

## MEDICINE AND SOCIETY

### Health Care Ethics Committees as Mediators of Social Values and the Culture of Medicine

Cynthia M.A. Geppert, MD, MA, MPH, MSB, DPS, and Wayne Shelton, PhD

Health care ethics committees (HCECs), bodies that mediate ethical disputes and dilemmas in patient care settings, began in the 1960s, assumed a prominent organizational role by the 1970s and 1980s, and emerged by the 1990s as the primary institutional mechanism for studying, educating about, and providing advice on value conflicts and dilemmas in medicine [1, 2]. The development of these HCECs was triggered by broad social, legal, political, and technological changes, especially questions at the beginning and end of life. Many HCECs took a leadership role in their institutions in upholding ethical principles and legal standards and, through this role, influenced the prevailing culture of medicine [3]. The primary trajectory of this cultural movement was away from a paternalistic, physician-driven culture toward a more patient-centered, autonomy-based one, which is now well established in American medicine [4]. HCECs' influence historically was exercised through the three primary functions of HCECs: (1) ethics education, (2) policy development, and (3) [ethics consultation](#).

In each of these functions, HCECs tended to mediate between the values prevalent in medical culture and those of society more broadly. For instance, in our experience, it's now common for bioethicists to question the primacy of the principle of autonomy, no matter how individual freedom is prized in American society. As a mediating force, HCECs are in a unique position, for example, to help balance self-determination with other neglected considerations, such as the obligations of health care practitioners to do good and avoid unnecessary harm to their patients, as well as to use resources prudently and justly.

This kind of mediation requires the critical distance and capacity to see many perspectives. But HCECs, which some have argued began as a countercultural force to resist medical paternalism and to help guide and reshape the new ethical and social values of medicine, have at times risked becoming tools to reinforce and defend the status quo in medical culture [5]. In this commentary, we examine potential challenges to HCECs: lack of expertise in policy formation [6], an underdeveloped ability to differentiate ethical questions from other organizational concerns, threats to impartiality and independence, and external mandates to establish HCECs without adequate institutional support. Failure to effectively manage these challenges could potentially

undermine the HCECs' ability to fulfill their function as mediators between value systems.

### **Lack of Expertise in Policy Formation**

Policy in many health care systems delineates the scope of ethics consultation and the subject matter of the ethics education HCECs provide; it also articulates the values and culture of the institution's leadership and mission. Because policy plays this pivotal role at the interface between medicine and society, lack of training and expertise in policy development and implementation can impede and derail the other key functions of HCECs and lead to failure to effectively and authentically communicate the mission of the institution to the community. Compared to the rich and growing literature on ethics consultation, the policy function of HCECs has received less scholarly attention, even though most ethics committees spend more time on policy development and policy has potential to influence medical culture at a systems level [7]. To develop sound policy, it is important to be able to assess the numerous forces within medical and social culture—legal, regulatory, economic, political, clinical, and institutional—that help shape medicine and influence HCECs. One related challenge is that many HCECs do not have the background and expertise in organizational policy development needed to craft policies that balance institutional claims and counterclaims and respect the core principles and standards of medicine in addition to well-established ethical and social values [6]. The current debates about resource allocation and physician-assisted death are examples of areas that will require advanced proficiency in policy formation.

### **Underdeveloped Ability to Differentiate Ethical Questions from Other Organizational Concerns**

HCECs receive many types of questions and concerns—clinical, political, [legal](#), organizational, regulatory, and human resource-based—that would be more appropriately addressed through other organizational mechanisms. HCECs must be able to differentiate among these types of concerns, focusing on the true values conflicts where their expertise resides and referring non-ethics questions to the proper resources [8]. If HCECs offer legal advice or medical recommendations, they risk conflicts of interest, diffusion of efforts, professional resentment, and a corresponding loss of credibility and influence [3]. HCECs' members must be trained to recognize when concerns are ethical in nature—that is, when they pertain to a genuinely value-laden conflict or dilemma—and to be able to differentiate these from conflicts borne of other organizational pressures, such as liability concerns or financial constraints. HCEC members can enhance their capacity for ethical discernment, like many other analytical skills, through structured education and mentored practice. It has taken time for the fields of clinical ethics and bioethics to be helpful to HCECs in this regard. Indeed, respondents to one survey identified a lack of scholarly background and education as the most serious obstacle to HCECs fulfilling their promise [9].

### **Threats to Impartiality and Independence**

One function of HCECs is to uphold established legal, professional, and ethical principles and standards. Thus, HCECs must above all strive to wield authority with careful, deliberate regard for those who have stakes in the outcomes within the institutional power structure [3].

*The need for diversity of membership.* For mediation to be effective and balanced, HCECs' membership needs to be representative of not only the health care community, but also patient populations—both those who serve and those who are served. Currently, the membership of some HCECs is too homogenous to achieve this needed balance. Fox's landmark 2007 survey found that 34 percent of ethics consultants were physicians and another 31 percent nurses [9]. Chaplains and social workers have invaluable and traditional roles to play on HCECs, as do newcomers, such as midlevel practitioners who provide much of the primary care and a host of allied health professionals. The perspective of administrators is crucial for policy development, but the presence of higher-level administrators can (perhaps unwittingly) stifle deliberations in ways that raise conflicts of interest [5]. The place of attorneys at the HCEC table has been a subject of debate, but attorneys are often invaluable as a source of health law expertise, so long as their input pertains to helping elucidate an ethical perspective in relation to the law [10]. It's been well established that community members and patient advocates are increasingly found on ethics committees but that some committees do not have a trained bioethicist [4]. A wide-ranging interdisciplinary membership is needed to reflect the diversity of the culture of medicine and the society to which it provides care.

*Relationship to health care institutional power structures.* Maintaining critical distance and the impartiality to mediate and clarify the pressing value conflicts in education, policy, and consultation are key to HCECs retaining their integrity. For example, in our experience, if the HCEC teaches trainees and staff that shared decision making should be the model for practitioner-patient relationships, and yet the ethics consultation service routinely resolves ethical conflicts between patients and the health care team in the team's favor, then its impartiality can and should legitimately be [questioned](#); certainly a reputation for bias or favoritism could result in the HCEC not being respected or utilized. Ideally, HCECs should be structured in a way that avoids inconsistencies in case-by-case reasoning and approach and communicates to stakeholders a cohesive ethical vision. The Department of Veterans Affairs' (VA's) Integrated Ethics (IE) Program has been a national leader in this respect; it has established a comprehensive and structured approach to ethical concerns in health care. IE represents a "radical departure" from traditional ethics committees. Instead of dividing HCEC activity into its traditional three functions—policy, education, and consultation—IE focuses on continuous improvement of ethics quality at three main levels: the level of organization and culture ("ethical leadership"), the level of systems and processes ("preventive ethics"), and the level of decisions and actions ("ethics consultation") [11].

The VA's inversion of the HCEC paradigm beginning at the top underscores the importance of leadership commitment to the success of HCECs. For HCECs to constructively mediate between society and medicine they must have a measure of independence from the leadership of the hospital and an ability to examine the surrounding culture of medicine with an open mind and an even hand [5]. This independence is difficult to achieve in institutions where leadership chooses HCEC members and where the HCEC is dependent upon that leadership for administrative support, funding for training, resources, and, most importantly, dedicated time to do good work [12].

Similarly, the HCEC should articulate and promote the mission of the institution while maintaining the ability to critically question the organization when actions or proposals contravene or compromise even more fundamental values, such as social justice and human dignity. Such conflicts are most poignant and difficult in hospitals where other powerful social forces such as fear of litigation, the profit motive, political pressure, or religious beliefs may limit the ability of the HCEC to adhere to well-accepted standards of ethics consultation, policy development, and education [13]. The extent to which institutional leadership takes the advice of the HCEC seriously is a strong commentary on the ethical health of that institution.

### **External Mandate Without Adequate Institutional Support**

One standard of acceptance of HCECs in American medical culture is evinced in the publication of the American Medical Association's 1984-85 report, "Guidelines for Ethics Committees in Health Care Institutions" [14]. Additionally, regulatory acceptance culminated in 1992, when the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandated that hospitals seeking its approval have in place a means for addressing ethical concerns [15]. The mandate is often represented as specifically requiring institutions to have HCECs in particular, rather than any mechanism of responding to ethical issues. Certainly, HCECs rapidly emerged as the predominant means of meeting this requirement. A review of survey findings shows the exponential expansion of HCECs: in 1983, 1 percent of surveyed hospitals had HCECs; four years later, over 60 percent had HCECs; and in 1999, nearly 93 percent of American hospitals with more than 400 beds and every federally funded health care institution had an HCEC [7, 16, 17].

These studies identify, as one of the greatest obstacles facing HCECs, the lack of institutional support such as dedicated staff time, space, and resources. Many HCECs are composed of volunteers who often have dual or multiple roles in the institution, which, especially in small hospitals and rural communities, may create overlapping roles with the potential for conflicts of interest [11].

For HCECs to secure a solid place in organizational structures, they must demonstrate the value HCEC mediation contributes to institutional success. The current preoccupation

of the culture of medicine with measurability, understood in quantitative performance measures, will require HCECs to be disciplined and creative in demonstrating to institutional leaders the value of the mediating activity HCECs perform. This demonstration must be more than is required for the formalities of JCAHO approval and eventually should be based on empirical data. One potential area that HCECs could develop is increasing patient and family access to the ethics committee, especially consultation services, as a way of improving patient satisfaction. HCECs will need moral courage and discernment to reconcile core ethical principles and professional standards of medical culture at its best with increasing pressures in society toward commercialization and utility.

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**Cynthia M.A. Geppert, MD, MA, MPH, MSB, DPS**, is acting health care ethicist at the Veterans Affairs National Center for Ethics in Health Care, the chief of consultation psychiatry and ethics at the New Mexico Veterans Affairs Healthcare System, and a professor of psychiatry and the director of ethics education at the University of New Mexico School of Medicine in Albuquerque. Dr. Geppert's interests include ethics consultation; medical and ethics education; and the clinical and ethical issues involved in the practice of psychosomatic medicine, addiction and pain medicine, and hospice and palliative medicine.

**Wayne Shelton, PhD**, is a professor of medicine and bioethics in the Alden March Bioethics Institute at Albany Medical College in Albany, New York, where he teaches in the medical school curriculum and the graduate program in bioethics. He is also a clinical ethics consultant at Albany Medical Center Hospital. His areas of interest are clinical ethics and medical education.

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**ISSN 2376-6980**