Clinical Ethics Training for Members of New York Ethics Review Committees (ERCs)
By Bruce D. White, DO, JD

[What is essential to the proper functioning of the ethics review committees under the Family Health Care Decisions Act, particularly in view of their newly expanded responsibilities, is comprehensive education for ethics committee members in a number of critical areas. (Morrissey, 2011)]

Introduction

With the passage of the Family Health Care Decisions Act (FHCDA) in 2010, the New York State Legislature went farther than any other U.S. state legislative body had ever gone with respect to creating statutory roles for hospital and nursing home ethics review committees (ERCs) (Miller, 2011). Under the statute, New York ERCs have binding decision making authority in at least three conflict situations, and are to be involved in several other cases through referral when disagreements arise in patient care. (Editorial Board, New York State Bar Association Family Health Care Decisions Act Information Center, 2011) (Holley & Otto, 2011).

Since 1986, the New York State Task Force on Life and the Law has encouraged institutions to have and use ERCs to assist in the resolution of patient care dilemmas (New York State Task Force on Life and the Law, 1986). The Joint Commission for the Accreditation of Healthcare Organizations has required that accredited institutions have an ethics “mechanism” to deal with ethical dilemmas that arise in patient care since the early 1990s. (Pope, 2009). This may have been trendy at the time (particularly with the growing concern about family conflicts over interventions, such as do-not-resuscitate orders and artificial feeding), but medical-moral committees had been functioning effectively in Catholic hospitals for several decades (Kelly & McCarthy, 1984).

There are other states that mandate that hospitals have ethics committees, either expressly (as in Maryland, New Jersey, Colorado, and Texas) or by implication (as in Florida) (Pope, 2009). But until enactment of the FHCDA, no jurisdiction had permitted an ERC to have a clear decision-making role that was to be binding on parties; heretofore, except perhaps for Texas, ERC participation in a case and any resultant recommendations had been advisory only (Fine & Mayo, 2003).

Ethics [Review] Committees have a clear obligation to seek the training, expertise, and information they need. At a minimum, training should include broadly accepted ethical principles for treatment decisions, committee members’ obligations and committee procedures, and the requirements of the FHCDA [New York’s 2010 Family Health Care Decisions Act] and other related laws such as the health care proxy law. (Miller, 2011)

Illustrative Case

The chair of the hospital’s Ethics Review Committee (ERC) called an emergency meeting to be held about six hours after the notice was circulated, at 5 p.m. later that day. One of the patient’s adult daughters had objected to the patient’s spouse acting as his surrogate under authority of the Family Health Care Decisions Act (FHCDA) and hospital policy. Because the daughter had formally objected, the matter was referred to the ERC, again as specified in the FHCDA and a hospital policy.

The hospital’s clinical ethicist had been involved in the case for several days. The clinical ethicist had met with the family and team members at least twice during the last 48 hours; each meeting continued for over an hour-and-a-half. The patient had been transferred from an outlying hospital with life-threatening traumatic injuries, including a potentially fatal injury to the head. Immediately after transfer the patient went to the operating room for several procedures. He had been in a coma since the accident; his Glasgow Coma Scale score had been recorded as 3 with no change during the entire hospitalization. He was intubated at the accident scene and had afterwards remained on assisted ventilation. The neurology service had been involved from admission. The neurology team told the family—that again, should he survive—it was entirely probable that he would progress to a persistent vegetative state (PVS) and no longer have any awareness of his condition or surroundings.

The meetings with the clinical ethicist had been primarily to discuss what the patient’s preferences might be under the circumstances so that the surrogate could participate in the medical decision-making process using either a substituted judgment standard or a best interests standard. The team asked for a clinical ethics consultation service intervention at this time because it had not
The patient is a 49-year-old male and currently estranged from his first wife; she had just been released from prison. His former wife had not visited the patient since the accident. Both his wife and his girlfriend have been at the patient's bedside almost every day since the accident. However, the patient's daughters believed that "stopping life sustaining treatment now is giving up too soon," and, as an extension of this belief, requested that the patient undergo tracheostomy and gastrostomy tube placement. The patient's spouse and the patient's siblings believed that he would prefer—given the clinical situation—that medical treatments be discontinued and that organ procurement services become involved to harvest any available donations should death occur immediately after removing the ventilator.

In conversation with the family members, the clinical ethicist learned that the family dynamics are in flux. The patient is a 49-year-old male and currently estranged from his wife, the person now acting as his surrogate under the FHCDA and hospital policy. The patient and his wife have been living apart for the past several months. The two have a six-year-old daughter. He was divorced several years ago from his first wife; she had just been released from prison. His former wife had not visited the patient in the hospital, but was in communication with the patient's oldest daughter. For the past several months, the patient had been living with a girlfriend. Both his wife and his girlfriend have been at the patient's bedside almost every day since the accident. However, the girlfriend has not participated in the medical decision making, nor has she made any effort to do so. (In conversation with the unit social worker about medical decisions, she said, "I know my place here.")

The patient is unemployed and has no health insurance. The patient's one natural daughter from his previous marriage is in her early 20s. There is another young woman at the bedside who introduces herself as the patient's daughter; however, she was never formally adopted by the patient. All family members agree, though, that the patient treated her as a daughter and had raised her as his own child, and that she should be involved in the conversation to the same extent as she were his natural or adopted child. Both the natural adult daughter and the adult common-law daughter have been at the patient's bedside continually. The patient has several brothers and sisters, and sisters- and brothers-in-law, who have visited the patient regularly during the intensive care unit stay. Several of the patient's siblings and siblings-in-law attended the family meetings with the clinical ethicist. (Relevant relationships are illustrated as a family tree in Figure 1.)

At the meeting of the ERC to review the daughters' objection, the group elected to limit the discussion to the surrogacy issue. There was some preliminary conversation about the role of the ERC at this stage: (1) To identify the most appropriate surrogate at this point; (2) to review the team's earlier decision to recognize the spouse; or (3) to suggest other ideas that may help the team with the surrogate identification and scope of authority issues.

One should recall that in mandating the referral to the ERC, the FHCDA is silent regarding the substantive and procedural aspects of the committee's involvement. This lack of legislative direction is not uncommon for statutes of this type (for example, the sections of the Texas Advance Directives that mandate an ethics committee review in disputed medical futility cases) (Fine & Mayo, 2003). The ERC has relatively broad discretion in the matter. Consistent with the traditional advisory role of ethics committee interventions, in this case the ERC elected to review the appropriateness of the team's identification of the patient's spouse as surrogate. The ERC met for about two hours. During this time, the ERC reviewed the facts as described in the medical record and the unit social worker's extensive notes, was told about the clinical ethicist consultant meetings and conversations, and debated the relevant provisions of the FHCDA and hospital policies. At the conclusion of the meeting the committee entered the following note in the patient's chart:

[Date, time redacted]

Clinical Ethics

The Ethics Review Committee met in a special called meeting to discuss an objection to the designated surrogate identification and her participation in the decision making process.

After consideration, we concluded that the team appropriately identified surrogate [name redacted], the patient's spouse, with due diligence in accord with accepted medical practice and hospital policy. It appears the [name redacted] has: (1) been making decisions in accordance with the patient's best interests; (2) has been in regular contact with the patient; (3) has been showing care and concern for the patient; (4) has been available to visit; and (5) has engaged in face-to-face contact with the providers.

We find that all family members who attended the meeting with [name redacted] this morning agreed that the patient's previously expressed wishes apply to this
sitation. We also agree that the patient’s surrogate is participating in the medical decision making process with the team in a manner consistent with the patient’s previously expressed wishes.

[Chair’s signature redacted]

In follow-up, the ERC learned that the team continued to recognize the patient’s spouse as the surrogate. There were no further objections. The morning following the meeting, the team removed the ventilator and instituted a palliative care plan. After withdrawal, and until he died two days later, the patient appeared comfortable and in no distress.

The vast majority of HEC [hospital ethics committee] members probably have little academic training or formal background in the field of healthcare ethics. Yet their position on the HEC implies that they are prepared to help others resolve ethical problems. Thus they feel the need for some education to give them confidence in their ability to help, and to give them credibility in the eyes of their colleagues who might turn to them. (Hackler & Hester, 2008)

Minimum Ethics Review Committee Training

Without question, there are a vast number of material facts and issues—some medical, some legal, some psycho-social, some others; some facts relatively simple, others far more complex—presented in this case with which the ERC must be familiar. Even if the ERC limits its involvement in the illustrative case to only reviewing the objection to the identification and authority of the patient’s surrogate—the triggering event here that mandated referral—to competently study the concerns, the committee must understand the underlying ethical, medical, legal, psycho-social, economic, theological, and health system facets implicated.

The American Society for Bioethics and Humanities (ASBH) first published its Core Competencies for Healthcare Ethics Consultation in 1998; it is now in its second edition (Core Competency Task Force, 2011). The core knowledge areas recognized in the ASBH report include: moral reasoning and ethical theory; common bioethical issues and concepts; health care systems and clinical context; the local health care institution and its policies; relevant codes of ethics and professional conduct; guidelines of accrediting organizations; and relevant health law. The illustrative case shows how important an understanding of the core knowledge areas are in real-life patient care. There should be no disagreement that the ERC be adequately prepared—trained—to meet its responsibilities under the FHCDA and hospital policies credibly and effectively.

The ASBH Core Competencies were drafted as a guide for ethics committees who are invited to participate in clinical cases via a consultation request. (Under the FHCDA, some cases will come to the ERC by referral, as in the illustrative case, rather than through a request from a patient, a family member, or a member of the institution’s staff). The ASBH Core Competencies accept that consultations may be offered by: (1) individual health care ethics consultants, (2) small groups of individuals or a sub-set of an ethics committee, or (3) the ethics committee as a whole. However, the Core Competencies also stresses that an advanced working understanding of all the core knowledge areas is essential if a consultation or review is provided appropriately, by whatever manner or mechanism. That is, if one person provides the consultation service, then that individual should have an advanced knowledge level of the core knowledge areas and the adequate skills to offer the consultation alone. Alternatively, whether a small group or the entire committee provides the consultation service, then that group collectively should together have an advanced understanding of all the core knowledge areas and a similarly adequate skills set. Moreover, some may argue that under the FHCDA, ERC involvement should be through a committee structure, particularly in those few instances in which the statute specifies that the committee has binding decisional authority or in which an issue should be referred to the ERC.

The Core Competencies is a pragmatic document. The expert authors understood that the consultation service for each institution would necessarily reflect a unique clinical and societal culture and fabric. However, the Core Competencies is also interested in consultation standards and focuses on participation and reviews being offered to meet minimum levels of expertise. The Task Force could not be clearer: if a consultation is provided, the work should be done competently.

A few years after the first edition of the Core Competencies was published, the Society’s Clinical Ethics Task Force issued its Improving Competencies in Clinical Ethics Consultation: An Education Guide (American Society for Bioethics and Humanities Clinical Ethics Task Force, 2009). This document has topical subject matter and content suggestions for those interested in learning the educational core competencies. Absent other nationally endorsed or peer-consensus standards for clinical ethics consultation services or a widely accepted curriculum for ethics committee members or health care ethics consultants, one might reasonably argue that these booklets should be considered definitively in developing educational topics and materials for ERC training. Moreover, the national standards expressly endorse the notion that
ERC member education may take several forms. (See Table 1.) And of course, it is not critical that all ERC members individually develop an advanced level of understanding of each of the core knowledge areas identified, so long as that expertise is otherwise represented on the committee by a member with that advanced core knowledge of the area (Core Competency Task Force, 2011). But it does seem reasonable that all ERC members have some basic understanding in each of the target areas. That too is an idea endorsed by the ASBH Core Competencies (Core Competency Task Force, 2011). By implication, a physician through medical training alone may lack the basic understanding of the core knowledge elements described in the Core Competencies. The same may be said of every discipline that is represented on ERCs. The FHICDA drafters must have given this idea of interdisciplinary expertise due consideration because the statute specified that for each institutional ERC there must be at least one physician, one nurse, and another individual who has no relationship to the facility (a “public” or “lay” member, are common terms used to describe this person) (Editorial Board, New York State Bar Association Family Health Care Decisions Act Information Center, 2011). However, these individuals alone—absent some level of expertise in the ASBH core knowledge and skills competencies—will clearly not be enough for the committee to meet its responsibilities.

Of course it will be the task of each institutional ERC to determine local educational standards absent some state or national authority mandate. It would seem, though, that the Core Competencies recommendations do set the bar. The extent to which these the core knowledge and skills competencies are met or exceeded locally may depend on the number of persons who serve on the ERC. This is the way in which many ethics committees have operated nationally for many years (Post, Blustein, & Dubler, 2007).

So to the direct question, how much training is required? The answer is simple: “enough.” It may not be sufficient, for example, if the lawyer who serves on the committee is a corporate attorney who knows little about relevant health law topics (such as informed consent, shared decision making, do-not-resuscitate orders, terminal sedation, palliative care, double effect, the process for the identification and authority of the surrogate, substituted judgment, and best interests standard), unless there is another member of the ERC that understands these topics at the advanced level. Again, each local ERC will need to establish its own criteria as compared to national standards. There are many bioethics and clinical ethics training options that are readily available to ERC members (several are listed in Table 1). Moreover, the ERC will need to design some method for continuing education over time. One-time educational programs—even to train ERC members initially—will not be enough. As technology and approaches change, so too must the ERC be prepared to deal with new challenges (Post, Blustein, & Dubler, 2007).

Conclusion

By enacting the FHICDA, the New York Legislature placed great faith in the integrity and professionalism of ERCs and their individual members. The legislature did so with the understanding that now, with the recognition of what had been before a purely advisory role to improve the care of patients, ERCs can perhaps play a greater role as an extra-judicial safeguard to speed and better reinforce traditional medical decision making processes, particularly in times of stressful and emotionally charged conflicts. Moreover, the legislature bolstered that belief that the ERCs would meet their duties competently by preemptively providing statutory immunity to institutions and committee members who act in good faith in carrying out their responsibilities under the law (Editorial Board, New York State Bar Association Family Health Care Decisions Act Information Center, 2011).

But, “with great power comes great responsibility” (Lee, Ditko, & Koepp, 2002). Now is the time for ERCs to prepare—with sufficient education and training—to meet present and future challenges they will confront.

Bibliography


The patient is indicated by the square with the arrow point; the patient's first wife is represented by the circle with the number 1; the patient's second wife is represented by the circle with the number 2; the patient's girlfriend is represented by the circle with the number 3; the circle labeled with '20s' are the patient's natural and common law adult daughters from his first marriage; the unlabeled circle represents the patient's six-year-old daughter from his second marriage.
<table>
<thead>
<tr>
<th>Type</th>
<th>Typical Format, Style</th>
<th>Example(s)</th>
<th>Contact Hours</th>
<th>Goals, Objectives</th>
<th>Credit Awarded</th>
<th>Typical Fee, Tuition</th>
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<tbody>
<tr>
<td>Institutional orientation (usually on-site)</td>
<td>Readings; organized group discussion or self-study; typically coordinated topically (systematic)</td>
<td>Flannigan R. <em>Ethics Committee Handbook—For New Member Orientation</em>. Available at: <a href="http://www.practicalbioethics.org/documents/guidelines/18-Ethics-Committee-Handbook-Flannigan-2008.pdf">http://www.practicalbioethics.org/documents/guidelines/18-Ethics-Committee-Handbook-Flannigan-2008.pdf</a> (accessed January 11, 2013).</td>
<td>Typically less than 5 hours</td>
<td>Varies; typically an introduction to terms, functions, operations focusing on institutional specifics</td>
<td>Typically no credit</td>
<td>None</td>
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<td>Institutional ethics grand rounds presentation or case consultation review (onsite)</td>
<td>Lecture or group discussion; typically uncoordinated topically with other presentations (sporadic)</td>
<td>Tenenbaum E. <em>Revitalizing Informed Consent to Protect Patient Autonomy</em>. Albany Medical Center Ethics Grand Rounds, January 17, 2013. Available at: <a href="http://www.amc.edu/Academic/bioethics/documents/Ethics_Grand_Rounds_-_011713.pdf">http://www.amc.edu/Academic/bioethics/documents/Ethics_Grand_Rounds_-_011713.pdf</a> (accessed January 11, 2013).</td>
<td>Typically 1 hour per session</td>
<td>Varies; instruction typically focuses on a single issue or case</td>
<td>Typically 1 CEU per session</td>
<td>None</td>
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<tr>
<td>Institutional mentorship</td>
<td>Patient encounters, on-the-job mentoring (sporadic)</td>
<td>Acre CA, Prager K, Hardart GE, Fins JJ. <em>Credentialing the clinical ethics consultant: an academic medical center affirms professionalism and practice</em>. Journal of Clinical Ethics. 2012;23(2):156-164.</td>
<td>Varies; typically about 5 hours per consult</td>
<td>Varies; mentoring typically focuses on a single set of issues within a case context</td>
<td>None</td>
<td>None</td>
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<tr>
<td>Intensive or emersion program (usually on-site)</td>
<td>Lectures, group discussions, seminars, standardized patient encounters, rounds; typically coordinated topically (systematic)</td>
<td>Mokwunye NO, DeRenzo EG, Brown VA, Lynch JJ. <em>Training in clinical ethics: launching the clinical ethics immersion course at the Center for Ethics at the Washington Hospital Center</em>. Journal of Clinical Ethics. 2012;23(2):139-146.</td>
<td>About 25 hours per seminar over five consecutive days</td>
<td>Structured, coordinated topical instruction (systematic)</td>
<td>Typically either CEUs or graduate course credit</td>
<td>About $2,500 per participant (expenses additional)</td>
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<tr>
<td>Series of coordinated seminars (usually on-site)</td>
<td>Lectures, group discussions, seminars, standardized patient encounters, rounds; typically coordinated topically (systematic)</td>
<td>White BD, Zaner RM. <em>Clinical ethics training for staff physicians. designing and evaluating a model program</em>. Journal of Clinical Ethics. 1993;4(3):229-235.</td>
<td>About 6 hours per seminar; or, about 25 hours for an entire series</td>
<td>Structured, coordinated topical instruction (systematic)</td>
<td>Typically either CEUs or graduate course credit</td>
<td>About $100 per participant per seminar within the series; about $400 for an entire series</td>
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<td>Graduate course (such as a course in clinical ethics on-site or online)</td>
<td>Lectures, group discussions; typically coordinated topically (systematic)</td>
<td>AMBI 503. Clinical Ethics. Information, available at: <a href="http://www.amc.edu/Academic/bioethics/educational_programs/graduate_programs/course_info/course_descriptions.cfm">http://www.amc.edu/Academic/bioethics/educational_programs/graduate_programs/course_info/course_descriptions.cfm</a> (accessed January 11, 2013).</td>
<td>About 100 hours per course</td>
<td>Structured, coordinated topical instruction (systematic)</td>
<td>Typically graduate course credit (about 3 credits per 100 contact hours)</td>
<td>About $2,500 per course</td>
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<td>Certificate in clinical ethics (typically a series of college courses on-site or online)</td>
<td>Lectures, group discussions; typically coordinated topically (systematic)</td>
<td>AMBI Graduate Certificate in Clinical Ethics. Information available at: <a href="http://www.amc.edu/Academic/bioethics/educational_programs/graduate_programs/degrees_certificates/certificate_program.cfm">http://www.amc.edu/Academic/bioethics/educational_programs/graduate_programs/degrees_certificates/certificate_program.cfm</a> (accessed January 11, 2013).</td>
<td>About 400 hours per program</td>
<td>Structured, coordinated topical instruction (systematic)</td>
<td>Typically graduate course credit (about 12 credits per 400 contact hours)</td>
<td>About $10,000 per program</td>
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<td>Graduate degree (such as a master of science in bioethics on-site or online)</td>
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<td>AMBI Comprehensive Master of Science in Bioethics. Information available at: <a href="http://www.amc.edu/Academic/bioethics/educational_programs/graduate_programs/degrees_certificates/master_science_bioethics.cfm">http://www.amc.edu/Academic/bioethics/educational_programs/graduate_programs/degrees_certificates/master_science_bioethics.cfm</a> (accessed January 11, 2013).</td>
<td>About 1000 hours per program</td>
<td>Structured, coordinated topical instruction (systematic)</td>
<td>Typically graduate course credit (about 30 credits per 1000 contact hours)</td>
<td>About $25,000 per program</td>
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<td>Fellowship in clinical ethics (on-site or through some distance learning and mentoring arrangement)</td>
<td>Lectures, group discussions, seminars, rounds, patient encounters, on-the-job mentoring; typically coordinated topically (systematic)</td>
<td>Clinical Ethics Fellowship, Albany Medical Center. Information available at: <a href="http://www.amc.edu/Academic/bioethics/documents/AMBI_Ethics_Fellow_2012-2013.pdf">http://www.amc.edu/Academic/bioethics/documents/AMBI_Ethics_Fellow_2012-2013.pdf</a> (accessed January 11, 2012); Cleveland Fellowship in Advanced Bioethics, Cleveland Clinic. Information available at: <a href="http://my.clevelandclinic.org/about-cleveland-clinic/ethics-humanities-care/bioethics/advanced-fellowship.aspx">http://my.clevelandclinic.org/about-cleveland-clinic/ethics-humanities-care/bioethics/advanced-fellowship.aspx</a> (accessed January 11, 2013); MacLean Center Fellowships in Clinical Medical Ethics, University of Chicago Medical Center. Information available at: <a href="http://medicine.uchicago.edu/centers/ethics/fellowship.html">http://medicine.uchicago.edu/centers/ethics/fellowship.html</a> (accessed January 11, 2013).</td>
<td>About 2000 hours (on-site full-time for one year)</td>
<td>Structured, coordinated topical instruction (systematic)</td>
<td>Typically a non-accredited fellowship certificate or graduate course credit</td>
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**Endnotes**

1. For complete education at the institutional level, these options must be coupled with training in local policies and practices.
2. CEU means a “continuing education unit” from an accredited professional continuing education provider.
3. AMBI is an acronym for the Alden March Bioethics Institute at Albany Medical College, Albany, New York 12208.

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