

Hospital Ethics Committees: Will America's Model Work in Asia?[†]

S Y Tan,*^{MD, JD}

Abstract

Hospital Ethics Committees (HECs), a well-established component of institutional healthcare in the United States (US), are beginning to take root in Asia. A major function of HECs is to provide ethics consultation in the clinical setting. Whereas the modus operandi for ethics consultation is reasonably uniform in the US, one should anticipate significant structural and functional deviations in Asia. For HECs to be effective in Asia, substantive and procedural modifications are necessary to accommodate fundamental cultural and attitudinal differences including differences within Asia itself.

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Introduction

In the 1960s, some hospitals in the US set up special committees to review decisions regarding abortions, renal dialysis and human experimentation. As many of the decisions centred on the ethics of autonomy, rationing, or consent, these early ad hoc groups can be considered the forerunners of our present-day Hospital Ethics Committees (HECs). Their *modus operandi* was never clearly articulated. Of particular interest was the group ("God Squad") in Seattle, where life-saving chronic hemodialysis first became available with the invention of the Scribner shunt. The group's deliberations over who should be fortunate enough to receive dialysis were never revealed, and the ethical basis for their decisions have been called into question.¹

In 1976, the New Jersey Supreme Court recommended that family and physicians use a hospital ethics committee to resolve cases like *In re Quinlan*² (the right to stop life-sustaining treatment, in this case, the use of a mechanical ventilator) rather than seek judgement in court. This highly unusual judicial recommendation provided the impetus for the creation of HECs across the country. Ironically, at the time, formal HECs were yet to be formed.

In 1983, the President's Commission released its report on forgoing life-sustaining treatment, and endorsed the

formation of HECs.³ The following year, the federal government promulgated the Baby Doe rules to prevent the perceived maltreatment of handicapped neonates and infants. The regulations failed to materialise into law, but they led to the proliferation of hospital infant care review committees, which in turn grew into HECs.⁴

Most of the 6000 hospitals in the US now have working ethics committees. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) deserves the credit for this phenomenal growth. In 1991, JCAHO, which accredits all US healthcare institutions for Medicare reimbursement, began requiring hospitals to have a mechanism for the consideration of ethical issues and to provide education to caregivers and patients on ethical issues in health care. Since that time, JCAHO has become more specific in its recommendations. In its latest version (Standard RI-1: "The hospital addresses ethical issues in providing patient care"), JCAHO advises that "Patient rights processes may include a variety of strategies, such as using an established ethics committee, a formalized ethics forum, ethics consultations, or any combination of these or other methods".⁵ With this written mandate, any residual inertia or resistance over establishing HECs quickly evaporated, so that such committees are now standard in virtually all US hospitals.

* Professor of Medicine and Adjunct Professor of Law

University of Hawaii

Director

The St. Francis International Center for Healthcare Ethics

Hawaii, USA

Address for Reprints: Professor S Y Tan, The St. Francis International Center for Healthcare Ethics, 2226 Liliha Street, Suite 222, Honolulu, Hawaii 96817, USA.

E-mail: siang@hawaii.edu

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Structure and Function of HECs in America

HECs are made up of various healthcare workers, with lay representation. Most scholars are critical of doctor-dominated committees, believing that they alone cannot always represent the patient's best interest. Lay members, on the other hand, are in demand, if only because they compel discussions at an everyday understandable level. Nurses and social workers definitely belong on ethics committees, since they spend much time with patients and family, gaining special insight into their wishes, concerns and dynamics. Theologians, administrators and philosophers sometimes populate ethics committees, and they too can provide useful perspectives.

One group appears unpopular: legal counsel. Perhaps it's a reflection of paranoia over lawsuits and legalese, or simply the belief that the law sets mandatory standards, whereas ethics is aspirational. Besides, the hospital lawyer is paid to protect the interests of the hospital, whereas the ethics committee is meant to protect the patient's interests. More often than not these interests coincide but occasionally they can diverge. Thus, the roles of HECs should be clearly differentiated from those of hospital counsel and risk manager. Nonetheless, lawyer members continue to serve on many HECs.

What do ethics committees do? Generally, they perform three functions: First, they influence policies on ethical issues governing patient care, e.g., the hospital DNR (do-not-resuscitate) policy. Second, ethics committees offer consultations to patients, their family and healthcare providers. These clinical consultations may involve difficult treatment decisions such as the withdrawal of life-support. Third, ethics committees sponsor teaching programmes to educate their staff and the public.

More recently, some committees members have found a role on Institutional Review Boards overseeing human experimentation, and in the new arena of organisational ethics.

Issues for HECs in Asia

HECs are catching on in Asia. A number of hospitals in Japan, Hong Kong, Singapore and other countries already feature committees that review medical decisions that pose ethical dilemmas. However, Asian HECs are still the exceptions, not the rule. Notwithstanding their shared values and superficial homogeneity, Asian countries are obviously not all alike. One is mindful therefore of the folly of asserting a single Asian identity, a single Asian perspective, on matters ethical.⁶ The comments that follow are therefore to be taken as broad sweeps of the Asian bioethical landscape, and these generalisations anticipate the admission of many exceptions.⁷

Challenges facing HECs in Asia may be divided into

procedural and cultural issues, and are discussed below according to the following classifications.

Procedural Issues

I. Who sits on ethics committees?

In the US, virtually anyone can be a HEC member, and doctors may be in the minority. Earlier HECs typically had all its members as physicians. Today, nurses, social workers, clergies, lawyers and administrators are involved. Lay representation is particularly sought, but may be difficult to get. The chair of HECs is usually a medical doctor.

Will emerging Asian HECs begin in the same way as their US counterparts? A slow metamorphosis is as inevitable as it is practical. To initially vest the authority in a doctor-run committee will meet with the greatest acceptance by the medical staff. Without this acceptance, the committee cannot expect to be recognised and therefore utilised for its expertise and usefulness.

II. Who is an ethics consultant?

The so-called "ethics consultant" is usually a HEC member who personally reviews the case for the committee. The main advantages of a designated and trained consultant over the entire committee are: 1) First-hand direct contact with the patient, family and healthcare providers; 2) Quick response time; 3) Enhanced accountability; and 4) Expertise. The rest of the committee members (probably the majority) help to group-review the consultant's recommendations.

In the event that the HEC does not have an available consultant-member to review the case, the job can be referred to an outside independent ethics consultant who will then report back to the HEC. This situation is less satisfactory, as it takes a great deal of the analysis and control out of the hands of the committee, whose function is then reduced to that of triage and receiving reports.⁸

What training qualifies an individual to be an ethics consultant? As yet, there is no US statutory board of ethics to certify an individual as a clinical ethicist.⁹ Standardisation can therefore be expected to suffer, as suggested by the results of a recent survey that asked 154 ethics consultants what they would recommend in 8 hypothetical variations of the persistent vegetative state — with predictably wide differences of opinions.¹⁰

Will Asia's traditional hospital staff hierarchy allow a non-doctor, say a nurse, to serve as an ethics consultant? This seems unlikely, at least for a while. In an unrelated op-ed article on Asian values and Western reality, Professor Choi of Korea hints at the reason, "*Asian values can be defined in many ways. Authoritarianism and Confucianism of hierarchy are major components of the Asian value system, whereas democracy, egalitarianism and individualism are the major components of the American system*".¹¹

Doctors may view ethics consultants as interfering with their work, believing that an outsider has no business reviewing the care of their patients, absent a complaint. In the US, the team-approach is gradually, if reluctantly, becoming more accepted. Nurses and others regularly perform “medical-type” functions such as histories and physicals, and in some states, nurses have legal prescription-writing authority.

One answer to this impasse is to publicly commit to the discipline by insisting on formal rigorous training, and ongoing self-education. The HEC chair, preferably a doctor, should visibly support and promote the competence and service of his/her consultants. All consultants should be senior, respected and clinically experienced healthcare workers, who have received formal training in medical ethics and write and lecture regularly on the subject.

III. Who has access to HECs?

Ethics consultations should be patient-oriented rather than physician-oriented.¹² Ideally, patients and their families as well as all healthcare professionals connected with the case should be able to access the HEC. However, in some hospitals, only members of the medical staff have access, and nurses and patients are excluded. Because an ethical opinion may be sought where disagreement exists among doctors, nurses and family, HECs should have an “open-door” policy to hear all sides of the issue. Patients and others will view with suspicion those committees that restrict access, and this in turn undermines their credibility and effectiveness.

The downside to an open-door policy is the risk of breeding open dissent and confrontation. In the US, referrals to HECs have been known to originate from nurses and social workers out of frustration over, even hostility towards, the doctor’s treatment plans. Such requests may even be made without the physician’s knowledge or consent. It is unlikely, however, that Asia’s hierarchical structure and its cultural aversion to combativeness will permit this to happen any day soon.

In Asia, will the medical staff permit anyone other than the attending physician to directly access the ethics committee? The answer may be an initial “no,” given the traditional captain-of-the-ship custom that prevails in the hospital hierarchy. Until Asian physicians reach a more equitable sharing of authority over decisions affecting patient care, a reasonable compromise is to require the approval of the attending physician of referral plans. If such consent is denied, there should be a policy that enables the healthcare provider to refer the matter to a supervisory staff or a hospital administrator for prompt resolution. Patient and family are a different matter. They should have direct and unquestioned access to HECs, since they are the

ones with the ultimate decision-making power, and are directly affected by treatment choices.

IV. Are recommendations binding?

Recommendations from HECs are said to be advisory in nature. However, if the clinical scenario is clearly and convincingly unethical, and/or patient harm is likely, then a policy that allows for the referral to the hospital chief of staff (a doctor-colleague) is necessary to protect the patient.

Substantive Issues

I. Patient autonomy and truth telling

The major difference between Asian and American ethical values is measured in the relative, not the absolute. Tsai¹³ has pointed out that respect for the 4 principles of biomedical ethics — viz., beneficence, non-maleficence, autonomy and justice — are clearly identifiable in ancient Chinese medical ethics (ACME), but autonomy is not specifically prescribed. Rather, ACME emphasizes beneficence, filial piety, family values, and the common good. Individuals are deferential to the choice of families and considerate of social values, and they are sometimes expected to sacrifice their autonomous right of decision-making. Socio-cultural factors favour the “beneficence-oriented” rather than the “autonomy-oriented” model which undergirds contemporary Western bioethics.

Not surprisingly, Asian physicians commonly obtain consent from family members rather than from the patient, and may withhold bad news. Of 20 internists interviewed in Beijing, none would inform patients of the diagnosis of terminal cancer, and 65% would allow family decisions to override those of the patient. In contrast, San Francisco internists scored 95% and 5%, respectively.¹⁴ Pang¹⁵ has coined the term “protective truthfulness” for this practice.

Given this cultural divide between East and West, the Asian analysis of an ethical issue dealing with decision-making especially over life-sustaining treatment [futility accounts for nearly half of all ethics consultations at our medical centre] can be expected to differ substantially from the West. Blind adherence to patient autonomy will not work in Asia. There is room enough to take into account patient self-determination, family wishes and medical paternalism.

II. Advance Directives

These are legal documents, sometimes called living wills, that are executed by competent patients to express their treatment wishes when they become incompetent and terminally ill. Advance directives are meant to preserve patient self-determination, as physicians are required by law to adhere to their instructions. Over the past 20 years, all states in the US have enacted advance directive legislation, and federal law (PSDA, 1990) requires that all

patients admitted to healthcare facilities be asked about advance directives and be provided information on how to execute such a document.¹⁶ Only about 15% to 25% of the population have executed advance directives; doctors and nurses, who should know better, have similar statistics.¹⁷

Many ethics consultations revolve around issues relating to a patient's advance directive. Recurring issues are whether they have been properly drawn up, whether they are ambiguous, and whether the patient should be certified terminal or irreversibly comatose. Additionally, there are many instances of family override of a patient's wishes despite clear expression in the advance directive.¹⁸

In 1997, the Republic of Singapore enacted into law a statute covering advance medical directives. Although the Singapore legislation differs in many respects from the typical American version, the law nonetheless expresses the society's belief in the primacy of patient autonomy and decision-making at the end of life. This bold and forward-looking public policy puts Singapore closer to the US than to other Asian countries, where similar laws are yet to be passed. And it can expect to encounter many of the same issues that the US faces regarding advance directives, such as underutilisation and family override.

In Asian countries without advance directive legislation, the traditional way of decision-making at life's end will continue. Family wishes, hopefully faithful to the patient's preferences, will govern treatment decisions even as they produce guilt and uncertainty. Doctor paternalism would continue to play a correspondingly larger role in these countries.

III. Rationing

The US continues to espouse a position that everything feasible should be done to save a life, however costly or minuscule the chance of success. This illusion is perpetuated in the hospital wards where bedside rationing is taboo, and individual patients are accorded all treatment options irrespective of cost, effectiveness or patient ability to pay.

Stacked against this policy are 40 million Americans, many of them children, who are medically uninsured and do not have ready access to doctors and hospitals. The US is also found wanting in its patchy prenatal care and childhood immunisation programmes. To say that rationing is morally indefensible is to ignore the fact that we already ration care by implicitly limiting the reach of these 40 million uninsured Americans.

In caring for its poor and uninsured, the state of Oregon recently set up an initial list of 696 diagnoses and procedures that were ranked in order of medical priority. The state legislature funded up to number 565, and excluded items such as heroic treatments for the incurably ill, and most types of plastic surgery. It is one State's bold, if controversial,

model of cost-containment in healthcare delivery.¹⁹

Asia is nothing if not pragmatic. It will solve this ethical issue by adhering to a policy that provides adequate and good medical care to all, irrespective of the ability to pay. But it will draw the line at paying for expensive interventions that produce marginal benefits for a very few. It will abide by a two-tiered system — those who can afford will be allowed to opt for the heroic and desperate measures — so long as they pay for the services from private out-of-pocket funds. Such a "pay-if-you-want-it" policy clearly favours the rich, and surely there are limits — e.g., buying organs for transplant. It's not ideal, but the alternative is a policy that risks bankrupting a system that can otherwise sustain the provision of universal basic medical services.

IV. The impact of legal precedence

It has been correctly stated that American bioethics is driven by law, rather than by medicine, philosophy or theology.²⁰ It was, after all, the Quinlan case of 1976 that spawned the initial proliferation of HECs. Judicial cases, including the 3 US Supreme Court decisions (*Cruzan v Missouri*, 1990; *Vacco v Quill*, 1997; *Washington v Glucksberg*, 1997)²¹⁻²³ palpably shape the debate over ethical boundaries, especially regarding end-of-life treatment decisions. Key court holdings have addressed the right to refuse treatment including artificial hydration and nutrition,²¹ the constitutional right to physician-assisted suicide (no such constitutional right),^{22,23} and the acquiescence to family insistence on futile treatment against medical advice (Wanglie, 1991; Baby K, 1994).^{24,25}

Legal cases provide precedence that physicians are obligated to follow. Fear of liability causes doctors to practice defensive medicine and to over-treat in many instances, and US HEC consultants are apt to be guided by the law in formulating their recommendations.

Unlike in the US, healthcare law, both statutory and case law, is relatively undeveloped in Asia. It is likely therefore that Asian HECs will go by customary or community medical practice as the standard to base their ethical deliberations. There is the temptation to revisit various clinical practices for their ethical propriety now that the West has developed this fast-growing body of law on the subject. Given the differences between East and West, and the instant access to global information in this Internet age, it is not difficult to project the coming controversy that will increasingly polarise bioethical debates in Asia.

Conclusion

The lessons learnt from 3 decades of HECs in the US are well worth remembering, for they have implications for both the US and Asia. End-of-life issues now occupy centre stage in contemporary American bioethics, with hot

debate surrounding futility, rationing and euthanasia.²⁶ Other agendas facing HECs are genetic screening and gene therapy, privacy and confidentiality issues in the electronic age, dilemmas at the beginning of life including research, and maternity ethics. At a functional level, experience reminds us that ethics consultants should not work from invalid assumptions, and should not allow their views to bias their reasoning, or their needs to prevail over the patient's needs.²⁷

In Asia, additional attention to cultural imperatives is mandatory. Respect for patient preferences, especially regarding life-sustaining treatment, must acknowledge cultural acquiescence to family wishes, but the patient should be given the chance to express and accept this choice. HECs can create a referral and review climate that is assisting, collegial and nurturing. Eventually, all healthcare providers, not just physicians, will contribute to the process towards greater ethical understanding. Properly structured with sensitivity and rapport, HECs can play an effective role in improving patient care in Asia.

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