987).

it is no wonder that the decade-old ethics committee movement is still trying to figure out what it is about. As Alex Capron has recently pointed out, if ethics committees are to give incompetent patients the protection some courts want them to, judges must give them substantive instruction about what counts as "reasonable" procedures for them to follow.[5]

I imagine that that comic wordmaster George Carlin would have a field day with the term "ethics committee." If we need committees to tell us right from wrong, some might say, we are in real trouble. Still, if we have learned anything from modern medical ethics, it is that good and well-informed people may differ on specific occasions of ethical choice. Perhaps if we get these people together around the same table they can reach a consensus. But then what is the moral significance of their consensus? Isn't the great lesson of the twentieth century that moral consensus can lead to disastrous inhumanity?[6] That about which we agree is not necessarily that about which we ought to agree, as Plato took pains to point out.[7] Imagine we leap this profound and largely ignored philosophical hurdle. I believe we may do so by developing sophisticated arguments that refer to Aristotle's concept of "practical wisdom"[8] or John Dewey's concept of "social intelligence."[9] On the whole, however, we lack a coherent theoretical framework that could provide a philosophical foundation for ethics committees.[10]

Perhaps the very use of the term "ethics" is gratuitous in this context. In my experience, these committees most often search for an accommodation among conflicting claims, using as guidelines general ideas such as respecting the wishes of the patient. (Fortunately), their deliberations resemble an Oxford seminar on moral philosophy far less than they do a clinical case conference. Their discussions not only involve moral questions, but also administrative procedures and legal opinions.[11] On the whole, it is hard to tell why they might not just as well be called "clinical dispute resolution committees."

---

5. *See* Capron, *The Burden of Decision*, HASTINGS CENTER REP., June 1990, at 36, 41.

6. *See infra* text accompanying note 16.

7. *See* PLATO, THE REPUBLIC 221-34 (Cornford trans. 1941).

8. *See* INTRODUCTION TO ARISTOTLE 304 (R. McKeon ed. 1947).

9. *See* J. DEWEY, LIBERALISM AND SOCIAL ACTION 69 (1963).

10. *See generally* Moreno, *Ethics by Committee: The Moral Authority of Consensus*, 13 J. MED. & PHIL. 411 (1988); Moreno, *What Means This Consensus? Ethics Committees and Philosophic Tradition*, 1 J. CLINICAL ETHICS 1, 38 (1990).

11. *See* Macklin, *The Inner Workings of an Ethics Committee: Latest Battle over Jehovah's Witnesses*, HASTINGS CENTER REP., Feb.-Mar. 1988, at 15.

Part of our problem is a dreadful lack of information about the activities of these committees, the backgrounds of their members, and the rules governing their functioning. Knowing little about how they are similar or different from one institution to another, it is hard to formulate reasonable standards of quality. What counts as an excellent ethics committee? One that is called upon for case review frequently or infrequently? One that is highly visible in the institution or one that works behind the scenes? One that takes clear positions and offers advice freely to staff physicians or one that prefers to remain neutral and assist in a negotiated settlement? One that is viewed by health care providers as friendly and supportive of their problems or one that is seen by patients as friendly and supportive of their problems?

For the most part, existing literature fails to ask or answer these questions;[12] perhaps some of them are not even all that important. But even more fundamental areas of uncertainty persist. For example, why is multidisciplinary representation so important? According to what criteria should members be chosen? Should all members have access to the patient's name and records, even if the patient declines to have his or her case heard by the committee? Does admission to a hospital imply willingness to receive the ministrations of the ethics committee? The ethics committee has an obligation to be concerned about the well-being of many parties: the patient, the institution, the medical staff, the community, and others. How are these obligations to be balanced? Surely no ethics committee properly-so-called can avoid this question.

About ethics committees, little is known and less is understood; Professor Hoffmann's study is an enormous service.[13] I have not even addressed the confusion and resentment ethics committees elicit among many physicians, who have been brought up to think of "good doctors" as those who are both technically proficient and morally virtuous. Legal mandate will not necessarily engender more cooperation from that quarter, and could even drive problems underground. But I am getting ahead of my story.

---

12. *But see* Povar, *Evaluating Ethics Committees: What Do We Mean by Success?*, 50 MD. L. REV. 904 (1991).

13. *See* Hoffmann, Does Legislating Hospital Ethics Committees Make a Difference?: A Study of Hospital Ethics Committees in Maryland, the District of Columbia, and Virginia (1991) (to be published in a forthcoming issue of *Law, Medicine & Health Care*) (unpublished manuscript on file with *Maryland Law Review*).

II. THEIR ANCESTORS

The historical precursors of ethics committees should give us pause. I believe it was Voltaire who once said facetiously, "Everyone up to the present generation was an idiot." We do have an annoying tendency to denigrate our antecedents as quaint and amusing, when we are not absurdly promoting them to superhuman status. When an ethics committee insists that the patient's voice must be heard and respected, that seems right to me. How will that seem twenty-five years from now? Twenty-five years ago, well-meaning people in places like New York and Seattle decided who should have access to kidney dialysis when the machines were new and in short supply.[14] Even they came to see their inclination toward middle-class patients with backgrounds similar to theirs as troubling.[15] Ninety years ago and less, groups of physicians selected some mentally disabled women as appropriate candidates for abortion, as part of an American eugenics movement with broad popular support that informed Adolph Hitler's *Mein Kampf*.[16]

But, of course, proponents of ethics committees will reply indignantly that it is just such experiences that gave rise to modern bioethics. The horrors of institutionalized genocide warrant the establishment of ethics committees as well as institutional review boards, to protect the individual.[17] But I maintain that an apparently trivial new element in a situation can result in an imperceptible shift in self-awareness. The tragedy is that we might not be cognizant of what has happened to us until much later. For example, the over-full intensive care units in our large urban hospitals encourage us to find alternative arrangements, including limiting treatment, for those unlikely to benefit from intensive medicine. On the whole this seems to me a sensible and even overdue approach, but in the future, this solution to the problem of overcrowding may be characterized as moral blindness.

Nevertheless, the fact remains that under conditions of uncertainty, health care professionals, and physicians in particular, frequently must make decisions that will not wait for the wisdom of the ages. My argument here does not advocate ethical relativism, but

---

14. For a discussion of the Seattle selection committee, see Alexander, *They Decide Who Lives, Who Dies*, LIFE, Nov. 9, 1962, at 102.

15. *See id.* at 127.

16. For a discussion of the American eugenics movement and its relation to Nazism, see R.J. LIFTON, THE NAZI DOCTORS (1986).

17. *See* Fletcher, *The Bioethics Movement and Hospital Ethics Committees*, 50 MD. L. REV. 859 (1991).

provides a reminder that collective moral perception is far from foolproof. There is no refuge in the defense that ethics committee decisions are merely advisory: given the right political arena, advice can be difficult to ignore.

III. BUREAUCRACY

Ethics committees are subject to the usual problems of bureaucratic entities called committees. Clearly no moral invulnerability is conferred upon ethics committees simply by virtue of the name bestowed upon them. Institutional politics and the intricacies of small group relations cannot be barred at the door of the conference room. Committee membership will not be sought only by those with a deep interest in the scholarly literature of medical ethics and an abiding commitment to the promotion of autonomy. Some who are motivated by unvarnished self-interest will seek to join, mainly to ensure that they know whose ox is being gored. Others will long for the halcyon "good old days" when doctors gave orders for the good of patients, and patients did not come to the consulting room with a lawyer's business card in their pockets. These people will want a role, not because they are venal, but because of skepticism about this patient self-determination business. Still others will be neither self-interested nor curmudgeonly, but simply clumsy, self-righteous, or both.

In our institutional life we tolerate all of these inadequacies in the committee system. Why should we expect ethics committees to be any different? The answer is that ethics committees are likely to be subject to a higher level of scrutiny than other functional bureaucratic agencies in a health care organization, or at least they should be held to a higher standard. Cynicism and idealism already coexist uneasily in modern hospitals. Although they represent divergent attitudes toward public life, they are separated by a fine line. An ethics committee that is perceived within the institution's rank-and-file as anything but an exemplar of judiciousness and probity is likely to be a greater liability than is the absence of an ethics committee.

Some bioethical writers have urged that ethics consultants may provide a superior solution to the problems that give rise to the creation of ethics committees.[18] As individuals, ethics consultants cannot so easily hide behind the veil of consensus, and they can be

18. *See* Ackerman, *Conceptualizing the Role of the Ethics Consultant: Some Theoretical Issues*, in ETHICS CONSULTATION IN HEALTH CARE (J. Fletcher, N. Quist & A. Jonsen eds. 1989);

expected to be truly expert in the growing literature of the field. The main advantage of the ethics consultant is greater accountability, but I am afraid that we know nearly as little about what the ethics consultant should be doing as about what the ethics committee should be doing. Further, there are probably fewer competent ethics consultants around than there are admirable ethics committees. Finally, the danger that physicians will be tempted to pass off every touchy situation to the hospital ethicists may be greater than if the alternative is the more formidable process of committee review.

If I am correct that ethics committees will, or at least should be, held to a higher standard than other committees in the health care organization, we must start to pay attention to the quality of ethics committee deliberation. This is especially important for those committees that are staffed largely by busy clinicians, to whom one hour a month is a substantial commitment. In trying to enhance the quality of committee functioning, we should refer not only to writings and principles in bioethics and health law, but also to the contributions of social psychology and management theory professionals. These are the people who know something about small group behavior and integrating the official role of an authorized committee into the dynamic everyday life of the institution.

For example, socio-psychological evidence suggests that the quality of consensus decisionmaking can be improved if certain simple procedural rules are followed.[19] What is called in that literature a "vigilant" decisionmaking strategy[20] includes the following steps: Obtain as much information as possible about the alternatives; thoroughly discuss the value of each alternative; after evaluating the alternatives, rank them according to the most and least desirable; if there is an unranked middle-range of alternatives, discuss and rank them; and systematically reconsider the rank assigned to each alternative, without hesitating to change a rank if that is warranted. Clearly this sort of systematic procedure would have to be adapted to fit the unique role of the ethics committee. For instance, one alternative the committee will want to consider from time to time is that of giving no advice at all.

It is worth noting that the potential contributions of the social sciences to ethics committees are appreciated in other parts of the

---

Ackerman, *Moral Problems, Moral Inquiry, and Consultation in Clinical Ethics*, in CLINICAL ETHICS: THEORY AND PRACTICE (B. Hoffmaster, B. Freedman & G. Fraser eds. 1989).

19. *See* Hirokawa, *Does Consensus Really Result in Higher Quality Group Decisions?*, in EMERGENT ISSUES IN HUMAN DECISION MAKING (G. Phillips & J. Wood eds. 1984).

20. *See id.* at 41.

world. In Argentina's most important center for medical humanities, the Mainetti Foundation, role playing is used to train new members of ethics committees throughout South America.[21] Applied social science can be a powerful ally of applied ethics.

IV. LEGISLATING ETHICS COMMITTEES

If mandated by legislation, the strengths of ethics committees are likely to be undermined. In light of the foregoing discussion, the reader may be surprised to learn that I think ethics committees do have strengths. In my experience, these committees tend to function best when, among other conditions, they emerge from the felt needs of the professional staff. A related factor is that the very ambiguity inherent in the role of such a committee can work to its advantage. I believe that, paradoxically, the relative clarity of role that follows from the external imposition on the institution of a particular committee structure gives the ethics committee less room to manuever, and stirs up the sorts of anxieties that commonly greet new regulation of the health care system.

The most important feature of the ethics committee idea is that hospitals increasingly are prepared to recognize that moral questions are part of the very tissue of modern health care. Though partly prodded by fear of lawsuits, our health care institutions largely have come to this recognition for sound intellectual reasons. My greatest concern is that legally mandated ethics committees will be seen as yet another instance of state intervention backed up by the attorney general's office, or as an extension of risk management. In my experience, Americans are unable to appreciate the distinction between the legal and the ethical, and such regulatory requirements do not help to sharpen the distinction in the public mind.

From this point of view, proposed federal requirements tied to Medicare would present additional dangers.[22] Surveys indicate that Americans, especially elderly Americans, are deeply suspicious of the motives of health care providers, and are highly sensitive to explicit government efforts to limit treatment.[23] Even if ethics com-

---

21. *See* Centro Oncológico de Excelencia, Hospital Ethics Committees, Course 1 (Sept. 21-23, 1989) (pamphlet describing hospital ethics committee coordinator training course) (copy on file with *Maryland Law Review*).

22. *See* Kinney, *Setting Limits: A Realistic Assignment for the Medicare Program?*, 33 ST. LOUIS U.L.J. 631 (1989).

23. *See generally* AARP Research & Data Resources Department, *Opinions of Older Americans on Medicare and Health Issues*, DATAGRAM (Nov. 1987) (newsletter published by American Association of Retired Persons); Lipton, *Do-Not-Resuscitate Decisions in a Community Hospital: Implications for Quality Care*, QUALITY REV. BULL., July 1987, at 226.

mittees are mandated by federal law in the most benign and noninvasive manner, they will still be seen by many as a front for the rationing of health care. Already bioethics is in danger of being characterized as a rationing procedure that discriminates against the elderly and the poor: in Oregon and in Alameda County, California, a group of bioethics consultants was retained to engineer the process whereby its novel system of Medicaid rationing was developed.[24] The resulting controversy illustrated the inherently ideological nature of an official role for bioethics in the management of a public insurance system that threatens to collapse. Many bioethical issues are artifacts of structural arrangements for financing the health care system,[25] but ethical decisionmaking should not be used as a cover for public officials who are reluctant to face the political choices inherent in health care resource allocation.

This is not simply a parochial plea to keep bioethics pure—an untenable position for an ethicist from Brooklyn. I refer also to the more general point that ethical standards normally need not be, and often should not be, interpolated into law. Currently in the state of New York we are struggling to assimilate into clinical practice a law governing cardiopulmonary resuscitation (CPR).[26] So far as I can tell, there is no serious disagreement with the intent of the law, which attempts to insure that no one who wants CPR is denied it. But problems of implementing legal requirements into hospital routine are daunting. Each year a new crop of houseofficers[27] must be persuaded that an additional sheaf of fifteen forms is necessary to protect hospitals from liability. Many patients suspect that authorizing a do-not-resuscitate order will result in the unwanted limitation of other forms of treatment, and their suspicions are not groundless.[28] Indeed, I hope that our educational efforts will result in greater control for patients over their destinies, but in the meantime, my impression is that in some of our hospitals the number of "no-codes" has actually decreased since the CPR law was passed, and the number of "slow codes" has increased.[29]

---

24. *See* Sasse, *The Rationing of Health Care Services: The Case of Alameda County, California*, 2 HOSP. ETHICS COMMITTEE F. 145 (1990).

25. Examples involve the issues of terminating treatment for low birthweight infants, and treatment of adults who have smoked excessively or who have alcohol-related disease.

26. N.Y. PUB. HEALTH LAW §§ 2960-2978 (Consol. 1990).

27. "Houseofficers" refers to doctors in post-graduate training.

28. *See, e.g.*, Lipton, *supra* note 23, at 226.

29. A "no-code" refers to an order not to resuscitate, whereas a "slow-code" directs staff to treat the patient slowly and let him or her slip away without documenting any

Urging caution about ethics committees is not the same as opposing their formation. Still, I will be more comfortable about offering counsel when more is known about them and when more attention is paid to the circumstances that result in their formation. In our eagerness to develop a means of addressing many of the human problems in modern health care, let us not rush to create more.

---

decision to let the patient die. In some hospitals the law has created so much bureaucracy that the "no-code" is not applied. The result is that patients are overtreated and the spirit of the law is defeated.