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EVALUATING ETHICS COMMITTEES: WHAT DO WE MEAN BY SUCCESS?

GAIL J. POVAR*

INTRODUCTION

Ethics committees are relatively new phenomena within the structure of health care institutions. In *In re Quinlan*,¹ the New Jersey Supreme Court proposed that the committee could serve to validate requests by clinicians, families, or surrogates to remove life-sustaining equipment if the committee, like the court, concluded that "there is no reasonable possibility of [the patient's] ever emerging from her present comatose condition to a cognitive, sapient state."² So understood, these committees really would serve as prognosis committees; their task would be to assess the probability of a particular medical outcome. As such, institutional ethics committees were assigned a clinical role quite distinct from the extant institutional review boards, whose task was to apply federal rules regarding the protection of human subjects in research to proposals within their own institutions.³

By 1984, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research proposed a much expanded concept of the institutional ethics committee.⁴ Based on such concerns as the expense, protracted nature, and adversarial character of court proceedings, the Commission proposed that the ethics committee might prove a more useful

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1. 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976).

2. *Id.* at 54, 355 A.2d at 671; see Cranford & Doudera, *The Emergence of Institutional Ethics Committees*, in INSTITUTIONAL ETHICS COMMITTEES AND HEALTH CARE DECISION MAKING 7 (R. Cranford & A. Doudera eds. 1984) [hereinafter INSTITUTIONAL ETHICS COMMITTEES]; *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2847 (1990).

3. See Glanz, *Contrasting Institutional Review Boards with Institutional Ethics Committees*, in INSTITUTIONAL ETHICS COMMITTEES AND, *supra* note 2, at 129; Fletcher, *The Bioethics Movement and Hospital Ethics Committees*, 50 Md. L. Rev. 859, 867-68 (1991) (describing the historical origin of institutional review boards).

4. Lynn, *Roles and Functions of Institutional Ethics Committees: The President's Commission's View*, in INSTITUTIONAL ETHICS COMMITTEES, *supra* note 2, at 22; see PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *MAKING HEALTH CARE DECISIONS* 187-88 (1982) [hereinafter PRESIDENT'S COMMISSION, *MAKING HEALTH CARE DECISIONS*].

mechanism to resolve questions of clinical ethics than the courts.⁵ Further, situating decisionmaking within institutions would provide for more institutional responsibility as well as more protection of confidentiality for the involved parties.⁶ The Commission therefore envisioned a role for ethics committees far beyond that suggested by the *Quinlan* court; in essence, they would serve as the internal mechanisms for review and resolution of ethically troubling cases.⁷

In 1984, the momentum to create committees to conduct case review increased, when the United States Department of Health and Human Services endorsed "infant care review committees" in the "Baby Doe" rules.⁸ These committees were created in response to the concern that handicapped infants might be deprived inappropriately of potentially life-saving intervention; the call for these committees reflected a public perception of institutional ethics committees as protectors of the legal rights of members of society in the health care arena.⁹ Whether or not this would become the predominant vision of the ethics committee function, the infant care review committee rules pushed the ethics committee movement into the institutional mainstream. Whereas in the early 1980s, only one percent of hospitals claimed to have in-house ethics committees,¹⁰ in 1985 the American Hospital Association reported that the number had doubled since 1983 to fifty-nine percent.¹¹

Institutional ethics committees' current roles are by no means limited to case consultation. An American Hospital Association Management Advisory suggests the following activities as "particularly suitable": (1) directing educational programs on medical ethics; (2) providing a forum for discussion of biomedical-ethical issues in the institution; (3) serving as an advisor and resource to people involved in decision-making; (4) engaging in retrospective review of decisions carrying bioethical import; (5) developing or providing input into institutional policies related to bioethical issues; and (6)

5. See PRESIDENT'S COMMISSION, MAKING HEALTH CARE DECISIONS, *supra* note 4, at 187.

6. Lynn, *supra* note 4, at 23-25.

7. See PRESIDENT'S COMMISSION, MAKING HEALTH CARE DECISIONS *supra* note 4, at 187.

8. Jaffe, *Institutional Ethics Committees: Legitimate and Impartial Review of Ethical Health Care Decisions*, J. LEGAL MED., Sept. 1989, at 394; see Guidelines Relating to Health Care for Handicapped Infants, 45 C.F.R. § 84 app. c (1984).

9. Jaffe, *supra* note 8, at 394.

10. *Id.* at 397.

11. P. McCARRICK & J. ADAMS, ETHICS COMMITTEES IN HOSPITALS 1 (June 1987) (Scope Note 3) (National Reference Center for Bioethics Literature, Kennedy Institute of Ethics, Georgetown University).

networking with other committees for educational purposes.¹²

I. WHY WORRY ABOUT THE MEANING OF SUCCESS?

Even though ethics committees have been in existence now for more than fifteen years, what counts as "success" is still subject to debate.¹³ The dictionary offers several possible definitions of the term, the first of which is "the favorable or prosperous termination of attempts or endeavors."¹⁴ Some committees, for instance, might view the number of consultation requests received by the committee as directly proportional to their "success" in the institution.¹⁵ Individual professional ethicists have evaluated themselves in this manner;¹⁶ thus, some might reason that committees providing consultation should measure their successes similarly. But how does a large number of consults reflect a "favorable" outcome? The term "favorable" is susceptible to many interpretations. The interpretation a committee chooses as a criterion for success might influence its efforts in executing each individual function.

The potential for ethics committees to adopt multiple roles further complicates the picture; these committees must not only identify criteria for success in each role, but must decide in which area it will be most important to succeed. Any conception of success must account not only for "favorable" achievements within each role, but also for the aggregate impact of the committee in its environment. Yet which activity becomes most important may depend on a host of factors. These range from the expertise of the committee at performing a given function (such as the skill of its members in consultation), to the needs of the institution's administration (for example, policies in response to local statutes regarding do-not-resuscitate orders), to the committee members' views as to their most important mission (perhaps the education of medical staff). Overall, then,

12. AMERICAN HOSPITAL ASSOCIATION, MANAGEMENT ADVISORY: ETHICS COMMITTEES (1990).

13. *Experts Share Secrets for Ensuring IEC Effectiveness*, MEDICAL ETHICS ADVISOR, Feb. 1988, at 17-28 [hereinafter *Experts Share Secrets*] (newsletter by American Health Consultants, Inc.; copy on file with *Maryland Law Review*).

14. RANDOM HOUSE DICTIONARY OF THE ENGLISH LANGUAGE 1899 (2d ed. 1983) (unabridged).

15. Gibson & Kushner, *Will the "Conscience of an Institution" Become Society's Servant?*, HASTINGS CENTER REP., June 1986, at 10.

16. See La Puma, Stocking, Silverstein, DiMartini & Siegler, *An Ethics Consultation Service in a Teaching Hospital: Utilization and Evaluation*, 260 J. A.M.A. 808, 808-11 (1988) [hereinafter *La Puma & Stocking*].

“success” depends not only on achievement within each role, but on the priority given to a particular activity.

It is increasingly important for committees to articulate and defend the criteria for success to which they will hold themselves accountable. Some commentators have examined the proper composition of committees.¹⁷ Susan Wolf and others have focused on the processes these committees ought to follow in conducting their tasks.¹⁸ Success, referring as the term does to the “termination” of an activity or to an “achievement,”¹⁹ may also be evidenced by outcomes. Ethics committees often demand substantial time commitments from participants, and to be effective, real financial commitments from administrators.²⁰ It is likely that these people will demand evidence of success, including defensible outcomes, in return for their investments of time and money. What will committees offer as the successes that justify their continued claims to these resources?

Ethics committees should be structured and operated so as to yield ethically defensible results. We need to develop a common understanding of success—of defensible results—if we are to judge whether our assumptions about these processes and structures are correct. Literature discussing this subject will help new committees as they establish themselves, and it will also aid existing committees in evaluating themselves both within their own institutions and as compared to others. Finally, as courts begin to pay attention to the products of institutional ethics committees in cases brought before them, the need for clear standards for the “successful” committee will be even greater.²¹

In this Essay, I will describe what I see as alternative possible conceptions of “success” where ethics committees are concerned. In particular, I will address the problems of defining success in fulfilling two critical committee roles: policy formation and case consultation. Then I will examine the validity of two possible criteria for success—institutional acceptance and consensus within the eth-

17. *E.g.*, Jaffe, *supra* note 8, at 410-15 (concluding that the best-received committees would be composed of physicians, nurses, members of the clergy, hospital administrators, attorneys, and people with backgrounds in social work, psychology or ethics).

18. *See* Wolf, *Ethics Committees and Due Process: Nesting Rights in a Community of Caring*, 50 MD. L. REV. 798 (1991); *see also* Veatch, *Advice and Consent*, HASTINGS CENTER REP., Jan.-Feb. 1989, at 21 (discussing patient confidentiality and procedures for disclosure of patient records to ethics committees).

19. RANDOM HOUSE DICTIONARY OF THE ENGLISH LANGUAGE, *supra* note 14, at 1899.

20. *Experts Share Secrets*, *supra* note 13, at 21.

21. Wolf, *Ethics Committees in the Courts*, HASTINGS CENTER REP., June 1986, at 15.

ics committee. As I explore each of these issues, I will also describe the particular structures and processes adopted by the George Washington University Medical Center Hospital Ethics Committee (which I have chaired for over five years) to demonstrate how these characteristics flow from a committee's understanding of what counts as success.

II. SUCCESS IN THE ROLE OF POLICY-MAKING

Numerous authors have envisioned policy generation as one of the more important tasks of institutional ethics committees.²² With its singular commitment to ethical concerns, the committee is indeed well placed to craft and recommend policies on a wide range of bioethical issues. A common starting point in the history of many committees is their deliberation on and ultimate recommendation of a policy regarding do-not-resuscitate orders.²³ In fact, since 1988, hospitals have been "required to have formal DNR [do-not-resuscitate] procedures for accreditation."²⁴ At least one commentator even suggested that ethics committees should extend their policy endeavors to address such complex social-institutional-professional issues as resource allocation.²⁵

What is "success" in the role of the committee as a policy-making body? One criterion of success in a bureaucracy is the amount of paper produced. The young, aspiring manager in a large company often is advised to draft memos frequently and to send copies to the boss to demonstrate his or her productivity. Similarly, an institutional ethics committee might attempt to establish its credentials as a productive member of the hospital bureaucracy by generating paper in the form of policies. From this perspective, the successful committee is one that creates or recommends the most policies—policies covering a myriad of subjects such as do-not-resuscitate orders, definition of death, informed consent procedures, and substituted judgment. Such a committee would be tempted to

22. See Cranford & Doudera, *supra* note 2, at 13; Jaffe, *supra* note 8, at 403-04; Thomasma, *Hospital Ethics Committees and Hospital Policy*, QUALITY REV. BULL., July 1985, at 205-07.

23. For examples, see Kushner & Gibson, *Descriptive Summaries of Extant Institutional Ethics Committees*, in INSTITUTIONAL ETHICS COMMITTEES, *supra* note 2, at 252, 259-60, 270, 273, 277, 281.

24. Emanuel, *Does the DNR Order Need Life-Sustaining Intervention? Time for Comprehensive Advance Directives*, 86 AM. J. MED. 87 (1989) ("accreditation" refers to the process of inspection and certification by the Joint Committee on Accreditation of Hospitals).

25. See Thomasma, *supra* note 22, at 205, 207.

churn policies out very rapidly in an attempt to address all the ethical deficiencies in clinical and institutional decisionmaking.

There are several reasons, however, to proceed with care and caution in the making of policy recommendations. Health care professionals are likely to offer considerable resistance to policies that provide normative standards for interactions between caregivers and patients.²⁶ Administrators and physicians may fear that such standards will expose them to liability, especially when current practice is far from meeting those expectations.²⁷ Physicians, in particular, are skeptical of external efforts to "direct" their practice of medicine; committees need to avoid either the appearance or the reality of usurping the decisionmaking responsibilities of caregivers and patients.²⁸

Moreover, a committee may render itself useless to the institution if, in its zeal to generate paper, it devotes its time and energy to policies that are interesting intellectually, but of little practical importance to the hospital. An example might be policies in a small community hospital addressing organ donations from anencephalic infants.

In addition, policy development is limited by, or must at least be sensitive to, national standards.²⁹ Where there is a paucity of literature or legal experience in a particular area, it is unlikely that any given institutional ethics committee will be sufficiently expert to write a policy that will be durable or find acceptance among clinical staff.

Finally, a deliberate approach to policy-making is necessary because good guidelines take time to create. One experienced ethicist has suggested that one year is not an unusual period of time within which to formulate policies governing a specific area;³⁰ in fact, a complex case involving blood transfusions for Jehovah's Witnesses occupied one well-established committee for two years.³¹ Thus, institutional ethics committees have good reason to proceed slowly in their policy-making roles.

As a result of the extensive national discussion and literature

26. *Id.* at 205; Levine, *Hospital Ethics Committees: A Guarded Prognosis*, HASTINGS CENTER REP., June 1977, at 26.

27. Levine, *supra* note 26, at 26.

28. *Experts Share Secrets*, *supra* note 13, at 24-25.

29. Jaffe, *supra* note 8, at 404.

30. *Experts Share Secrets*, *supra* note 13, at 25.

31. See Macklin, *The Inner Workings of an Ethics Committee: Latest Battle over Jehovah's Witnesses*, HASTINGS CENTER REP., Feb.-Mar. 1988, at 15-20.

surrounding decisions to withhold or withdraw life-sustaining therapy, and in particular, concerning resuscitation orders, confronting this issue has become a natural initiation rite for many committees. After all, as mentioned earlier, the impetus to create institutional ethics committees came initially from the *Quinlan* case, which revolved around precisely such concerns. National standards and published policies were available to many committees as they worked to design guidelines for their own institutions.³² Even so, a policy that is appropriate in one setting is not necessarily transferable en bloc to another. The individual culture of an institution inevitably must influence the committee's choices.³³ Smaller rural community hospitals, for instance, may require different approaches from those taken in large urban teaching centers because the nature of the physician's role in the community may be radically different.³⁴ Therefore, even policy questions already resolved by established committees are time-consuming and challenging to draft.

At the George Washington University Medical Center, we have taken a very slow, deliberate course in policy formation. On the one hand, we believe that the existence of policies in certain areas, for instance governing do-not-resuscitate orders, may be needed to prod medical staff and the institution into grappling with issues and recognizing an emerging national consensus. More often, however, we have waited to see what issues would emerge in informal or formal interactions with patients, caregivers, and administrators. We believe that policies should respond to some anxiety or felt need—not exclusively on the part of physicians, but from within the hospital community as a whole.³⁵ Like many committees, we used the opportunity to develop a policy on forgoing life-sustaining therapy to educate ourselves both on the relevant substantive issues and more generally on policy-making. A do-not-resuscitate policy served similar educational functions, and met the need of the medical staff and the institution for such a policy.

32. See Cranford & Doudera, *supra* note 2, at 5-11 (describing regulatory policies that have produced national consensus); see also Procedures Relating to Health Care for Handicapped Infants, 45 C.F.R. § 84.55 (1984) ("Infant Doe" regulations recommending establishment of infant care review committees); J. ROSS, HANDBOOK FOR HOSPITAL ETHICS COMMITTEES 5-8 (1986) (detailing historical development of ethics committees).

33. See, e.g., Emanuel, *supra* note 24, at 87 (discussing divergent views on do-not-resuscitate orders and responses of physicians).

34. See *supra* text following note 28.

35. Fleischman, *An Infant Bioethical Review Committee in an Urban Medical Center*, HASTINGS CENTER REP., June 1986, at 16.

While actively engaged in policy formation in these areas, we have hesitated to define the meaning of "futility" in medical care or to provide guidelines regarding the withholding of therapy on such a basis, despite pressure from certain segments of the medical staff to promulgate such standards. The polarity of views on this subject in the medical ethics literature and within our own community requires an initial effort to seek out as many opinions as possible from within the institution.³⁶ Educational programs and retrospective review of individual cases with the involved parties have stimulated discussion and helped us to identify the complex issues at stake. This question of when a patient's health has so deteriorated that the physician may unilaterally decide to withhold treatment certainly provokes sufficient anxiety to provide a "teachable moment"³⁷—a circumstance in which education is most likely to have impact. In time, our ethics committee will formulate policy in this area. But careful groundwork will be essential to avoid generating a document that appears to be imposed upon—rather than arising from—the requirements and sensitivities of the institution.

Thus, our policy-making is driven not by the demand to generate large numbers of policies, but by the need for policies that make sense within our institution's evolving culture. One might ask if policies arrived at in this manner ultimately reflect the status quo rather than push medical practice to a higher moral plane. After all, our objective as an institutional ethics committee is not to validate ethically unsupportable practices. A committee has means of altering the institutional environment beyond plunging ahead with a policy. Our committee sees education as a means for raising awareness about troubling ethical matters, for stimulating interest in setting policy, and for eliciting community participation in identifying the directions the policy ultimately should take. Educational programs provide opportunities to question the existing patterns of behavior and to alter the boundaries of the institution's medical culture. Cases brought before the committee often occasion follow-up conferences that in turn suggest needed policies. Indeed, the educational function of the institutional ethics committee is considered paramount by virtually all commentators—even those who oppose other roles.³⁸ Ideally then, the committee should not generate poli-

36. Niemira, *Grassroots Grappling: Ethics Committees at Rural Hospitals*, 109 ANNALS INTERNAL MED. 981, 982 (1988).

37. See *Experts Share Secrets*, *supra* note 13, at 25-26; Levine, *supra* note 26, at 26.

38. See *Experts Share Secrets*, *supra* note 13, at 20-25; Siegler, *Ethics Committees: Decisions by Bureaucracy*, HASTINGS CENTER REP., June 1986, at 23-24; Bayley & Cranford, *Tech-*

cies based upon its own assessment of institutional needs. Rather, policy-making should occur when the community members, educated by the institutional ethics committee, approach the committee and request it to promulgate guidelines in reference to a particular subject.

III. SUCCESS IN THE ROLE OF CASE CONSULTATION

One of the more contentious roles assumed by institutional ethics committees is case consultation. Many have counseled caution in this area³⁹ and some oppose it outright, claiming that committees are neither expert enough nor sufficiently flexible to respond to the time pressures of the clinical milieu.⁴⁰ Nevertheless, ethics committees may be tempted to interpret the number of times they are consulted as evidence of trust and acceptance within the institution. Does the number of times a committee is consulted constitute an appropriate measure of success? A guarded response is in order.

One might first ask why "consults" come to the ethics committee in the first place.⁴¹ Do they indeed reflect genuine moral disagreement posing ethical issues for resolution? In our institution, and in the experience of others with whom I have had contact, many consults arise more from failures of communication than from clear ethical discomfort. Indeed, in any number of cases, it has been unclear whether there really existed any argument on moral grounds between two groups because they had been unable to meet in a setting that allowed them to examine their differences. In such cases, the institutional ethics committee facilitates communication between affected parties or even adopts the role of conflict mediator, rather than assisting in the identification and resolution of ethical problems. If one can argue that institutional ethics committees are not sufficiently educated in ethics to resolve purely ethical conflicts responsibly, it is even less obvious that they are ideally situated to act as experts in communication problems. If a committee receives many consults of this kind, it may succeed in filling a void in the

niques for Committee Self-Education and Institution-Wide Education, in INSTITUTIONAL ETHICS COMMITTEES, *supra* note 2, at 150-55.

39. See, e.g., LO, *Behind Closed Doors: Promises and Pitfalls of Ethics Committees*, 317 NEW ENG. J. MED. 46-49 (1987); ROBERTSON, *Committees as Decision Makers: Alternative Structures and Responsibilities*, in INSTITUTIONAL ETHICS COMMITTEES, *supra* note 2, at 85-95; Jaffe, *supra* note 8, at 405-09.

40. See Siegler, *supra* note 38, at 23-24; La Puma & Toulmin, *Ethics Consultants and Ethics Committees*, 149 ARCHIVES INTERNAL MED. 1109, 1111-13 (1989).

41. See Fletcher, *supra* note 3, at 877-78 (communication breakdowns in physician-patient relationships present ethical problems).

institution; however, the ethics committee is not necessarily the appropriate entity to resolve these problems. Of course, communications issues are often intertwined with moral ones; a committee may have to deal with both.⁴² But the institutional ethics committee should review its experience to assess whether it is serving as a forum for review and resolution of moral problems, or whether it is serving primarily as a "Band-Aid" for an institution's dysfunctional communication mechanisms.

Yet another problem in counting consults as a measure of success lies in the validity of the committee procedures themselves. The number of consults a committee is asked to do may be high because its procedures exclude patients from the meetings, thereby reassuring physician-staff that their behaviors and thought processes will not be observed by patients.⁴³ In fact, recent literature suggests that many committees do not provide patients and their families with access to the ethics committees' services.⁴⁴ Whether or not committees provide for due process so that patients' views are heard and defended adequately is a real concern.⁴⁵ Indeed, one writer has argued that the demands of confidentiality are such that no case ought to be heard by the institutional ethics committee without the patient's explicit consent.⁴⁶ On these grounds, a committee that receives many consults in part because it is perceived to protect the clinical staff from such considerations may well have failed in its consultative responsibilities.

Committees may also be sought after if, in a particular institu-

42. In our institution, consults may be initiated by anyone directly involved with a case. See *infra* at 915.

43. See Lo, *supra* note 39, at 47 (restricting access of patients to committees may allow for more frank discussions among physicians). In our consultative process at the George Washington University Medical Center, patients or their surrogates are virtually always interviewed by members of the ethics committee.

Approximately one-half of consultations coming to the full committee for review have resulted in joint participation in the meeting by patients and/or their surrogates and their caregivers. Reasons for *not* including patients or their surrogates in such meetings include an assessment that their view is well represented by a caregiver advocate, that the patient is unable to attend and there is no adequate surrogate, or that the triage group believes that the full committee process would be both terribly traumatic for the patients and surrogates and that their viewpoint has been well understood from prior interviews. See also *infra* at 915.

44. See Nash, Leinbach & Fought, *The Hospital Ethics Committee: Who Knows It Exists and How to Access It*, H.E.C.F. 9, 9-11 (1989); Hoffmann, *Regulating Ethics Committees in Health Care Institutions—Is It Time?*, 50 Md. L. Rev. 746, 748 n.10, 762 (1991) (likely goal of proposed Maryland legislation requiring ethics committees is access for all patients).

45. See Wolf, *supra* note 18; Lo, *supra* note 39, at 47; Jaffe, *supra* note 8, at 418.

46. See Veatch, *supra* note 18, at 20-22.

tion, caregivers opt to give over their ethical decisionmaking responsibility entirely.⁴⁷ In my own experience, physicians unrealistically may expect the committee to resolve uncertainty, with the result that they are unsympathetic towards committee recommendations that acknowledge the ambiguity of the clinical situation, or that offer the possibility of more than one right answer to a troubling question. Failed expectations ultimately may result in a smaller number of consultations. Therefore, ethics committees must strive to clarify the role they expect to play as consultants.⁴⁸ Such clarity actually may reduce the number of consults, for it will deter individuals from asking the committee for answers that it neither can nor should deliver. Once again, relying on the number of consults, rather than on what they achieve and how they achieve it, is a dubious method for evaluating the success of an institutional ethics committee.

Finally, the question of the committee's expertise in consultation is a difficult, as-yet unsettled matter and must be taken seriously. Some have argued that consults should be carried out by a single ethicist or only by clinician-ethicists.⁴⁹ Alternatively, it has been suggested that the goal of ethics committees in such consults should not be expected to be "ethical expertise" so much as combined wisdom, or "social intelligence."⁵⁰ Those who prefer the model of the committee as consultant question whether a single consultant can always offer an appropriate solution to every case.⁵¹ This view expands on the notion of wisdom as reflecting the moral climate of the institution and the community, and sees the institutional ethics committee as more effective in offering such wisdom than the individual consultant.⁵² To some extent, the number of consults a committee receives may depend upon whether the physician community in particular is more comfortable with a clinician colleague serving as a "beeper ethicist" in the traditional consultational mode, or whether they accept this alternative vision of the

47. Siegler, *supra* note 38, at 22.

48. Ross, *Why Cases Sometimes Go Wrong*, HASTINGS CENTER REP., Jan.-Feb. 1989, at 22.

49. See La Puma & Stocking, *supra* note 16, at 811; La Puma & Toulmin, *supra* note 40, at 1109-11.

50. See Moreno, *What Means This Consensus? Ethics Committees and Philosophic Tradition*, 1 J. CLINICAL ETHICS 38, 38-42 (1990).

51. See Gregory, *Consensus—Real or Imaginary*, 1 J. CLINICAL ETHICS 43 (1990); Shenk, *Consensus—The Measure of Ethical Permissibility: A Response to Jonathan Moreno*, 1 J. CLINICAL ETHICS 45 (1990).

52. See Gregory, *supra* note 51, at 44.

correct process for ethics consultation. On the face of it, more comfort with one procedure than another does not confirm the rightness of the procedure per se. Much more must be learned about what constitutes a "good" outcome of an ethics case consultation. Only then can we identify with some certainty the correct means of achieving this goal.

Our own committee has developed a process that, we hope, addresses the need for flexibility on the one hand, and expertise and social intelligence on the other. Initially, consults are received and evaluated by a "triage group" of three committee members, typically of three different disciplines, who are on call by beeper twenty-four hours a day for one month rotations. Anyone directly involved with a case—patient, family, caregiver—may request a consult. The triage group gathers primary data by meeting with concerned caregivers, interviewing patients and their families or other loved ones, and reviewing the patient's medical chart. The three committee members then decide together whether they can address the case themselves or whether a full committee consult is necessary.

If the consult requires facilitating communication about a moral problem or interpreting and applying existing policy rather than resolving an ethical conflict, the triage group usually handles it independently. For example, an intern may be unsure how to approach the issue of capacity to decide with regard to a patient who has some neurological compromise. The triage group could advise the team on how to manage the issue and what guidelines to use for capacity.

If it appears that the case raises issues not addressed by existing policy, the triage group will request a meeting of the full committee as part of the consultative process. A recent case of this sort involved a young person with uncertain and unstable housing who repeatedly refused therapy for a significant skin infection, but who also refused to leave the hospital because he preferred it to returning to his insecure life outside. The case presented a complex set of questions about the patient's capacity to decide, communications with his caregivers, and the extent of the hospital's obligation to provide shelter to a patient who refused therapy. The triage group rightly felt that it was far too complicated a matter to resolve on the basis of three persons' wisdom and sought the larger community's understanding of the moral culture. In such cases, all concerned parties are invited to attend, including the patient or the patient's representative. Occasionally, if those involved believe that a patient's attendance at the committee meeting will unduly upset him or her, the patient will be interviewed by representatives of the

committee. The committee relies on the data and opinions of all involved, including the triage group. A closed committee process follows in which the committee identifies acceptable options, which are communicated to the attending physician and written in the patient's medical chart along with a discussion of the rationale for the committee's recommendation. This tiered or two-stage process allows the committee to respond in a timely fashion while retaining the capacity to invoke the broader experience and expertise of the larger committee when necessary. Although the committee has received up to fifteen consultations in various forms each year, the full committee typically has been called into consultation only three to six times in the same period.

Occasionally, a case is brought to the full committee for reasons other than the nature of the ethical conundrum itself. Mindful of the educational opportunities provided by a committee meeting, we take advantage of the full committee consult option if we feel that the parties involved will be more likely to take the committee's activity seriously, or more likely to participate in a process involving a larger peer group.

How do we judge whether our consultative process is successful? Informal feedback is solicited from involved parties following each consult, and when possible the patient's chart is monitored to follow up on the case. The committee also holds periodic retreats to evaluate its experiences and reassess its approach. Finally, we consider the consult a particular success if the involved department, staff members, or others request a follow-up teaching seminar. Such a request, we feel, means that we have raised caregivers' awareness that the committee can help them to improve their care of patients. Because our ultimate goal is to educate ourselves and others, we would rejoice if every consult resulted in someone saying to us "I need to learn"; that is, if every consult resulted in a "teachable moment." This outcome—an increased desire for education—is one mark of success, perhaps a better one than the total number of consults received.

IV. IS CONSENSUS A MEASURE OF SUCCESS?

Real consensus surrounding a decision exists when each and every person participating in the decision can honestly affirm the correctness of the decision. Jonathan Moreno has argued that consensus alone ought not to be seen as conferring moral authority, but as a condition of decisionmaking that is desirable for an institutional

ethics committee.⁵³ Others point out that honest consensus does confer a measure of legitimacy insofar as it reflects the tolerance of the institution's moral culture and the combined intelligence of a group of well-chosen decisionmakers.⁵⁴ The desire for consensus-based decisionmaking arises in part from discomfort with assigning a particular percentage of a vote as sufficient to define an acceptable moral recommendation.⁵⁵

The achievement of meaningful consensus is difficult and indeed may represent successful articulation of the core values of the ethics committee and its community. The difficulty lies in differentiating real consensus from "pseudo-consensus." A particularly persistent, articulate, or domineering member of a committee may bring about acquiescence to his or her viewpoint; but this is not consensus. This phenomenon is often revealed when members voice their concerns in private after a meeting, rather than during it.⁵⁶ Alternatively, general agreement on an issue may be achieved, but at the expense of losing real dialogue or tolerance of dissension in the discussion. When committees lack adequately divergent views, their members may agree with each other, but fail to represent the "social intelligence" that broader consensus can offer. The danger of "groupthink" is ever present for a committee that works together over long periods unless its members make deliberate efforts to prevent it from occurring.⁵⁷

The George Washington University Medical Center institutional ethics committee has adopted several approaches to avoiding these pitfalls. First, in case consultations, all views that seem to be supportable from a moral standpoint are included in the committee's recommendation. The possibility of conflicting, but equally good answers exists at all times. In reality, the group often agrees on major principles, but identifies several alternative approaches to achieving the desired goal. If no single option clearly gains every member's positive support, then the remaining choices are explored and offered if defensible. Not demanding consensus as an outcome leaves committee members free to voice and justify differing viewpoints.

Policy-making requires a different approach. If the committee

53. See Moreno, *Ethics by Committee: The Moral Authority of Consensus*, 13 J. MED. & PHIL. 411, 411-32 (1988).

54. See, e.g., Gregory, *supra* note 51, at 43; Shenk, *supra* note 51, at 45.

55. Shenk, *supra* note 51, at 45.

56. Macklin, *supra* note 31, at 18-19; Ross, *supra* note 48, at 23.

57. Lo, *supra* note 39, at 49.

cannot arrive at a policy statement that each member can affirm as valid, it is unlikely to be an effective policy for the institution as a whole. However, when a policy statement can gain universal support only when it is so vague as to be meaningless, the committee is likely to delay its decision, taking time instead to examine the issues more closely and to work harder on listening to and educating the community and one another. Here, attention to the details of the group process is critical. The committee chair and each committee member bear responsibility for ensuring that quiet as well as talkative members are heard and that no issue is brought to premature closure. As discussed earlier, the need for real—as opposed to apparent—consensus is another reason to allow policies to mature through frequent debate rather than to be turned out in just a few meetings. Real consensus can be the hallmark of success, but its achievement takes time.

V. IS ACCEPTANCE A MEASURE OF SUCCESS?

The last question I wish to raise is whether acceptance is a valid measure of success. It seems to me that on this subject, institutional ethics committees must walk a difficult line. The popularity of a committee's decisions and policies may suggest that they do not challenge the existing institutional culture. Respect without acceptance, however, can render a committee functionally irrelevant. Committees ultimately may find themselves in confrontations with their institutions if they decide to address the role of the institution in its community.⁵⁸ Similarly, resource allocation questions are likely to be particularly delicate—especially when economic agendas and ethical values are in conflict.⁵⁹ I believe it is essential that ethics committees strive to strike a balance between seeking acceptance and playing the role of the friendly critic, skeptic, and Socratic presence.

CONCLUSION

Institutional ethics committees must begin the process of identifying standards to which they will be held accountable both within their institutions and within society. They are, however, still relative newcomers to the health care arena, and as such should continue to explore how best to achieve these goals. Premature assumptions

58. Gibson & Kushner, *supra* note 15, at 11.

59. Wesbury, *Trends in Ethical Decision Making*, in *INSTITUTIONAL ETHICS COMMITTEES*, *supra* note 2, at 31-32.

about the meaning of success may impede their efforts. Much research is still required to illuminate what characterizes a “good” policy, a “good” consult, or a “good” committee. In the meantime, ethics committees will continue to examine their structures and processes to identify those that seem most likely to produce the desired success. I would suggest that if these committees are forced to become standardized too soon, they will have become victims of a failure of imagination in our evaluative and legal strategies. Institutional ethics committees should continue their evolution, and, like nature, try many forms—each of which may find a useful moral niche in a particular institution’s ecology.