

A few years ago Kevin Costner starred in a film titled *Field of Dreams*, the story of an Iowa farmer who turned his corn field into a baseball field because a deep, mysterious voice instructed him to "build it and they will come." He did, and they came. He plowed under his corn crop, laid out a baseball diamond, and deceased baseball players emerged to play ball. *Field of Dreams* was a sweet movie about faith and cosmic relationships, but it was pure fantasy, not a reasonable plan for an ethics committee. It will take more than faith for ethics committees to fulfill their potential and to make the positive contributions they are capable of making. In order for this to happen, we need to reshape ethics committees into a more active model.

At Midwest Bioethics Center, discussion about what changes are necessary for this new model to emerge have resulted in discussions about "integrated ethics programs" (IEP), rather than traditional ethics committees.

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The ethics committee model empowers a small group of people with knowledge and authority so that they become a resource pool for others to consult. An IEP would convert ethics committee members into *ethics faculty* whose function would be to disseminate ethics throughout the organization.

Not everyone accepts the tenets of the IEP model. One of Midwest Bioethics Center's board members, William Bartholome, clinical ethicist at the University of Kansas Medical Center, believes ethics committees should not be pro-active but rather should "quietly infect the institution with ethics." Bartholome believes it may be risky for a committee to be overt, and may make the committee vulnerable to others who are more powerful and who may be threatened by aggressive behav-

ior. However, others involved in ethics committee development at the Center believe it is time to be bold and are enthusiastic about experimenting with the new model.

The first step in this reformation is reconsideration of the ethics committee's mission statement. Surprisingly, few committees with whom the Center works initially have mission statements. Among those who do, the statements usually read something like the following:

The mission of the ethics committee at \_\_\_\_\_ is to provide a forum accessible by patients, their surrogates and providers for the discussion of ethical issues that arise in the delivery of health care.

It describes a specific place, a forum, in which ethical discourse can occur. Ethical dialogue should take place *everywhere* in a health care providing organization. A preferable mission statement would read as follows:

The mission of the ethics program at \_\_\_\_\_ is to create an environment in which ethical dimensions of health care are recognized as important and are addressed throughout the organization, from the level of individual practice to system wide policy.

The point is, a committee's mission should be a far more active one.

Once a revised mission statement is agreed upon and approved by whomever holds jurisdiction over the program—the board, the administrator or the medical staff executive committee—a strategic plan of action should be developed. Such a plan should include the traditional activities of an ethics committee: education, policy review and development, and case consultation. Both short and long term objectives and goals should be explicated.

In addition, participants should seek membership on "strategic" committees within the organization.

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# Integrated Ethics Programs: A New Mission for Ethics Committees

by Myra J. Christopher

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*Although there is no shortage of ethical conflict in today's health care institutions, ethics committees too often are idle. Integrated Ethics Programs (IEP) is a new, active model for ethics committees that could change that situation. IEPs would convert committee members into ethics faculty whose function would be to disseminate ethics throughout the institution, rather than waiting for ethical problems to come to them.*

Ethics committees, like characters in Greek tragedies, may be inherently flawed. Well intentioned, dedicated members of ethics committees increasingly are disenchanting when, after years of legitimate preparation and systematic development, their committees often sit idle, hearing about difficult ethical issues and complex cases at their institutions only second hand.

Committee members study the history of the bioethics movement, theoretical and clinical ethics, health law, cultural and religious diversity, and mediation techniques. They study landmark cases and develop policies and procedures to guide their committee's actions. They rehearse case consultation. They host ethics symposia, publish brochures about how to access the committee, and they sit. It reminds me of the Maytag commercials that featured "the loneliest man in town." But unlike the Maytag man, ethics committees are not lonely because everything is working perfectly. They are lonely because the model of today's ethics committee is flawed and should be reconsidered.

The main problem with the functioning of ethics committees is that the current model is a passive one. It assumes that when an institution charges a group of people with providing a mechanism for dealing with ethical issues, then people in that institution will turn to the group for expertise. Those who thought clinicians would welcome the opportunity to turn to others for advice, or at least for moral support, have been proven wrong.

It is common for ethics committees, even in large teaching institutions, to report at the end of a year that they have done only three or four case consultations. When the Midwest Bioethics Center hosts its annual dinner meeting for ethics committee chairpersons, attendees express frustration because their committees are not called upon more frequently. Ideally this would be because ethics committees are engaged in innovative ethics programming and doing outstanding policy review and development; ethical conflict, consequently, simply is not occurring. Nothing could be further from the truth.

There is a preventive aspect to ethics committee work. Education and good policies help keep ethical conflicts from occurring. However, there is no shortage of ethical conflict in today's health care providing organizations. Both advancements in biomedical technology and health care reform generate ethical conflicts at geometrically occurring rates. (We haven't learned to manage either our miracles or our resources very well yet.)

What, then, is the problem? Why aren't ethics committees deluged with requests for consultation, information, and assistance on policy matters? I describe it as the "We built it—why haven't they come?" problem.

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# Ethical Decision Making in Managed Care Environments

by Judith Wilson Ross

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*Ethics committee members need to look carefully at their frequently unarticulated beliefs about the value of health care and the role of health care institutions and professions before considering what constitutes an ethical response to changes in the way that health care is delivered.*

Hospitals that once had few managed care patients now contract with one or more plans which account for a large number of admissions. This shift to managed care introduces new ethical issues with which ethics committees are not always familiar and which they are not always confident in approaching.

This paper addresses some of the new issues, illustrated by an ethics committee case analysis. The analysis reveals committee members' ambivalence in dealing with managed care problems, showing *support* of change in health care, and simultaneous *fear* of change.

## Ethical Issues

There have always been inconsistencies and injustices in a health care system organized around ability to pay. Now, however, managed care plans evaluate not only the need for the patient's admission, but the need for each day of continued care and treatment. Thus caregivers face more directly a third party payer's willingness to pay for treatment. Moreover, managed care plans' policies on payment differ one from another. Health care professionals, consequently, are dealing with inconsistencies in length of stay from patient to patient, all of whom are insured. In addition, there is vast variation in whether certain diagnostic tests and preventive measures are reimbursable. The following case study illustrates these points.

## Case Example

A terminally ill patient in a managed care plan was admitted to the hospital on a Friday evening after her physician was besieged by the woman's family to "do something." The managed care plan refused to authorize the admission because the skilled nursing facility in which the patient was residing could have provided the same care as the hospital. The refusal did not occur until Monday, by which time the patient's condition had deteriorated. She was still stable enough to transfer to the nursing home, although it was clear to those caring for her that she was dying. Because of slowness in the hospital system, the discharge order was not written until Tuesday, by which time the patient *was* unstable and in the dying process.

When the case came to the ethics committee as a retrospective review, the response of most committee members and of most care team members was to attack the managed care plan and the case manager who had relayed the information to the care team and, eventually, the hospital administration for failing to intervene. It was a prime example, most felt, of the uncaring nature of managed care: the insistence that a dying patient be put in an ambulance and shipped back to a

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