NETWORK NEWS

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ACCREDITATION AND ACCOUNTABILITY IN THE PRACTICE OF MEDICAL ETHICS

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Introduction

The topic of qualifications/credentialing of ethics consultants and monitoring of the quality of Hospital Ethics Committees (HEC) was recently discussed at one of our monthly Bioethics Case Conferences at University Medical Center. Standards for performance for many health care services are being developed, and the clinical practice of medical ethics is likewise subject to the development of standards and criteria for performance.

Background

The primitive HEC was born in the State of Washington with the development of dialysis. The first successful shunt placement for dialysis was reported in 1960. In 1961, King's County Hospital in Seattle had a three-bed dialysis unit. A committee of laymen and the King County Medical Society was developed to determine who would have access to this scarce and life saving technology. In 1962, Shana Alexander and this "God Committee" was pictured in Life magazine. The "God Committee" was widely criticized, but is the godparent of the modern HEC. The spread of HEC's in the 1980's was initially fueled by: (1) difficulty with matching the increasing capacity of medical technology with the medically appropriate application of this technology; (2) patient attitudes towards the personal experience of the bodily invasion of medical technology; (3) individual concepts of health, sickness, and death; and (4) increasing social concern regarding the "cost-effectiveness" in the application of technology.[1] With the Patient Self Determination Act (PSDA)[2] and increasing focus of the Joint Commission for Accreditation of Hospital Organizations (JCAHO)[3] upon the function of HEC's, with a Joint Commission mandate in 1991,[4] the presence of an HEC at an institution has become *"defacto"* required. Training programs in biomedical ethics are burgeoning, as are the number of individuals calling themselves ethics consultants.

There is a resultant move afoot to develop ethics consultation as a medical subspecialty.[5] An alternative approach is to have ethics consultants accredited through an independent accrediting body, such as licensure by the State Department of Professional Regulations. The inherent problem in these ideas relates to the fact that the "practice" of Biomedical Ethics includes physicians, nurses, philosophers, behaviorists: individuals who come to medical ethics from widely diverse backgrounds.[6] How do

you decide who in fact really does know enough to "practice" medical ethics? This has recently been discussed by Scofield[7] and Fletcher[8] with respect to the individual ethics consultant, and by Fletcher[9] and Fleetwood[10] with respect to HEC's. Fry-Revere has written a monograph on the issue of accountability for ethics committees and consultants.[11]

Fry-Revere asserts that there is a need for accountability in order to ensure due process, institutional integrity, and professional credibility. Two examples illustrate her concern. First, an Ethics Committee consultation performed for Elizabeth Bouvier, a quadriplegic who decided she wanted to die and had been admitted to the hospital where she refused to be fed, resulted in a recommendation that the institution could not support this request and she must be fed against her will. This case subsequently went to court.[12] Second, there are some individuals marketing themselves as experts in medical ethics who are on the road as expert witnesses and paid ethics consultants.

A Local Approach

The development of the HEC and the ethics consultant has been very grass roots and laissez faire. The story of our own HEC is illustrative. At our institution, the HEC was created in 1986 when, as Director of Critical Care Services, I was being repeatedly asked questions regarding level of care and distribution of resources by other physicians and recognized the need for hospital-wide education in these matters. The HEC was proposed for this purpose and has developed a life of its own. The people who are on it are trained haphazardly at best. My personal qualifications for being chairperson of the HEC are that it was my idea, I attended a two week course in 1986, have attended a course anywhere from two to seven days at least once a year ever since, and have read voraciously. I have some experience in politics and a good bedside manner. That is not exactly the background that would usually qualify one to sit down and take a licensure exam. We do have a "card carrying ethicist" on our committee: he did a year of mail correspondence course work in medical ethics that awarded him a certificate in medical ethics.

When our colleagues call us for problems, what are they getting? Are they getting someone who himself/herself has a code of ethics? Who keeps the consultant or committee in check? Who makes sure that we avoid conflicts of interest? Who is going to make sure that we have a patient-centered attitude? Who is going to make sure that we are honest with ourselves, that we avoid self-righteousness and that we avoid arrogance? Who is going to make sure that we ensure due process for the patient and family under conditions of conflict? For these and other reasons, the lay persons on our committee serve a very important role; they keep us honest.

The composition of the HEC, its concept of its own role, and a healthy sense of humility are very important here. Our committee is purposefully made up of no more than half doctors. The distribution of the physicians on it reflects the general composition of the medical staff. We can have up to five lay persons on the committee and recently we obtained approval to permit our lay persons to participate in prospective consultation. We have four to five nurses including bedside nurses. There is a representative from patient relations and social services. All of the chaplains participate as does risk management. We have several attorneys - we have a physician, a chaplain and a risk manager who are also attorneys. We have, however, been very careful not to have a hospital attorney on the committee: the loyalties of lawyers is to whoever pays them as part of their own code of ethics and there is potential conflict of interest for an institutional lawyer. The institutional lawyer serves us best as a consultant to our needs without direct membership in the HEC.

The HEC is not a jury or a "God Committee." Our primary role is self-education and institutional education. A formal orientation, monthly case conferences, an annual educational retreat, and many readings are required. Regular attendance at meetings and conferences is required to retain membership on the committee. We did not start policy development until after we spent a year on our own education. We did not start ethics consultation until after we spent three years on our own education and two years on institutional education. We admit that no one on our HEC is "trained." Self taught knowledge and on-the-job training in a committed individual can be as effective as formal training; the question of whether it is good enough for this profession remains.

In our HEC, we try to protect each other from going off "half cocked" by having our colleagues observe us. One of the reasons more than one person goes on an ethics consult is to make sure that the "lone ranger" type of ethics consultation does not occur. More than one individual is assigned to consult in order to have more than one perspective. It is important to preserve due process and at the same time keep any individual from having unchecked ethical bias. Our consult team is made up of untrained ethicists who are at various degrees of experience and education in medical ethics. First call is always one of the most experienced members of the HEC. The third member of the consultation team is a brand new member of the ethics committee and is learning by observation.

One of the first qualifications of our HEC members is that they are not intimidated by other individuals who are "in positions of power." We do, however, always have an M.D. on the consult team to facilitate communication with the referring M.D.'s and to ascertain the medical facts. When the attending M.D. was not the individual who requested the consult, the team notifies the attending physician that a consult has been requested. It is not necessary to have the attending physician's full and enthusiastic endorsement for a consult. Anyone can request a consult at our institution. To protect a "whistleblower," it is not necessary to report who requested the consult to the attending physician. It *is* necessary to get the patient's or the family's consent to proceed with the consult if they themselves have not requested it. Once all of the issues have been aired they tend to fall into context. What is ethically permissible becomes a list of options, sometimes a very short list. By airing the issues any conflicts that existed between patient/family and health care workers or among health care workers may be reduced. Written analysis and options are placed in the medical record, signed by all members of the consulting team.

It is the responsibility of this "SWAT Team" to recognize when the situation is so difficult that they need more help and should start calling legal consultation, a full committee meeting, and/or a "real" ethicist. The full ethics committee, as a group, reviews every consultation that has been performed at the monthly business meeting. This retrospective review is instructive for future consultations. Errors in process, analysis, and philosophy are fully discussed. In these ways we depend on the group to minimize the pitfalls inherent in the consultative process.[13]

This approach is a home grown one, but one that is being widely adopted. We could easily become a "CYA" committee for the institution; we could easily fall into a "group think" approach to decisions. Focussing on the individual responsibility of each committee member to share his or her thought processes, even if in conflict with the group, is very important. The ability to think independently is a critical requirement for committee members.

<u>Summary</u>

Until the "ethics industry" is regulated, it is our responsibility to regulate ourselves. I suspect that regulation or certification will

be a long time in coming, due to the diversity of backgrounds of the individuals who are making very important contributions in this field. Home grown committees and ethicists will make mistakes, but so can any certified professional. Certification or credentialing does not ensure accountability which is in fact the real issue at the heart of the matter.

The most important element of our responsibility, regardless of our accreditation status, is our own active and ongoing education in the field of medical ethics. We must be accountable to ourselves and each other. If a healthy dose of humility and the capacity to think critically is added, and the limitations of our mission remembered, then we serve our function as a resource for our patients, staff and institution.

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HEALTH CARE ADVANCE DIRECTIVES, LEGISLATIVE UPDATE

Submitted by **Hana Osman, LCSW,** Manager/Social Work Department, Tampa General Hospital.

The 1994 legislative session ended after revising the health care advance directives statute 765. The revisions are effective July 1, 1994 and they include:

1. If a guardian is appointed, the court will determine if the patient had designated a health care surrogate prior to incapacity, and specify in the letters of guardianship what authority, if any, the guardian shall exercise over the surrogate. The court may modify or revoke the authority of the surrogate to make health care decisions for the patient under certain circumstances (744.3115).

2. The court may modify or revoke the authority of the surrogate to make health care decisions if the surrogate has failed to fulfill his/her duties because of incapacity or illness, because of abusing powers, or if the patient has regained sufficient capacity to make his or her own health care decisions (765.105).

3. If neither the designated surrogate nor the alternate is able or willing to make health care decisions on behalf of the patient **and** in accordance with the patient's instructions, the health care facility may seek the appointment of a proxy (765.202).

4. If, after the appointment of a surrogate, a court appoints a guardian, the surrogate shall continue to make health care decisions unless the court has modified or revoked the authority of the surrogate (765.202).

5. If the patient completed a living will expressing his or her desires concerning life-prolonging procedures, but has not designated a surrogate, the attending physician may proceed as directed by the patient in the living will (765.304).

6. In the event that a patient has a living will and a dispute or disagreement concerning the attending physician's decision to withhold or withdraw life-prolonging procedures arises, the attending physician shall not withhold or withdraw life-prolonging procedures pending review in the form of judicial intervention (765.105). If a review of a disputed decision is not sought within 7 days, the attending physician may proceed in accordance with the patient's instructions (765.304).

7. In the event that health care providers of facilities refuse to comply with the declaration of the patient, facilities, as well as providers, are now expected to make reasonable efforts to transfer patients to other health care facilities that will comply with the patient's choices (765.308). All provisions that apply to providers will apply to facilities as well.

8. The 1994 legislation confirms that before the proxy exercises the incapacitated patient's rights to select or decline health care, the proxy must comply with the pertinent provisions applicable to surrogates, except that a proxy's decision to withhold or withdraw life-prolonging procedures must be sup ported by clear and convincing evidence that the decision would have been the one the patient would have chosen had the patient been competent (765.401).

9. The only reference to do not resuscitate orders (DNR) appears in the inclusion of such orders as an advance directive. All other references to DNR related issues were removed from the health care advance directives legislation and included in statute 401.45 (765.101).

THE RISE OF ETHICS COMMITTEES: DO WE NEED GUIDELINES OR STANDARDS?

Submitted by **Glenn R. Singer, M.D., F.A.C.P., F.C.C.P.**, Chairman, Bioethics Committee, Broward General Medical Center, Fort Lauderdale, Florida - Member, Board of Directors, Florida Bioethics Network.

The last decade has seen a tremendous increase in the number of ethics committees. In 1982 committees existed in only one percent of hospitals in the United States. More recent surveys show that over 60% of hospitals with over 200 beds have committees. In addition, committees are forming in nursing homes, hospice units, and dialysis centers.

Ethics committees have been touted as key players in healthcare by such diverse groups as the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, the American Medical Association, and the American Hospital Association. Some states such as Maryland and New Jersey have legislated their existence.

Perhaps the biggest impetus, however, came from the 1991 Joint Commission on Accreditation of Healthcare Organizations. The most recent manual includes a requirement for a "mechanism" to review ethical problems and provide education for health care providers and patients. A recent article in the Network News describes the JCAHO review of the Shands Hospital Bioethics Committee (Florida Bioethics Network News, First Quarter).

How are ethics committees working now?

What have we brought forth? A new entity now exists in the clinical arena without a well defined role, but with several important questions.

There are important structural issues. Are these committees of the medical staffs or of the institutions themselves? Do all participants have an equal voice? Most ethics committees have members from outside the institution. Should these participants go through a rigorous credentialing such as a new applicant to a medical staff? Should the hospital attorney and/or risk manager be on the committee and what should be his/her role?

Most ethics committees consider education to be an integral function. This includes education of the medical and professional staff, patients, and the community. How can we ensure, though, the education of the ethics committee members, themselves? Professional ethicists will certainly not be available to every hospital staff. At what point can the committee begin educating others, formulating policy, and offering ethics consultations.

Who should be allowed to request an ethics consultation? Ordinarily, only physicians call for consults. Can nurses or family members ask for ethics consultations?

There are many questions about case consultations. What consultations, ad hoc committees, or full committees? If an individual, what kind of individual? Physicians may lack ethical perspectives and non-physicians may lack clinical experience. If the consult is done by less than the full committee, should the full committee review the proceedings?

Should a consult give specific recommendations or a list of appropriate options? Are recommendations binding or optional?

The method of recording the ethics consult varies as well. The attending may simply record the recommendations in the chart as in the Tumor Board model. A formal consult may be placed into the chart, but then comes the question as to who should sign it?

Should the participants in ethics consultations receive civil and criminal immunity? The absence of immunity may dissuade involvement on ethics committees. Such immunity already exists for peer review.

Nevertheless, questions exist regarding the rigorousness of the ethics process. Is some always representing the patient's interests? Do we ensure all interested parties are appropriately notified of the ethics proceedings? Are recommendations consistent with similar cases and with hospital policy? Is there a mechanism for parties to lodge timely complaints and appeals?

How should we proceed?

Bioethics committees are important new entities. The potential for contribution to clinical medicine is great. The possibility of a misinformed or misguided clinical decision leading to inappropriate care or death is unfortunately also present.

The Board of the Florida Bioethics Network is considering setting forth guidelines or standards for committees. The importance of safeguarding patients in decisions which often involve life and death, appropriately

allocating precious resources, and providing the highest level of patient care cannot be mitigated. We solicit your comments and suggestions in the hope of representing your concerns. Please respond to Glenn R. Singer, M.D., c/o Florida Bioethics Network, Post Office Box 531107, Orlando, Florida 32853-1107.

Selected References

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"DIVERSITY-THE CHALLENGE TO ETHICS COMMITTEES" THEME OF 1994 ANNUAL CONFERENCE

Submitted by **John Alfano**, Vice President/ Educational Services, Florida Hospital Association; Staff Liaison, Florida Bioethics Network.

This year's conference features a variety of presentations on diversity. With over eight breakout sessions for interaction among participants, the conference is designed to provide many networking opportunities. A special preconference was initiated this year on September 21 for those new to ethics committees.

One of the highlights of the conference will be a presentation by **Annette Dula, Ph.D.**, entitled "Miss Mildred." Her presentation will address the question, "What do health care providers need to know about the culture of elderly black women to best serve their health care needs?" Dr. **Dula's** narrative will provide a cultural window to display the interrelationship of family, religion and community. The narrative will be accompanied by slides of African American art that help portray the life of the elderly African American woman.

The conference will be held September 22-23 at the Clarion Plaza Hotel, 9700 International Drive, Orlando, Florida. Extra brochures are available by calling **Sherry Greenhalgh** at 407/841-6230.

1994-95 ELECTION OF OFFICERS

Please complete your ballot to elect the open positions on the board and the President-elect. This year's board is pleased with the slate of very qualified nominees for the open positions. Mail or fax your ballot to **John Alfano**, Florida Hospital Association, P.O. Box 531107, Orlando, FL 32853-1107 or fax 407/422-5948.

WELCOME NEW MEMBERS!

The Florida Bioethics Network welcomes new members **Bob McKinley,** Director/Program Development, Barry University, Miami Shores, 305/899-3283; **Dr. James Orlowski,** VP/Medical Director-Surgical, University Community Hospital, Tampa, 813/979-7437; and **Preston Ponce,** Chaplain, Hospice of North Central Florida, Gainesville, 904/378-2121.

UPCOMING CONFERENCES

FBN 4th Annual Conference, "Diversity - The Challenge to Ethics Committees", September 22-23, Pre-conference September 21, Clarion Plaza Hotel, Orlando, Florida.

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The Barry University School of Podiatric Medicine (BUSPM) recently received a grant from the Florida Humanities Council (FHC) to conduct "Biomedical Ethics: Challenges to the Medical Profession" at the Indian River Plantation, November 4-5. This exciting program will examine topics such as withdrawal of nutrition and hydration, values in the health care profession, patient self-determination, and establishing biomedical ehtics committees. The program will feature Ray Moseley, Ph.D., FBN Advisor and Associate Professor & Director of the Medical Humanities Program, University of Florida, College of Medicine. All lectures will be free and open to the public. Due to space limitations, registration is required for all attendees.

The conference is the first in a planned series of activities sponsored by the Treasure Coast Biomedical Ethics Council of Barry University. Application has been made for twelve hours of continuing education credits for nursing, social work, physical therapy, medicine, and podiatric medicine. A $20 CME/CEU registration fee will be assessed for those seeking credit.

This conference is co-sponsored by Martin Memorial Medical Center, Indian River Memorial Hospital, Columbia/HCA Medical Center of Port St. Lucie, Columbia/HCA Lawnwood Regional Medical Center, Columbia/HCA Raulerson Hospital, and Barry University's Schools of Nursing, Social Work, Podiatric Medicine, and Department of Theology and Philosophy.

For further information, please contact Bob McKinlay, MPS, Project Director at 305/899-3283.