Origins and Development

The relationships of ethics committees and ethics consultants to the history of medicine are quite different. These differences highlight an interesting tension between the two, even though they are both manifestations of the institution of bioethics.

The Hippocratic texts (those attributed to a historical personage Hippocrates or to a cult of male physicians) are explicit about the physician’s role as including the projection to patients and their families of a certain moral standing. In this tradition the healer’s charisma is closely associated with his (at least apparent) wisdom and personal carriage. The appreciation for the close linkage between the qualities of wisdom and technical proficiency in the healer’s art is remarkably persistent both historically and cross-culturally, including those that stem from non-Hippocratic (e.g., Jewish and Islamic) medical ethical traditions. To a large degree, the role of the ethics consultant is an extension of that of the wise physician.

In other respects, however, the ethics consultant is quite a different figure. Most obviously, many modern ethics consultants are not doctors of medicine. In fact, though the Hippocratic authors counselled the use of consultants in hard cases, they did not seem to anticipate a non-physician consultant whose sale function was ethical rather than medical assistance (Ackerman, 1989). Further, while the Hippocratic doctors were guided mainly by the values of non-maleficence and beneficence, today’s ethics consultants concern themselves with other values as well, such as autonomy and justice. But though the modern ethics consultant is undeniably a product of the bioethics movement, for which autonomy is the usual ethical ‘trump’, it is possible that this is less often the case at the bedside than it is for bioethicists who operate in more rarefied settings.

It is not clear who the first modern ethics consultants were, but the occupation can be traced in general terms from several antecedents. Including hospital chaplains and theologians who taught medical students in the 1960s, academic philosopher-bioethicists who became interested in the clinical setting in the 1970s and ethics committee members who offered their services for helping with emergent ethical disputes, also during the 1970s (Rothman, 1991). Today ethics consultants often work in tandem with ethics committees, or members of ethics committees who are on call may consider themselves ethics consultants (Wear, 1990). However, there is also a small but vigorous movement of professional ethics consultants who work as independent entrepreneurs, usually in positions supported by hospital receipts.

While the recent origins of ethics committees are more clear than those of ethics consultants, they are notable for the virtual absence of ancient predecessors. The Hippocratic physician was a solo practitioner who, following apprenticeship, did not seek the moral advice of a committee, and certainly not a committee dominantly comprised of non-physicians. Instead, the ethics committee is a creature of a liberal, Western and pluralistic society. It is also indebted to the highly bureaucratized institutional structures of modernity, structures that include working groups known as committees. Moreover, ethics committees are mainly identified with secular bioethical theory, which is dominated by ‘mid-level’ principles that seek to avoid reference to a single foundational philosophy or to imply that certain actions are ethical and others not (Beauchamp and Childress, 1995). Liberal democratic pluralism, committee systems–mid-level principles all emphasize procedural solutions to social controversy. As a result, ethics committees are process-oriented to the extreme.

The predecessors of ethics committees in the United States were not as determinedly procedural, nor were they at first controlled by non-physicians, though their evolutionary vectors are plain (Moreno, 1995). As part of the eugenic movement early in the twentieth century, sterilization committees were composed mainly of those experienced in the management of the mentally ill (trained neurologists complained there were not enough ‘real experts’ on these committees). They made what they took to be objective decisions based on the goal of avoiding the social burdens of inherited ‘idiocy’ through prevention; only much later was it appreciated that few instances of cognitive deficiency are inherited. Until the early 1970s in the United States, abortion selection committees often identified those whose medical or psychiatric condition warranted an elective pregnancy termination. Compared to sterilization decisions, this was a somewhat less ‘hard science’ judgement. Another ancestor of ethics committees was panels for the determination of which patients suffering from terminal kidney disease should have access to the dialysis machines that were in short supply in the 1960s. Composed in many cases mostly of non-physicians, kidney dialysis selection committees made explicit value choices for the allocation of a scarce life-saving resource. The most famous of these was the ‘God committee’ at Swedish Hospital in Seattle, Washington, which was the subject of major media coverage in the early 1960s. The publicized experience of this committee was for many people their first exposure to the vexing problem of fairness in the allocation of scarce life-or-death resources (Alexander, 1962).

In a 1974 law review article, the physician Karen Teel reported that many hospitals used ethics committees to help make difficult decisions. Her article was cited by the New Jersey Supreme Court in its landmark ruling on the case of Karen Ann Quinlan. Quinlan was a young woman who fell into a persistent vegetative state of irreversible unconsciousness after collapsing at a party. The court found that if the family requested discontinuation of treatment, and if there was no reasonable possibility of Karen Quinlan returning to a ‘cognitive, sapient state’ and if a hospital ethics committee agreed, then the decision-makers would be immune from civil and criminal liability. The judges’ citation of Teel’s article was, the first great
spur for the growth of ethics committees. Ironically, however, the judges seem to have misunderstood the function of ethics committees, confusing them with more traditional and technically driven prognosis committees (Moreno, 1995).

None the less, the New Jersey court’s decision was the first of a series of events that gave impetus to the ethics committee movement in the United States in the years since. Another important development was the Reagan administration’s attempt, in the early 1980s, to require aggressive treatment of severely disabled newborns, regulations that included reference to ‘infant care review committees’ (Moreno, 1987). More recently, the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO, 1992) has established as a condition for accreditation that hospitals have a mechanism for addressing ethical disputes, and several states have legislated requirements that their hospitals have ethics committees. As a result, virtually all larger hospitals, and most smaller ones, now claim to have ethics committees in place.

In the United States, ethics committees vary greatly in many of their specific features, but it is a given that they must represent various perspectives, including that of the institution’s ‘community’, and that they should not be dominated by physicians. This is a reflection of the fact that the ethics committee idea is legitimized as an expression of certain themes of democratic liberalism, including especially the notion that moral controversies are best resolved through a process that takes into account multiple perspectives on the nature of the good life. But while ethics committees have an essentially cosmopolitan aspect, the same is not quite true of the idea of ethics consultation, which retains the option of physician dominance. I will return to some of the philosophical implications of ethics committees and ethics consultation later in this article.

One obvious near relation of the ethics committee is the committee for the scrutiny of the use of human subjects in medical research. The idea of prior group review of experiment proposals involving human subjects dates back at least to the late 1940s in the US Atomic Energy Commission’s Isotope Distribution Division, though its most famous early manifestation was at the Clinical Center of the National Institutes of Health in Bethesda, Maryland, beginning in 1953 (Advisory Committee for Human Radiation Experiments, 1995). But unlike the ethics committee movement, the current system of local review boards owes its growth mainly to a series of well-publicized ‘scandals’. One of these was the infamous Tuskegee Syphilis Study, in which over 400 poor African-American men were medically followed by public health officials for decades without being told their diagnosis, even when effective treatment became available. Therefore, in the United States the use of human research subjects is subject to government regulation, and ‘institutional review boards’ have certain codified legal obligations, while ethics committees do not, at least not at the federal level.

The Functions of Ethics Committees and Ethics Consultants

I have noted that human subjects review panels were largely a response to allegations of investigators’ misbehaviour. By contrast, the origins of ethics committees are not nearly so readily identifiable. Thus it is not surprising that their goals are not as clear, for they include assisting physicians in dealing with their ethical dilemmas as well as helping hospitals avoid lawsuits and bad publicity; little reflection is required to register the fact that these goals are not necessarily compatible.

There is broad agreement that ethics committees have three functions: case review, policy advice and staff education. Beyond these functions, and a membership that includes multiple perspectives, there are wide discrepancies among ethics committees. Some report to the hospital’s organized medical staff, others directly to administration; some are passive and de-emphasize bedside consulting, others have active leadership and try to assert a presence on the wards; and some include members who are familiar with the bioethics literature and theory, while the members of others have had virtually no previous experience with ethical analysis.

Of the three ‘classical’ functions of ethics committees, case review has received far and away the most attention, staff education the least. This is perhaps because case consultation is the ‘sexiest’ of the functions, but it is also the most potentially volatile and the most labour-intensive. The vast majority of committees have operated on what is known as an ‘optional-optional’ basis for case review. This means that whether a case is brought to the committee is optional, as is whether the attending physician follows the committee’s advice.

Not all of the functions of ethics committees were foreseen when they were first organized, and some diverge from the optional-optional model. In some states ethics committees serve to satisfy certain legal requirements. For example, in New York State there is a unique law that mandates the consent of the patient or her appropriate surrogate to a physician’s DNR (‘do not resuscitate’) order. In the event of a dispute between the surrogate and the physician a dispute resolution committee must be formed, and some ethics committees fulfill this function. Dispute resolution mechanisms are also part of some state laws concerning the assignment of durable powers of attorney for health care, and again ethics committees can convenient venues for this role.

Of the two other classical ethics committee functions, staff education is arguably the most important and the most efficient. A staff that is well-informed about local advance directive mechanisms and actively encourages their use by patients can thereby prevent many problems that might be presented to an ethics committee. However, the practical conditions under which most in-hospital personnel must work make the provision of such ‘cognitive’ services a low priority.

Policy review and consultation can be of great benefit to the institution’s administration especially if it leads to more reflective and philosophical policy-making than is usually the case when left in the hands of the hospital’s attorney. Some committees have drafted truly innovative policies on end-of-life issues, for example, and these efforts have sometimes been made part of a general effort to bring staff together in an educational setting as well. Again, however, these kinds of contributions require a sophisticated ethics committee, which in turn depends upon an initial investment by the institution for the training of committee members. This is especially true of the committee chair, who may also have to be released from some other responsibilities in order to function optimally in this position. If the’ chair is a physician this could represent a substantial financial commitment by the institution.
In this writer’s experience as a member and consultant for numerous ethics committees since 1984, institutional commitments, to ethics committees, and their resulting quality, vary widely. Ethics committees are often created amid great excitement and optimism about their anticipated contributions to institutional culture, education and morale, but after the first two years obviously suffer from what the bioethicist John Fletcher calls the ethics committees’ ‘failure to thrive’ syndrome (Fletcher, 1995: 228). In many cases the aetiology of this syndrome turns out to be a passive committee style. The more successful committees tend to be those that actively insert themselves into day-to-day clinical and educational activities, creating relationships with staff members and the sense that the committee is a vital resource for everyone concerned.

For all their remarkable growth and undeniable popularity, there are many unanswered questions about ethics committees. For example, what is the legal status of an ethics committee’s non-binding recommendations in a court of law? Should hospital lawyers be voting members of the ethics committee? Who should be able to bring a case to the committee? Should a designated patient advocate sit the ethics committee? What about the hospital’s risk manager? Should an ethics committee record its recommendation in the patient’s chart, or only that it discussed the case and offered some assistance?

One possible function of ethics committees that was unforeseen in the mid-1970s is that of resource allocation. As the financial pressures on health-care worldwide increase, explicit rationing is a looming possibility. No less a figure than the editor of the Journal of the American Medical Association has suggested that ethics committees help develop practice guidelines for their institutions to identify when treatment may be withheld on grounds of (so-called) futility (Lundberg, 1993).

Ethics consultants may work with ethics committees or as independent actors. In either case there is a lively debate in the United States about how they should operate. According to what might be called the ‘soft’ model, the ethics consultant’s job is to bring the parties together, help clarify the issues and arrange a mutually acceptable resolution (Ackerman, 1989). On the ‘hard’ model the ethics consultant resembles a consulting physician who performs an assessment of the patient’s condition, identifies the relevant medical, social, legal and ethical facts and issues a recommendation (LaPuma and Schiedermayer, 1991). The latter model is supported mainly by those who regard formal medical training as a prerequisite for the competent ethics consultant. Although the potential for disciplinary division within the ranks of ethics consultants is ever-present, so far it has been largely contained. Yet if reimbursement for ethics consultation becomes available, one can imagine that the discussion will become less civil. Similarly, the question whether there should be a certification process for ethics consultants is a flashpoint in the practice.

However one approaches this issue, it is plain that the ethics consultant’s role is a terribly complicated one, calling for a broader range of skills than can be found in nearly any other field. At a minimum, the competent ethics consultant must speak the languages of medicine, law and ethics, must be interpersonally skilled and cognizant of social-psychological issues and must have the ability to inspire confidence among patients and their families as well as her medical colleagues (Moreno, 1991). So described, ethics consultation perhaps deserves the characterization that was once applied to psychoanalysis as ‘the impossible profession’.

Just as there are serious practical questions about the ethics committee phenomenon, the ethics consultant role is also puzzling. Even apart from the problem of which model of consultation to adopt, there is an inherent difficulty with the notion of ethics consultants who are vulnerable to conflicts of interest when they are salaried by the hospital. Short of a version of academic tenure, or at least long-term contracts, the ethics consultant is in a poor position to take a principled stand that is incompatible with administrative goals. Perhaps this is why most who have performed the ethics consultant role have been members of faculties whose primary association is with some associated academic unit, such as the medical school or the philosophy department. The salaried consultant, compensated from hospital revenues, must exercise unusual self-discipline and independence to retain professional integrity. Although this can be done, it presents such an inherently conflictual role that ethics consultation may always be a marginal activity. Though ethics committees are also made up mainly of hospital workers, the group nature of their discourse may provide some more protection than can be true of the ‘loan ethicist’ on the wards.

One initial obstacle to the establishment of ethics committees and consultants appears to have been dissipated, at least in the United States: the resistance of attending physicians. Especially in the early days of the ethics committee movement, many physicians seemed to take the suggestion of committee involvement as an indictment of their personal moral character. More recently, younger physicians seem to embrace the ethics committee as a source of moral guidance - or, less admirably, as an opportunity to ‘turf’ a complex and legally ominous issue. The latter is a special concern with respect to ethics consultants, who could easily be viewed as providing ‘ethical cover’ in tough cases. Thus one reason for the popularity of ethics committees and ethics consultants could be that they provide an opportunity to shift responsibility for decisions that are born in ambiguity and which can provoke anxiety among physicians.

It remains to be seen whether ethics committees and ethics consultants will become permanent fixtures of modern health-care decision-making, or whether they are temporary, transitional arrangements while a new and settled consensus on the use of powerful medical technologies sorts itself out. But then, the same question can be asked of bioethics itself.

The Significance of Ethics Committees and Ethics Consultation for Bioethics

As interesting as the phenomena of ethics committees and ethics consultants are in themselves, they also raise provocative questions about the nature of bioethics as an institution. Elsewhere I have argued at length that bioethics must be understood in the same way social scientists understand any other social institution, namely as a set of social practices (Moreno, 1995). That is, the intellectual and academic origins of bioethics should not obscure its sociological functions. Central among these functions is not only to serve as a multidisciplinary forum for raising interesting value questions about health care and the applications of the life sciences, but also to serve as an agent for certain social forces of which it is itself a product.
In particular, bioethics functions partly as a social reform movement, especially in so far as it has participated in the revolution in the way most people think of doctor-patient relations. Surely no profession has undergone more change in public attitudes in a shorter time than has medicine, and no profession’s values have undergone more relentless scrutiny - in spite of the fact that medicine is also profession that has historically been the most jealous of its prerogatives. Barely years old, the lifetime of bioethics is also the period in which the official values ‘paternalistic’ medicine have been shattered.

Bioethics has not only been a foremost voice in the emergence of a new social consensus about doctor-patient relations, it has also established itself as an agent the development of a new consensus about a myriad of moral questions made by the emerging biomedical technologies. Among the vehicles for the creation of this new consensus have been ethics commissions, operating at regional national levels, and ethics committees and consultants, operating at institutional levels.

As vehicles for consensus creation in institutions ethics consultants are a mixed What I have called the ‘hard’ ethics consultation model is an instrument of only in the sense and to the degree that people are likely to defer to expertise. But contemporary skepticism of expert consensus is one of the sources of modern bioethics. The ‘soft’ model of ethics consultation, which aims at transforming a morally problematic situation into one of relative moral clarity, is perhaps a more promising source of consensus creation. However, it too is limited by the dynamics of intervention by an individual consultant who is too easily viewed as the ‘ethics expert’. Ethics experts must, it seems, possess several characteristics, including analytical discernment and a knowledge of medical ethical issues and the relevant literature.

Ethics committees are more promising vehicles for institutional consensus creation. In general, well-integrated groups composed of individuals who are respected within the institution are far more powerful agents of change than any lone consultant could be. But for what sort of change should ethics committees strive? What makes one consensus morally superior to another?

Philosophically, this is surely the root problem for ethics committees and ethics consultants: the fact that there is a certain moral consensus does not imply it is a morally sound one. This appears to be an instance of the fact-value problem, and according to standard analytical philosophy it raises notoriously recalcitrant obstacles to the generation of morally adequate conclusions from social decision processes. There seem to be two ways to deal with this dilemma. One is to accept it as insoluble and conclude that moral truth (however one understands this term) and social consensus coincide accidentally, if at all.

An alternative is to reject a simplistic fact-value dichotomy in favour of a naturalistic moral epistemology in which valuation is viewed as emergent from states of affairs. On this view, morally value-laden conclusions are seen as ‘evaluations’, literally, ‘drawing the value from’ state-descriptions. This approach has its locus classicus in the work of John Dewey, whose model of ‘social intelligence’ seems uniquely well-suited to arrangements like ethics committees. Dewey’s model was that of an informed citizenry reaching tentative conclusions (or ‘hypotheses’) together for the solution of common problems, subjecting them to field tests and then revising the hypothesis in light of the results (Dewey, 1958).

The notion of social intelligence, a happy corollary of the scientific method, seems to presuppose a shared culture, or at least shared moral values. However, if the value premises differ among deliberators, there is no guarantee that consensus will be reached, even if there is agreement about the empirical premises. Thus consider two ethics committees faced with problematic cases having identical fact patterns, but one committee operates in a religiously affiliated hospital that caters to patients of that faith tradition, the other operates in a secular hospital. Though the committees may be similar in all other respects, their value-based differences will often generate divergent results.

A somewhat different problem infects the relationship between the committee and the patient community served by the institution. Thus a value consensus reached by a committee composed mainly of well-educated white males may not be shared by many patients or their families. Even the apparently content-free value of autonomy may not be esteemed or understood the same way in all cultures or subcultures.

Of course, the ethics committee itself faces the challenge of achieving intern a consensus on the issues it faces. The fact that ethics committees are themselves subject to small group processes has been the source of much criticism of these committees, since interpersonal relations in any group can distort what should be orderly deliberations. This possibility recommends at least that ethics committee processes should be subjected to empirical study.

Some data about ethics committees is already available, and it has interesting philosophical implications. For example, how shall disagreements within ethics committees be resolved? Under what conditions can it be said that the committee has reached an end to its deliberations on a particular matter? Data collected through self-reporting indicates that the vast majority of ethics committees consider themselves to operate according to ‘consensus’. Moreover, most committees seem to be uncomfortable about taking explicit votes on substantive questions (Hoffman, 1991). Moral issues, it seems, are not to be settled by recourse to the usual parliamentary procedures.

It might be expected that there would be consensus among ethics consultants. at least on the basic issues of contemporary bioethics, just as we expect consensus among experts on scientific questions. However, what little data are available on this question suggests that it is not necessarily the case. In their survey of ethics consultants, Fox and Stocking (1993) found great disagreement concerning several case scenarios. They surveyed 154 ethics consultants for their reactions to a case of a patient in a persistent vegetative state receiving artificially administered food and fluids. Of the several scenarios in which non-treatment was an alternative, the one that specified that the patient had left instructions that she would not want life-prolonging treatment and her family agreed was the only one in which the consultants tended to agree (87 per cent) that the patient should not be treated. The other cases, in which the wishes of the patient and the family were varied, received no more than 50 per cent agreement to stop treatment.
Conclusion

Ethics committees and ethics consultants are among the most visible manifestations of a highly public, social reform-oriented and multidisciplinary field. Yet for all the enthusiasm and wide acceptance that has greeted them in the past few years, beyond some generalizations there is little that can be said with confidence about their functions and goals. Their future seems closely tied to the further evolution of bioethics, especially whether the field continues to be a vigorous presence beyond the academy.