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Toward a Clear Definition of Ethics Committees

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The impact of technology upon medicine's ability to prolong life, save the life of the premature or defective newborn and provide new and innovative therapies for a variety of illnesses raises significant value questions for patients, practitioners, the medical community and society. Answering these questions is difficult. Various suggestions are put forth to describe a method or process to resolve value and ethical questions. The legal system is used by some, especially through the courts, although there are some who seek solutions through statutory law. Ethics committees, or health care institution committees, or medical moral committees are used by others.[1] In addition, some suggest that those involved in the provider-patient relationship resolve issues within this relationship without outside intervention.

The purpose of this article is to examine the various suggestions which have been made to enhance medical decision-making through "ethics committees" and to evaluate their various uses. There is a place for ethics committees in contemporary health care, but their setting and focus must be defined more carefully than it has been in recent literature. Demanding too much of an ethics committee, or using the misnomer "ethics committee" to describe a committee whose function is different, muddles the medical decision-making process.

The case of Karen Ann Quinlan was one of the first cases to receive national attention where physicians, family and the courts attempted to resolve difficult ethical questions through the use of an ethics committee. The court's mistaken presumption that each hospital had an operative ethics committee which could provide direction in making these decisions raised difficult questions about the various roles which such a committee would take.[2] What relevant information is necessary in the decision-making process? Who should decide? How can society deal with the ambiguities and uncertainties of medicine when such critical decisions must be made?

The false presumption of the court in the Quinlan decision l to debate about the description, composition and function of such " om- mittees."[3] What the court asked for in an ethics committee was ore accurately a prognosis committee. This left some critical que ons unanswered. Who had the final authority to make the decisions r ces- sary about Karen's treatment? Was it her father as court-appc ted guardian? Was it the court? Was it the father only if he was in ree- ment with the "ethics committee"? Or was it really the "ethics om- mittee" which had the final word in the decision-making process The ruling of the court sparked discussion in health care institutions d in medicine, and the treatment of critically and terminally ill pa nts. The ensuing years marked the beginning of a number of comm ees, known as "critical care committees," "optimal care commi es," "prognosis committees," designed to aid people in the de ion- making process in areas of life and death.[4]

"Ethics committee" is presently a generic term used to d ribe many of these committees as hospitals and health care instit ions wrestle with the difficult ethical questions. Recent public ions, including the President's Commission for the Study of Ethical Prob- lems in Medicine and Biomedical and Behavioral Research's ork, *Deciding to Forego Life-Sustaining Treatment*, indicate the v rious functions which committees might play in this area.[5] Perha s the most significant suggestion is an "ethics committee" not in n all- encompassing sense, but as a committee which directly ad esses ethical issues in health care.

Functions Suggested

Some "necessary" functions suggested for "ethics committees" by the federal government and some authors should be performed by already existing committees or within the already established and generally accepted guidelines of medical practice. Decision-making, in cases of death and dying, for example, is something which should be arrived at consensually by the patient or the patient's guardian and the health care provider and not be relegated to a committee.[6] Certain tacitly recognized canons of medical practice, such as a need for consultation or second opinions, should be respected by the physician in difficult situations. In such cases, a decision should not be made until such an opinion has been received and issue of prognosis resolved. In other cases, genuine ambiguity about a patient's condition and prognosis may exist. A larger number of people making a decision will not clear up medical ambiguities which are a part of the patient's condition. What is unknown in the medical context will not become known in an "ethics committee." Good medical decisions in difficult cases are not made in isolation. Subsequently, the observations, knowledge and reflections of a "health care team" will be important. This should be part of "normal" medical procedure and, hence, part of the decision-making process and not cause to create a committee. Each service in a hospital setting will have certain factors to consider in the decision-making process. It is better that this be done on the floor where clinical decisions ought to be made, rather than in a committee.

There has been some suggestion that so-called "ethics committees" which make medical decisions will help diffuse the responsibility for making some of these difficult decisions. In addition, this might reduce the liability risk to the institution as well as to the attending physician. Risk is an inherent part of medicine today. Such risk ought not be rushed into foolishly.[7] In some cases, risk cannot and should not be reduced. Therapies and decisions should not always be avoided because there is risk. The future of medical care and new knowledge may be affected by the avoidance of all risk. There is, indeed, need for limiting liability in the medical profession. However, that will be better accomplished when medical education and the public sector recognize that perfect technical medicine is a myth and that, in some cases, a "prudent decision" is the best decision.

Health care providers must also recognize the place of informed consent, the time factors needed for good decision-making on the part of the patient or the patient's guardian, the various nonmedical factors which may be determinate in a patient's decision-making, and the place of law and ethics in the medical decision-making process. Competence in these areas is as important as scientific and technical competence. Again, these goals will not be adequately realized in a committee setting, although certain committees may aid the health care provider in evaluating the various factors. Rather, good decision-making, which may help limit risk and liability, is better realized in a consensual process between physician and patient.

The various forms of "ethics committees" which have arisen in the post-Quinlan era are addressing important issues at the intersection of public policy, ethics and medical decision-making. It is important, however, to ask whether these committees are the best or most appropriate way to deal with these issues. Death and dying decisions, for the competent or the incompetent, the old or the newborn, are not the only ethical issues which confront modern medicine. The Quinlan case and many recent court cases have too narrowly focused our attention on one set of ethical dilemmas.

Modern medicine requires review committees whose responsibility it is to ensure quality care. Ethics committees, however, should address other issues of concern for health care delivery. These committees will service institutions and health care providers by reflecting carefully upon the foundations of medicine, health care delivery, and health care institutions. Ethics committees should help articulate the values operative in contemporary medicine and, hence, their implications for medical practice, through the development of policies for the

health care institutions, consultation for health care seekers and alth care providers, and education for institutions, individuals and th om- munity. As such, they may help to resolve some of the difficult sues presented at the edges of life. However, their broad mandate y l go beyond death and dying and be a place for the reflection and ar ula- tion of the intrinsic values of medicine and health care deliv y in contemporary society.

Values and Medicine

Medicine is not a scientific endeavor devoid of values or a dis pline which seeks some value or ethical reflection outside its clinical per- ience.[8] Medicine, by its very nature, is intrinsically a value-o nted discipline. The reason for this lies in the nature of the medical t nsac- tion.

The "medical relationship" is established through a mutual con- sensual coming together of two people. There are basic needs which the patient has which he or she seeks to fulfill through a relati nship with a health care provider. Both people in the relationship are s eking the same goal: well-being for the sick person. This is a perso rela- tionship which is dependent upon mutuality if the goal is to be realized. This mutuality is expressed in the relationship by the "need" which each partner of the transaction has for the other. The pa ient is needed by the professional to realize the goals of helping and caring which medicine professes, while the patient needs the profess nal if the goals of well-being and cure or care are to be attained.

Within this relationship one expects certain traits to be manifested. The provider ought to be skilled and competent, to have mastered a certain body of knowledge, to be aware of personal limits, and be genuinely concerned about the patient. The patient is expected to evidence honesty, trust, care about oneself, and compliance with cer- tain therapies, if cure or care is to be realized.

If one changes the characteristics of this relationship, one gets something "other" than medicine. A lack of mutuality or shared goals indicates that one is being used as a means rather than as an end. A health care provider, for example, who *uses* patients in such a fashion, would be called a shyster or a charlatan or, worse, a butcher. Hence it becomes clear there are a host of values which are foundational to the medical transaction. Values are not incidental or relative to the medi- cal relationship; rather, they are a constitutive part of the medical transaction. Health care providers who set aside the primary value of this relationship may be adept technicians, but they fail in providing "good care."

If values are an *intrinsic* part of the medical relationship, then it is clear that one cannot separate value issues in decision-making from the

clinical settings in which medicine takes place. To establish an ethics committee for making value-related decisions apart from the clinical setting would be bad medicine. To allow or to require that the pri- mary decision-makers seek a decision from some "ethics committee" would in itself be unethical. This does not negate the possibility of consultation or of openly examining the various possibilities which might exist. Such discussions might be extremely helpful and aid good decision-making practice. What ought to be avoided is a separation of medical and ethical concerns in the decision-making process or in the decision-makers themselves.

It is not just medicine and ethics which have an intrinsic relationship. Similar things may be said about the relationship of medicine, ethics and health care institutions. A hospital is not simply a place where medical care is dispensed. As an institution it has a "moral" character which embodies values which should be recognized in the practice of medicine.[9]

Central to the identity of any hospital, regardless of its organiza- tional structure or affiliations, is patient care. It is expected that patients will receive medical care from providers in the institution under the supervision of trustees and administrators who create and implement policies which ensure quality care. The relationship between the institution and patient-benefit is the focal point of reflec- tion for ethical issues within the institution.

In addition to the relationship of the institution with the individual patient, there is also a relationship between the community and the institution. A hospital stands as a place where the sick may find com- passionate care. The changes which take place in medicine also affect the hospital and its relationship to the community.[10] Increased tech- nology raises fundamental value questions for the institution. Is technology — newer, bigger and better — the motivating force for expansion and health care delivery? Does the acquisition of new tech- nologies improve the quality of care patients receive? Because of increased cost does it limit the class, race or group of people who have access? If so, what is being done for these people? What does increased and expensive technology do to the relationship between administra- tors, health care providers, patients and the community? If the central concerns of the health care institution are the rights and care of the patient, what does this mean for the way in which health care is delivered and the way in which hospital expansion and diversification decisions are made? As in the case of medicine, a separation between the hospital, medical care, ethics and decision-making is a false dichotomy.

Questions about medicine, health care institutions and patients have a social dimension. Any adequate discussion of the person must include social realities. Health, the delivery of health care and health care institutions, as well as the decision-making process, do not occur

in a vacuum or solely in a one-on-one relationship. There are ıpor-
tant social dimensions which have to be considered. Increasing , this
is the case in health care economics. Decisions in one area of m icine
have ethical implications in other sectors of the health care stem.
Decisions to modernize or move an institution may leave a rtain
sector of the population underserved. Resolving some of the hical
issues which confront medicine today requires a careful anal is of
social values and social goods.

Discussions about ethics and medicine must keep all three o these
realities in mind. What are the intrinsic values of medicine, f the
delivery of health care and of social life which must be foster l and
developed as society and medicine change?

Ethics Committees

Committees, or some forum in which ethical questions a e dis-
cussed, are crucial at this point in the history of medicine. These
forums can serve as a place where various ethical issues are aised,
discussed, critically examined and where a number of discipline come
together to examine the implications of contemporary medicine upon
life. Realistic expectations and accurate descriptions of the functions
of such committees are important if they are to be helpful.

"Ethics committee" is an accurate title for one such committee as
long as the parameters of the committee are sufficiently clear. The term
should not be used as a generic or umbrella term for actual medical
decision-making committees or for retrospective study committees
which have disciplinary or grievance responsibilities. Most of these
tasks should be carried out by other already established processes.[11]

Grievance committees should be structured in each health care insti-
tution and it is the responsibility of the administrator to see that such
committees are in place and can and do function. Peer review and peer
discipline are things which every branch of the medical profession has
sought to claim for itself. Such should be the case. Tissue committees
and quality assurance committees, along with other committees
designed to ensure the practice of quality medicine, should be allowed
to perform their functions without hindrance. In all committees,
patient care and patients' rights should be a concern. The value or goal
of all activity in the medical profession is the well-being of the patient.
The purpose of such committees is to ensure that this stated goal is, in
fact, realized personally, professionally and institutionally. If these
goals are not realized, what is needed is not an ethics committee but a
"watchdog committee" which will, in all likelihood, be comprised of
outsiders to the institution and the profession. Such a situation does
not appear to be in anyone's best interest. It would be a fundamental
statement that the medical community cannot be trusted. If such a
statement were made, one would wonder about the long-term implica-

tions this would have for health care delivery and patient well-being.
Trust is significant in the medical relationship. It ought not be
violated.

Medical decision-making requires certain considerations which are
outside the bounds of an ethics committee. First, one presumes that a
therapy is used because it is at least thought to be in the best interest
of the patient and that the therapy, all things considered, will best
advance the goals of patient well-being. If there is uncertainty, which
requires another opinion, then the presumption is that the attending
physician will ensure that other opinions are sought. When other opin-
ions necessitate more than one other physician or require a consulta-
tion with a team of health care professionals, one assumes it will be
done. It is the "nature" of medicine. If information is available and
interpreted well, even where ambiguity exists, then the decisions made
will usually be good. Often those who suggest that a prognosis com-
mittee be established to evaluate or check on every decision made for a
terminally ill incompetent patient or other critical care cases such as
defective newborns, are implying, first, that real decision-making
powers belong to someone other than the guardian of the patient in a
consensual relationship with the provider(s). Second, they are imply-
ing that physicians are not acting prudently in the decision-making
process, do not practice "good" medicine and, therefore, they have to
be "checked" by a committee. Third, they might be implying that the
real issue at stake is not physician competence, but legal liability.
What happens to the value structures of institutions and physicians
when legal reasons are the ultimate basis for decision-making? One
would grant that medicine, law and ethics share similar goals —
respecting the life of the patient, autonomy, well-being — but that
does not mean that a legal decision is necessarily the best decision.
The "discretionary space" necessary for good ethical and medical
decision-making can be compromised too easily by excessive legal
concern.[12] Fourth, medicine by its very nature is not static. What is
true of a patient today may not be true tomorrow and what is indi-
cated as therapy today may be contraindicated tomorrow. Again, the
"discretionary space" needed for such decisions is not provided when
medical decisions best made on the floor are checked continually by a
committee.

More positively, the primary goal of ethics committees is to deal
with *ethical* issues through the health care delivery institution, in
broad or general principles, providing patient and provider with an
opportunity to explore the interconnections between values and medi-
cine. The objective of the committee is to establish procedures for the
implementation of these values in the health care delivery system
through educational offerings, policy development and voluntary con-
sultation at the request of a provider or a patient. Ideally, if good
opportunities are offered to explore the values in medicine and their

implications for patient choice, medical practice and administ tion, then clear policies should be able to be formulated which will l the decision-making process. Such a committee will also respect the trinsic relationship between medicine, values and health care deliv y by drawing out already existing values, rather than by imposing e insic values or legal solutions. Such a committee will strive to bring t ether the goals of medicine, law and ethics for patient benefit.

Each of the three objectives of the ethics committee sho d be considered in an interlocking paradigm. These are not separa and distinct projects. Rather they are overlapping concerns. It is t pri-mary responsibility of the administration of the institution to s that it works smoothly in providing quality care for the patient. T stees must be brought into a more active role in some institution Ulti-mately it is the trustees, through their administrators, who ould answer to the public, assuring the community that the institu ion is securing care for the sick in a just manner. Consequently, the thics committee is an administrative committee addressing these pro lems.

Objectives of Ethics Committees

The first objective, education, is perhaps the most importan . This is not an endless didactic task taken on by an institutional ethic st, but is rather an attempt to "draw out" in the sense of "educa e" the values implicit in the practice of medicine. The primacy of the patient, doing no harm, benefitting the patient, trust, consensual agreements, all find their roots in the medical relationship. The question is how these values are respected in the changing practice of medicine. Education is the process of helping all providers realize the implicit values in modern technological medicine. It is the process of helping the healer to be healer rather than technician. Education is the reflective process of understanding the implications of one's action and ensuring quality care for the patient.

There are a variety of ways in which education can be accomplished and each institution may seek a different format to realize this goal. Education may be done in normal continuing educational seminars sponsored by professional groups. Grand rounds provide another opportunity for people in a given speciality to examine the value-issues which are a part of their medical practice. Less formal modes of education are also possible in response to general cases on a particular service or in the news. Discussions between various professionals involved in one service of the institution may also prove valuable. Each of these formats lends itself to a discussion of ethical issues in medicine. The fundamental objective in these situations is to articulate the presumptions or assumptions which underlie medical care.

An oncology service may be used as one example. What are the assumptions about medical care and what is valuable or right or good

for the various professionals involved in treating a person in this service? What does one think about terminal illness? What are the values or disvalues one holds in regard to pain, suffering, death? What about other providers on the floor — the dietitian, therapist, pastoral care person? What happens when these different assumptions conflict? Are the patient and the patient's benefit always at the heart of the decision-making process? If some of the values and assumptions are worked through more clearly, will it be possible to provide better care in a "healthier" atmosphere?

Problems in other medical services can be identified. There are economic values which can be discussed: resource issues, what happens when an institution is understaffed, how competition in the marketplace affects the kind of care a patient gets, what other needs besides physical needs a patient has.

If education is successful, issues will be raised, treatment procedures will be discussed, the delivery of health care will improve, greater communication between staff may develop, and the increasing use of technology will not put distance between the patient and the professional staff. Such a committee will not replace the vital services of an educational in-service department within the institution. The presumption would be that the ethics committee and in-service education would collaborate as necessary.

Some of these experiences, especially those which take place within certain services, will give rise to the second objective of the committee, which is policy development. Discussions may uncover the need for the health care professionals to communicate more clearly or define roles more carefully. This may be the case with "Do Not Resuscitate" orders, with patient discharge issues for further care, with team-oriented decision-making in the case of the incompetent or of defective newborns. Policy issues may be raised about other problems. One might ask what the institution's relationship is to the rest of the community. How do different services meet the needs of those in the community? How does the institution treat a certain class of people, such as rape victims, chemically dependent individuals, geriatric patients, disabled individuals? What is the hospital's charity budget, bad debt budget? What does this mean for the delivery of health care to the poor and the needy? Does the institution have a role in the community beyond the delivery of health care?

Procedural issues may be written policies which reflect carefully and accurately the state of the art of medicine, the possibility of patient benefit, and other concerns which facilitate good medical practice. Policies should reflect the values which medicine and the institution use to identify themselves. More importantly, policies are never rigid or chiseled in stone. They are created to enhance patient-benefit. Medicine, as it grows and changes, will find better and different ways to accomplish the goals of curing and caring for people which may

require policy changes. The definition and determination of d th is an example. If the institution is incapable of review and nge periodically, it will die. Flexibility and adaptation are required e to the very nature of medicine. Also, policy should be loose eno h to provide latitude for individual judgments in medicine required the fact that patients are not the same.

One last point about policy-making issues is the disseminat n of information. It is the responsibility of the board of trustees, to ther with the administrator and providers, to make hospital policy. ose responsible must consult with those who will be affected by a p licy. However, even if careful consultation exists, every effort has be made to communicate the policy clearly. Compliance and the r liza-tion of values will not occur if this fundamental communicatio does not exist. Those most adversely affected by this lack of comm ica-tion will be the patients.

If there are regular discussions available for people to ex nine values in medicine and their implications for health care delivery and if sound policies are developed, there is a greater likelihood that und medical decision-making will take place in the clinical setting. E ucational events and policy formation, however, do not guarantee cl r or sound principles in each case for each person. Patients, nurses, lied health care professionals and physicians have questions about p rtic-ular cases. In these cases, the ethics committee can be the sou ding board for ideas and alternative treatments. Case discussion ca be beneficial.

The role of the ethics committee in such a situation is to listen to and assess the medical facts and other relevant data in order to discuss the values operative in a particular medical situation. Responsible and conscientious members of such a committee, along with other invited members, such as family or other "experts," would give the physician, health care team, or family an opportunity to explore all the viable possibilities. Consistent with good medical decision-making practices, it is then the physician's responsibility, perhaps in cooperation with a larger health care team, to make the final decisions in a consensual manner with the competent patient or with the guardian of an incompetent patient. This is an "educational" endeavor in which one is drawing out the values of patient, situation, physician and the medical process in order to make a sound ethical medical decision.

Consultation of this sort aids medical decision-making. The ethics committee is not a substitute for the spiritual, social or moral counseling that a patient or a provider might need. It may aid in making a decision, but there are other recognized groups within the medical establishment which should also be functioning in difficult cases. The social work department, the pastoral care department, the significant counselor of the family or the patient should have access to the patient and should fulfill their specific roles. It is not the role of the

ethics committee to replace an inefficient department in the institution. Likewise, the ethics committee ought not to take over one of the roles of the attending physician and/or health care team which is to help the patient understand his or her illness and make some important decisions in regard to treatment.

Ethics Committees in Catholic Hospitals

Catholic hospitals are faced with the same issues as are other health care facilities in this country. They also need to reflect on the relationship between values, medicine and the institution and its implications for patient care. Like other institutions, care givers, administrators and trustees must articulate the underlying values which are important to quality care for the whole person. Differences in the "moral code" which develop from this reflection may arise, but the *need* to reflect upon and articulate values is the same.

Catholic facilities differ from other institutions in mission statements, where the poor and needy are concerned, and certain moral directives which guide hospital policy and practice due to the theological concerns of health care ministry. They also share a more detailed, common moral vision derived from *The Ethical and Religious Directives for Catholic Health Facilities.* An ethics committee can help the institution reflect its distinctiveness and mission in a variety of ways.

First, there is a concern for the very setting of the health care institution. It witnesses to the fundamental mission of the Church, announcing "the saving presence of Christ." Concerns about spiritual as well as physical health are important. One can treat a patient in the Catholic institution only when one remembers that health care involves the "total" person, regardless of religious affiliation. Care for the total person requires that the institution reflect upon its relationship to the community which it serves, the needs of those who provide health care and those who seek care within the institution. On this level, an ethics committee reflects the fundamental visions of the person in light of the Gospel and what this means for a Catholic facility. However, translating these general statements into the concrete situation of each institution is difficult.

Second, consideration must be given to the particular or individual problems which arise for the Catholic facility. Advances in science and technology require new reflection on new problems as well as renewed reflection upon old ones. While the *Directives* provide a solid basis for this reflection in the health care facility, they cannot be counted upon to resolve every issue with ease. Part of the function of an ethics committee can be to evaluate and reflect upon new events in medicine which may be crucial to the health of those who use the institution. Genetic counseling is one example of this problem. This recent advance in science and medicine can be used for great good in prepar-

ing families for children who are suffering from certain disabilit , in helping children overcome physical and mental disabilities, perh s *in utero*, and helping families make sound reproductive decisions hen they are aware that they are carriers for possibly devastating g etic disease. An ethics committee may help to develop procedures nich respect the values of nascent life and family life while engaging n an important dialogue in the scientific and medical community. C tin- ued discussion will ensure the values which underlie the *Directiv*

The ethics committee's function for the Catholic institutio like any other health care facility, ought to help the administrato and health care providers be faithful to the basic mission of the hos l as a place for care and cure by ensuring education and discussion out the values of medicine and health care. The ethics committee the Catholic facility is not meant to be an enforcement arm for the *irec- tives.* The *Directives* were never meant to be a recipe for the s tion of medical-moral problems. The distinctiveness of the Catholic titu- tion may be aided by a lively and courageous group of people lling to realize the fundamental values of the *Directives* in the daily a ivity of the institution.

Final Reflections

An ethics committee of this type avoids certain pitfalls which ould complicate the decision-making process and possibly not be of nefit to the patient. This committee does not replace the decision- aking process which properly belongs to the physician and patien . The committee is not a prognosis committee. If it is to realize the bove- mentioned tasks, various people will have to be a part of the c mmit- tee. Such variety precludes only physician and medical membership.

In addition, an ethics committee may incidentally reduce liability for the institution or a particular physician by indicating that, in fact, the physician was not negligent or that he or she discussed important issues with other colleagues and gathered other opinions where neces- sary. This may be an advantage in an age of adversarial relationships. However, this is not the primary task of the ethics committee and it should not be made the primary task. If liability becomes the primary concern, then the issues raised will always be approached from a legal perspective asking certain questions such as, "Is this within the frame of the law?" "What is my chance of being sued if I perform this particular action as opposed to that one?" In fact, the issues ought to be asked first from an ethical and medical perspective. While legal issues may then limit what can be done, the initial discussion should take place on a different plane.[13]

Ethics committees may also benefit the health care profession by giving it a place to discuss ethical issues which fall outside the scope of interventive care. An ethics committee can allow an institution to

discuss the issues of justice, fairness, access and economics. Beyond patient issues, the committee can also address the issues which arise in forming and maintaining a health care team, relationships between various categories of providers and other similar issues which have an impact upon quality care. "Prognosis committees" and "optimal care committees" or "infant care review committees" cannot service these issues for an institution. There may be need for some of these commit- tees, but the role and function of an ethics committee is different.

Other troubling issues about the deliberations of these so-called "ethics committees" have been raised. Should committees have min- utes? Are the minutes open to the public? Are meetings open to the public? It is important to realize that an ethics committee and the work it does has a certain responsibility to people in whose com- munity the institution is established. As such, deliberations about values should be publicly addressed in certain circumstances. Minutes may provide one form of accountability for the committee as well as the institution. However, openness and minutes cannot compromise the right of a patient to privacy and confidentiality. Such principles will override the desire for public access both to meetings and to information. Separating these two roles should not be too difficult.

Should an ethics committee be liable in court for certain decisions? The place for decision-making rests with the physicians and the patient and the patient's family in a consensual manner. This commit- tee will not be making these decisions. Therefore, some liability issues are not a problem. However, this does not mean the committee ought not be held accountable for areas where it does have responsibility. It cannot allow itself to be manipulated by members of the board of trustees, the administration or the medical staff. It is a committee which serves the whole institution. If, in its proceedings, it educates poorly or negligently or proposes policy foolishly, then it ought to be held responsible for its decisions and behavior. What that means in a court of law is uncertain.

Ethics committees ought to employ, as much as possible, a consen- sus model of decision-making. Decisions about policy recommenda- tions, for example, should be committee decisions. If the committee's work is owned by some and disowned by others, it will not help in the decision-making process and in health care delivery. In all likelihood, the committee will become a burden, dreaded and useless. Such results leave the medical establishment where it is now, with no arena in which to discuss medical-ethical issues which encompass a broad hori- zon of the health care profession. Again, those adversely affected are the patients.

Lastly, one has to ask questions about the place of ethics commit- tees in larger corporate or multi-institutional systems. Larger institu- tional entities may be ideal for reducing costs through central supply or shared computer facilities, but this does not necessarily translate

into better ethical decision-making. Certain issues may benefit th ugh corporate discussion, such as the corporation's response to the h alth care needs of the poor. However, the individual needs of a ven community may better be answered by a group of people wh are very "local" and can reflect more carefully on the relatio hips between the health care institution and the needs of the comm ity.

Ethics committees are designed to promote the discussion of lues in medicine as they affect the health care delivery system. C eful attention to the field of medicine and the values of the commun y in which a health care institution is located can be a positive expe ence and influence in modern medicine. Such a committee does not r gate the need for other committees to discuss other important issues such as the prognosis committee, but the two committees and the i por-tant functions they can serve should not be confused.

REFERENCES

1. Summaries of the suggestions can be found in *Deciding to Forego Life-Sustaining Treatment: Ethical, Medical and Legal Issues in Treatment Decision*, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Washington, D.C.: U.S. Government Printing Office, 1983), pp. 153-170, 439-457. Also see Kalchbrenner, Kelly, McCarthy, "Ethics Committees and Ethicists in Catholic Hospitals," *Hospital Progress*, Sept., 1983, pp. 47-51.

2. Veatch, R., "Hospital Ethics Committees: Is There a Role?" *Hastings Center Report*, June, 1977, pp. 22-25.

3. Much of the literature in the past 10 years indicates the importance of clarifying what the committee is expected to do. A broad representation of people, many of whom would not be physicians in a certain subspeciality, would have difficulty carrying out the wishes of the court with any certainty. Clear definitions of the committee's purpose will resolve issues such as membership, mode of decision-making, openness to other parties, etc.

4. Cohen, C., "Interdisciplinary Consultation on the Care of the Critically Ill and Dying: The Role of One Hospital's Ethics Committee," *Critical Care Medicine*, Nov., 1982, pp. 776-784; Esqueda, "Ethics Committees: Four Case Studies," *Hospital Medical Staff*, Nov., 1978, pp. 26-30; Stadler, "Ethical Committees in a Pediatric Hospital," *European Journal of Pediatrics*, May, 1981, pp. 119-122; "Optimal Care for Hopelessly Ill Patients: A Report of the Clinical Care Committee of the Massachusetts General Hospital," *New England Journal of Medicine*, Aug. 12, 1976, pp. 362-364; Cassem, "Consultation to Continue or Stop Treatment Measures in Irreversible Illness," *Advances in Psychosomatic Medicine*, Nov., 1980, pp. 119-131.

5. *Deciding to Forego Life-Sustaining Treatment, op. cit.*, p. 451.

6. The philosophy of medicine provides an understanding of the structures or parameters within which medicine is practiced and the decision-making process that is used. Due to the nature of the physician-patient relationship, an outside committee empowered to make decisions is intrinsic.

7. Hirsch, "Establish Ethics Committees to Minimize Liability, Authority Advises," *Hospital Risk Management*, April, 1981, pp. 45-58. Although the concept brought out in the interview is important, the expectation that an ethics committee would be responsible for such minimized risks indicates a lack of clear thinking about the role of ethics in medicine and a confusion between sound legal practices and sound ethics. They are not synonymous.

8. For various approaches to this relationship of values and medicine, see Pellegrino and Thomasma, *A Philosophical Basis of Medical Practice* (New York: Oxford University Press, 1981); May, *The Physician's Covenant* (Philadelphia: The Westminster Press, 1983); Veatch, *The Theory of Medical Ethics* (New York: Basic Books, 1981); Ramsey, *The Patient as Person* (New Haven: Yale University Press, 1970); Papper, *Doing Right: Everyday Medical Ethics* (Boston: Little, Brown and Company, 1983).

9. Ashley and O'Rourke, *Health Care Ethics: A Theological Analysis, second* edition (St. Louis: Catholic Health Association, 1982), pp. 113-145; L. Veatch, "Community Participation in Health Care Decisions," *Ethics and Health Policy*, ed. by Veatch, Branson (Cambridge: Ballinger, 1976), pp. 289-305. Similar concerns of the ethics of the institution arise in ethics and health planning.

10. Starr, in *The Social Transformation of American Medicine* (New York: Basic Books, 1983) traces some of these developments in the history of American society. Current changes will again affect the development, delivery and quality of medical care for better or worse.

11. Freedman, "One Philosopher's Experience of an Ethics Committee," *Hastings Center Report*, April, 1981, pp. 20-22, recounts one experience where consultation and discussion clarified issues without assuming the decision-making role.

12. Engelhardt, Spicker, Towers, eds., *Clinical Judgment: A Critical Appraisal* (Dordrecht: D. Reidel, 1979).

13. Most people suggest the presence of a lawyer in these committees. Their presence can be valuable as long as it does not cause undue focus on legal solutions rather than ethical issues. Primary focus should be placed on the ethical issues of the institution and legal accommodation made only when necessary. This would be especially true when policies are being developed.