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Organizational Ethics Committees

The first official healthcare ethics committee convened in 1971.[i] But the origin of such committees came years earlier in response to a rising tide of moral concern in health care. "Committees for the Discussion of Morals in Medicine" were formed by U.S. Catholic Hospitals in the 1960s in response to increasing social awareness of personal rights and the new dilemmas created by evolving life saving medical technology. At that same time many of us remember the selection committees that were established, in this institution and others, to decide which patients with renal failure would be allowed to receive kidney dialysis. In the 1970s some states called for abortion review committees to legitimate requests for therapeutic abortion, and in the 1980s the infant care review committees were encouraged in some states to satisfy federal regulations that were formed to prevent discriminatory practices against critically ill infants and ward off federal "Baby Doe Squads" who might descend and close down the NICU. These two decades represent a time of evolution, and sometimes fear, as incongruous and often emotionally laden discussions of medical morality ultimately evolved into the structured and more deliberative discipline of medical ethics that our Clinical Ethics Committee attempts to apply today.[ii]

The Quinlan case in 1976 identified ethics committees as an important resource for assisting in end of life decisions and Cruzan in 1990 ultimately lead to the Patient Self Determination Act of 1991. Now all health care organizations that receive Medicare and Medicaid payments are required to have a mechanism in place, preferably an ethics committee, to ensure compliance with the PSDA regarding health care directives. Today 93% of U.S. hospitals have ethics committees compared to 1% in 1983.[iii] Committee work typically incorporates varying degrees of case consultation, education, and policy work, however most committees identify education and clinical consultation as their most important functions, and end of life as the most important issue that they deal with.[iv]

But, there is a greater depth and breadth to today's healthcare culture and the traditional role assumed by ethics committees in the past may fall short of addressing the needs of the future. The modern demands and deficiencies of healthcare require an expanded and more proactive role for the ethics deliberation, as systems and practitioners now confront the economic realities of the market, provider shortages, increasing regulation, shrinking reimbursement, unhappy practitioners, litigious patients, resource allocation, and the impact of individual incentives being poorly aligned with quality improvement within institutions. Discussions are occurring in many places nation-wide as to the role organizational ethics committees should now be assuming in health care for the new millennium.[v]

At University of Missouri Health Care the Clinical Ethics Committee continues to provide case consultation when needed and we are actively working toward policy development and offering guidelines that will assist providers with difficult clinical situations, such as defining futility and guidelines for withdrawing or withholding treatment when requested by patients at the end of life. But the ethical challenges extend beyond the bedside. There are now serious concerns related to manpower shortages leading to provider strain and loss of services, medical error reporting and disclosure to patients and their families, professional conflicts of interest when dealing with private industries, limiting work hours for residents, and the ongoing need to teach ethics and professionalism at all levels. The CEC also be working to partner with other committees in the hospital such as the Palliative Care Committee, and the Institutional Ethics and Patient Rights Committee in order to create a cohesive direction for these important initiatives. Case consultation will always an important component of any institutional ethics committee, but the ethical challenges of today have a greater breadth and depth and we must be prepared to deal with them effectively in order to be an ethically sound health care institution.

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[iii] G McGee, A Caplan, J Spanogle, and D Asch. A National Study of Ethics Committees. *AJOB*. 2001;1(4):60-64

[iv] McGee, G, J Spanogle, A Caplan. Success and Failures of Hospital Ethics Committees: A National Survey of Ethics Committees Chairs. *Cambridge Quarterly of Healthcare Ethics*. 2002;11:87-93

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