

BIOETHICS

Bioethics Committees - A Health Communication Approach

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ABSTRACT. The modern health care system is being transformed as a consequence of scarce resources and better informed consumers. In this transformed health care system human communication has become a crucially important process. This essay examines the health communication functions performed by bioethics committees in health care delivery and makes recommendations for promoting the effective use of these groups within the modern health care system. The essay describes how bioethics committee can help establish a climate in which physicians and other committee members can share relevant health information, learn about patient and family concerns, promote health education and informed consent, and facilitate effective decision making about complex health care practice issues.

It is argued that clear recognition and attention to the

central role of effective communication within the bioethics committee is essential for the survival of the modern health care system since ethics committees depend on sharing relevant information to diagnose health problems, provide health care, promote health education, help in the formulation of new health care policies, and provide much-needed decision-making support to health care providers and consumers. The role that health communication expertise can perform in the effective operation and utilization of bioethics committees is described. We conclude that in order to provide needed support in addressing the many complexities of modern health care, bioethics committees must develop clear communication processes, norms, and roles. *Key words: Bioethics committees, Health communication, Health Care System*

In a health care system that is being transformed as a consequence of scarce resources and better informed consumers, an additional personal communication effort seems to be a good standard of practice. It is well established in the literature that failures in communication between health care providers and patients or family, between patients and their families, or among health care providers cause many dilemmas (1). One of the bioethics committee's major functions is to provide a climate in which physicians and the other committee members will say what they honestly believe. Health care providers also need to hear what the patients and families are saying. A typical case that comes before a bioethics committee is

one in which families disagree with physicians. A physician may have suggested withdrawing life prolonging treatment, but the family members may feel distressed and guilty. The physician will then ask for committee discussion, to get the support of additional responsible individuals (2). In this way, the bioethics committee performs an important communication function in facilitating sharing of relevant information between interdependent participants within the health care system and helping these individuals make good informed decisions about health care. In this paper we examine the health communication functions performed by bioethics committees and makes recommendations for promoting the effective use of these groups within the modern health care system.

Communication and Bioethics Committees. Even when philosophical ethics is central to bioethical inquiry, philosophical analysis is not sufficient for the bioethics committee. Practical bioethical decisions require communication among individuals who have expertise in clinical medicine, nursing, law and social work, in addition to the traditional areas of philosophy, religion and literature. Lay persons are also represented in the

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Committee, who will bring to the Committee opinions, values and feelings of those who serve (3).

A visible communication barrier in bioethics committees are dominant personalities. Physicians are most likely to act in a dominant communication style because they are accustomed to a commanding role in medical decision making. Occasionally a paternalistic physician assumes a dominating leadership role and destroys the committee's ability to share relevant information. A lawyer may also take control, frightening the other members with predictions of damage suits or criminal prosecution. It may be difficult to distinguish between efficient leadership and disruptive domination. The latter can negate one of the committee's primary advantages—that it applies diverse viewpoints to ethical dilemmas (2).

On many committees, however, physicians both numerically dominate the group and vocally dominate discussions. Such committees are likely to demonstrate a continuing lack of genuine interdisciplinary achievement. Without interdisciplinarity, the committee cannot truly be called an ethics committee. It may be a committee about doctors' solutions to their ethical problems in the same way that nursing ethics committee is about nurses' solutions to their ethical problems, but it has not yet been born as an interdisciplinary ethics committee (4).

A Requirement for Better Health Care. The Joint Commission on Accreditation of Health Care Organizations, which is the national agency that grants accreditation to hospitals and other health care institutions in the United States has required since January 1992 that hospitals and other health care organizations establish organizational mechanisms for formulating ethics policy and addressing ethical conflicts within the health care setting. These committees assist institutions and individuals in confronting the major bioethical issues of the twentieth century (3).

These Committees are a product of the 1980's and exist in major hospitals.

Its primary purpose is to raise the level of "ethical" discussion and awareness in hospitals. It may also set policy for particular areas (e.g., DNR orders and terminating treatment on incompetent patients). The committee is sometimes available for consultation, and if a patient is having a problem getting rights recognized because the attending physician (or anyone) feels it is "not right" or "unethical" to do what the patient requires, consulting the committee chairperson might be helpful in resolving this conflict (5).

Bioethics Committees. A Response to a Communication Need. Most ethics committees divide their time among three functions: education, case review

and policy and guideline recommendation. A trend for ethics committees is the establishment of networks, especially in the United States. These networks usually are located in and in some way, supported by, university medical centers or hospital system ethics centers. However at least one is allied with a state medical association, another with a hospital trade organization, and a third with a freestanding ethics center.

The networks have a variety of activities. Some conduct educational programs (ranging from occasional to regular intensive programs) for their constituents, some produce regular publications, some carry out surveys, some provide a community forum for discussing the successes and problems of individual ethics committees, and some have ventured into community-wide solutions to problems that are experienced by all institutions.

However, the focus of all networks is to develop some sense of larger community relationships among institutional ethics committees (whether in acute care hospitals, long term care facilities, or intrainstitutional groups). Some involve membership fees or program fees; others operate without any specific income, depending on individuals volunteering time on behalf of their employing agencies. For the most part, their structure appears to be fairly informal (4).

It is one thing to say that ethics committees should conduct education on ethical issues, recommend policies that are ethically important, and review cases with respect to ethical issues. It is another thing to determine exactly what activities can fulfill the mission. New committees tend to restrict themselves to self-education; after completing that phase, they devote time to educating others, to hearing cases, and to writing policies that are requested. More mature committees tend to broaden the notion of the issues identified as "ethical". They may consider pain management, nurse-physician communication, or patient education in areas other than forgoing treatment. They also tend to be more personally aware of, and responsive to, issues as opposed to waiting for an issue or a concern to be brought to them.

It has been suggested that ethics committees reflect on questions related to: (1) Where and how people wait for care, (2) Where and how families are given bad news and asked to make decisions, (3) Privacy of information and person, (4) The language we use when speaking about patients, especially those who are very sick, old or demented, (5) The way we respond to patients of different ethnic backgrounds, including our efforts to achieve good communication and (6) Staff symbols among/between staff members (4). It appears obvious then, bioethics committees have an immediate need to set-up a health communication agenda.

The Bioethics Committee Communication Agenda.

At least 35% of a total of 70 activities mentioned for bioethics committees were directly related to communication. Some of the most obvious were:

1. Study body language and its meaning in communication.
2. Develop a better understanding of conflict resolution, communication styles, group dynamics, or effective public speaking to enhance education effort.
3. Make demonstrations on how to talk to patients about advance directives, explain terminal care decisions, or deliver bad news. Ask members of the committee to role-play the patients.
4. Write a regular column for the hospital newsletter informing the community about new policies, new court cases, and controversial topics in bioethics and what the hospital is doing or might do about them.
5. Distribute an occasional information sheet to hospital staff and physicians updating them on important committee work or ethical issues.
6. Hold a bioethics week with a special activity each day.
7. Develop brochures on forgoing treatment decisions, advance directives, CPR and DNR orders, case consultation, or other relevant topics for patients. Test them for readability with patients and family members before printing them (7).

Even when the discipline of health communication parallels several fields of study including psychology, medical sociology, biomedical communication, behavioral medicine, behavioral health and medical communications, it maintains a focus on communication issues in health care (8). Much more evidence is mounting than leads to believe that the educational role of the bioethics committees requires competent and strategic communication skills not only in the organizational context but interpersonally as well.

Health Communications and Informed Consent.

Health communication is an integral part of the policy making function of bioethics committees. An illustrative example is a policy set for Informed Consent in a Community Hospital. In this policy informed consent is defined as the voluntary, competent, and comprehended authorization of medical treatment. It is clear in the principles stated in the policy how vital interpersonal communication is. Issues that are mentioned in the principles are:

1. The document should encourage the patient to ask

questions that he or she may have regarding the procedure. The document should also inform the patient that he or she may withdraw from the treatment where this is possible.

2. The committee encourages physicians to develop informed consent documents that are intelligible to the medical lay person.
3. Physicians are encouraged to delay, if possible, any medical procedure if there is a reason for thinking that the patient does not adequately comprehend the issues that confront him or her (7).

In addition, they can help educate other health care providers on the advantages of informed consent and persuade them to discard misconceptions. They can help patients and families learn about illness in general. They can help improve informed consent techniques. For example, it would seem unnecessary to educate health care providers on the desirability to know about informed consent because practically everyone in the Institution is already convinced. When the committee members turn to particulars, however, they will find that the purpose of informed consent is often unachieved.

It seems to be apparent that bioethics committee members could further the goals of informed consent by heightening the awareness of health care providers to its value and patients need for it. They could emphasize the studies that show that patients often want more information than doctors think they do. They will want to avoid recommending a simple minded shifting of responsibility from the physician to the patient, however, and instead will speak of the advantages of mutual decision making (2).

For health care professionals, one of the most frustrating aspects of the informed consent doctrine is that a physician can often do a first rate job of disclosing relevant information to competent patients but still fail to secure the informed consent of the patient. For if the competent patient fails to understand the information that is disclosed, the physician has not given informed consent. To understand information is to process an accurate appreciation of its meaning and its implications. In medicine, understanding is associated with appreciating the consequences of action. The professional has a duty not only to disclose information but also to do it successfully (9).

Health education is an essential first part to gaining informed consent (9). The provider must be able to educate the client about the nature of the diagnosed health problems and the different modes of treatment (and their repercussions) being suggested before ascertaining whether the client agrees to the suggested forms of treatment. Eliciting full understanding between health care

providers and consumers during health education efforts is not a simple process. Often health care providers have operated under the simplistic notion that if they tell their patients about a health care procedure, their clients should automatically understand the often complex information provided (4). Unfortunately, this is often an incorrect assumption. Due to many communication barriers such as clients levels of medical knowledge, familiarity with complex health care terms and jargon, and even preoccupation with fear and discomfort due to their health conditions, health education efforts often fall short of providing understanding (5). The more diverse the cultural backgrounds and orientations of the health care providers and clients are, the more challenging it often is to develop culturally appropriate message strategies to promote shared understanding during health education efforts (6). Yet, it is the responsibility of the health care provider to seek feedback from clients to ascertain level of understanding, and when understanding is limited to provide additional messages (employing different message strategies such as using new forms of language, visual aids, and examples) to increase relevant information available to clients. Only after the provider can ascertain that health education efforts have been successful and his or her clients have developed a good understanding, can the provider elicit agreement from the clients to pursue specific forms of treatment (3). The bioethics committee can help providers understand the cultural complexities involved in establishing informed consent with their patients. Since the different members of the committee approach health care issues from unique perspectives themselves, they can provide relevant feedback to promote culturally enriched communication strategies in health care delivery.

Health Communication. A New Tool for Bioethics Committees. The field of communication in health care contexts which has been developing over the last twenty-five years as an important field of study concerned with the powerful roles performed by human and mediated communication in health care delivery and health promotion could be an alternative to enhance the work of Bioethics Committees (8). To this end, health communication inquiry is usually problem-based, focusing on identifying, examining and solving health care and health promotion problems. While communication is certainly a powerful process in health care, the dynamics of communication in health contexts are also very complex, the communication channels used numerous, and the influences of communication on health outcomes powerful (8).

Health communication takes place in a variety of health contexts. At the level of mass communications, health

communication refers to areas such as national and world health programs, health promotion and campaigns, and public health planning. It is closely aligned with social marketing and it is grounded in the larger theory of diffusion of innovations. In the area of public communication, health communication refers to presentations, speeches, and public addresses made by individuals on health related topics. In organizational contexts, health communication may be involved with areas such as hospital administration, staff relations, and organizational communication climate. Within small group contexts, health communication refers to areas such as treatment planning committees, staff reports and quality circles. Health communication in interpersonal contexts include those variables in the human communication process that directly affect professional-professional and professional-client interaction. In intrapersonal contexts it refers to our inner thoughts, beliefs and feelings and our "self talk" about issues that influence our health directed behaviors. Communication in these contexts has a common health related focus, however, the specific aims of communication as well as the number of people involved in the process may vary considerably (10).

It has been suggested in the literature that there is a strong need to have health communication experts participate in bioethics committees (6, 11). These health communication experts can help facilitate interaction among committee members, encourage full participation within the group, and elicit collaborative decision making on complex ethical issues (9). There is an evolutionary process of "growing" ethics committees that enables these groups to develop effective communication processes, norms, and roles (5, 11). The health communication expert is ideally suited to help direct the development of these effective group communication processes in bioethics committees (11). It is only through the successful use of the communication process, sharing relevant information and making collaborative decisions, that the ethics committee can hope to achieve desired health outcomes for directing health care practice in the complex modern health care system (1).

Elaborating Health Communication Functions for Bioethics Committees. Traditionally a third of the members in Bioethics Committees will be physicians, most of whom will be specialists in areas where bioethical problems commonly occur. Another third will be nurses, who will ordinarily will come from the upper levels in the institution; they will be associate directors of nursing and head nurses. The other third may include social workers, chaplains, patient relations representatives and lawyers. People from the institution, members may include lawyers, clerics (usually from a different faith than

the institutions chaplain) and philosophers who teach ethics courses in local universities. A few committees have lay community representatives as well.

Bioethics committee members can promote effective communication in performing their counseling function, making sure all pertinent facts are on the table and that patients, families, and health care providers are talking to the others. That alone can resolve many dilemmas. Bioethics committee members may help others increase patient's knowledge about their illness. They could work with department heads and the institution's patients relations representative in obtaining informational materials, including free pamphlets on particular diseases from government agencies such as the National Institutes of Health.

If the Institution has a closed-circuit TV system, committee members could suggest the procurement of tapes on ethical aspects and human values in medical decisionmaking. They might also encourage tape viewing in areas removed from patients rooms. They could ask that the patients librarian install videotape machines in the library and stock tapes on common medical problems (2).

The institution's medical library could also be a resource for patients. Witnesses at meetings of the President's medical ethics commission suggested that the libraries be opened to patients and their families, so they could read authoritative articles and books.

Bioethics committee members might also encourage the recording of doctors advice. They could ask the patients' librarian or television concessionaire to rent cheap audio recorders to patients and families. Patients have hesitated to ask permission to tape conversations with doctors, for fear of offending. The committee members could overcome such hesitancy by inserting in the patients' handbook or other publication a notice that recording the doctor's advice was routine.

Bioethics committee members could also explore whether nurses could have a more active role in informing patients. Granted, nurses traditionally have told patients that it was up to the doctor to reveal information. In their newer, patient advocate role, nurses are franker and may be more effective than doctors in communicating with clients. They might also be able to protect the institution by effectively communicating with patients and guaranteeing that full informed consent is obtained.

Whether to tell the patients the truth at all times has occupied much attention in the bioethical literature (11). Many Americans believe the truth should be withheld in some circumstances. Others, believe that lies may harm patients. In the midst of this dilemma Bioethics Committees could take a most helpful role in evaluating

the specific issues concerning who to tell, what to tell, and how to tell sensitive health information (9).

Survival of the Bioethics Committees. Bioethics Committees appear to be a phenomenon with a secure future due primarily to their functions of protecting patients from some of the negative outcomes of advanced medical technology, decisions that do not always respect unique cultural values or personal rights, and ensuring the best use of resources for the enhancement of quality of care (4). Even though the forecast for Bioethics Committees is good, there is very limited data-either empirical or anecdotal-about how and why bioethics committees function within the modern health care system. Furthermore, there is great disagreement in the literature about how ethics committees should do what they do. Leaders in bioethics as well as ethics committee members themselves have very different understandings of what an ethics committee is about: its mission, its ethos, its metaphors (9). Some think of Committees as bureaucratic bodies; some think of them as small groups with considerable intimacy; some think of them as groups of ethics experts; some think of them as hospital peacemakers; and some think of them as mini-courts.

The multidisciplinary that is understood to be an essential quality of the ethics committees may in fact be a source of much uncertainty. Physicians and nurses see ethics committees through their professional eyes as forums for the exercise of technical expertise. Lawyers see them through their professional eyes as assemblies for legal review and legislation, and philosophers and clergy see them through their professional eyes as classrooms for adult learning. These three primary models for understanding ethics committees are matched to the committees' primary functions: education (the educator's view), policy making (the lawyer's view) and consultation (the clinical expert's view).

It is clear that the critics do not object to ethics committees' providing for example, education, for themselves and others. Although they do object to it not being done well enough. On the other hand, nobody else appears to want to be charged with providing it, so education probably is safely within the orbit of the ethics committee. Bioethics theorists such as Annas appear very dubious about the abilities of ethics committees to steer a clear course. . Annas is also worried about its legalistic tendencies (4).

On the other hand, it must be acknowledged that the needs of each institution are different, as is each institution's capacity to establish such committees firmly. Some of the roles are more problematic than others. None of the functions however, will be successfully integrated within the hospital unless the ethics committee is part of

an educational effort that involves both the primary disciplines responsible for patient care and the personnel responsible for hospital governance (14).

The emphasis in the literature on case review suggests that the future of ethics committees is linked directly to their ability to encourage interest in case review among their colleagues and to conduct case review in an effective and timely manner. The future of ethics committees as case consultants also is intimately tied to the question of their authority (both moral and practical). To be effective in the consultant role, with its implications of expertise, committees must have some institutional authority. The nature of their moral authority is not a function of their ethics expertise and thus is not well connected to case consultation insofar as case review appears to require ethics expertise.

Although committees lack moral expertise and thus may not be able to determine what is morally correct in a given treatment dilemma, they can provide a focus and forum for discussion on ethical issues. Many ethics committees feel that they function as "ethics experts" by default, because the institution has delegated this area to them and has established the committee without clearly defining the nature of its authority or responsibility. Doing ethics seriously means institutional and individual change. Too often, the administration or medical staff has ordered up a committee to do education, policy writing, and case review, without any real commitment to any of those activities or without thinking seriously about what an ethics committee doing case consultation really means.

It is possible that future public policy will provide stronger functional (if not moral) authority for ethics committees and their role in case consultation. It is said that in the future the mission of ethics committees should be mainly educational. They should be a resource for information on ethical perspectives and current ethical debates.

If ethics committees were to understand their primary mission to be education, they also would be able to see that the ethical issues in their institutions do not begin and end in the intensive care unit or the operating room. The emphasis on case consultation has served to limit ethics committees' understanding of ethics in health care as the ethics of the physician-patient relationship rather than the ethics of health care as manifested in the hospital. The ethics of health care institutional practices are much broader and should be of equal and even of greater concern to the ethics committee. It would be a sad irony if patients were all treated with exquisite ethical practice when it came to their rights to consent to and refuse life-sustaining treatment, but with ethical indifference during all their

other interactions in the hospital, medical center, or long term care facility. The fact that forgoing life-sustaining treatment decisions was an early focus of bioethics does not mean that the field is defined solely by that issue. Not should ethics committees define themselves or allow others to define them by that issue.

If an ethics committee were to think about its relationship to the practices of the entire hospital, it would understand its work differently. It could see itself as a force for institutional change (rather than for physician change); it could look to the sources of problems in the systems themselves rather than in the individuals who work within those systems. Many of the ethical problems in health care are systemic rather than individual. Within its educational mission, it can lead the way to recognizing the sources of problems and providing those who do have responsibility with different understandings and a stronger voice to bring about change. Ethics committee should select the work it chooses to undertake from a broader perspective and a wider range of issues than individual patient care decisions. Such issues might include exploring ways that:

1. Physicians and nurses could work together more collegially.
2. The hospital could become more user friendly to patients and families. (For example, why do hospitals in areas with large numbers of Spanish-speaking patients so often have no Spanish language sign?).
3. Everyone could become more reflective about health care resource use.
4. Physicians and patients could talk to each other more easily and more clearly.
5. Everyone could be more sensitive to helping one another practice universal infection control.
6. Patients could feel that they are heard and that their voices are respected in little things, not just in crisis treatment decisions (4).

Becoming a force for institutional change means risking failure in a more public and obvious way. These risks can be taken only if the committee has been successful in creating an internal sense of meaning and belonging among its committee members. Ultimately, ethics committees are about the moral nature of being a health care professional, about why it is that health care professionals and their institutions have special obligations and special powers, and about why there is concern about misuse of those powers.

There is something about the idea of ethics committees that goes deeply to the heart of many health care professionals. Perhaps it is because, as the health care institution has increasingly focused on its business concerns, the workplace has felt increasingly barren of

values. Those values continue to be affirmed in ethics committees and their members are grateful for that. However, the ethics committee of the future will need to do more than affirm those values. It will need to show where the institution has lost or neglected them and how they can be restored or reaffirmed in creative ways (4).

Clear recognition and attention to the central role of effective communication within the bioethics committee is essential for the survival of this system. Ethics committees depend on the sharing of relevant information to promote education, help in the formulation of new policies, and provide much needed support in addressing the many complexities of modern health care situations (11). To provide needed support in addressing the many complexities of modern health care, bioethics committees must develop clear communication processes, norms and roles.

Resumen

El sistema moderno de cuidado de salud ha estado en transformación como consecuencia de la escasez de recursos y de consumidores que están mejor informados. En este sistema de salud transformado, la comunicación humana se ha convertido en un proceso crucialmente importante. Este trabajo examina las funciones de comunicación de salud que realizan los Comités de Ética en la prestación de cuidado de salud y hace recomendaciones para promover el uso efectivo de estos grupos dentro del sistema de salud moderno. Este trabajo describe como los comités de bioética pueden ayudar a establecer un clima en el cual los médicos y otros miembros del comité puedan compartir información relevante, aprender acerca del paciente y las preocupaciones de la familia, promover la educación en salud y del consentimiento informado, así también facilitar

una toma de decisiones efectiva acerca de asuntos complejos relacionados a las prácticas en el cuidado de salud.

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