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Some Considerations about Decisions and Decision-Makers in Hospital Ethics Committees

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Abstract

This paper presents a brief history of the development of hospital ethics committees. Following the introduction, areas of decision vulnerability are considered. Areas of potential concern include committee composition, including the influence of experts upon the decisions and decision makers. Also considered are bounded rationality, herd behavior and informational cascades. The paper ends with some suggestions about decisions and decision-makers for hospital ethics committees.

Keywords:

Hospital Ethics Committee, Rational Herding, Informational Cascades, Expert Decision Making, Bounded Rationality

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Introduction

The ethical questions faced by hospitals generally have less to do with the science of health care and more to do with normative choices, such as quality and quantity of life. Hospital ethics committees (HEC) evolved as a court suggested answer to ethics questions raised in the Karen Ann Quinlan case (Scheirton & Kissell, 2001). Her case brought to the forefront the complexity of the questions raised when the boundaries between life and death become blurred. As their numbers have grown, so too as the importance of HECs in the fabric of the health care system. Today, ethics committees provide a formalized mechanism to address the bioethical questions that arise in the performance of health care through assistance with decision-making, consultation, ethical education, and institutional policy development (Scheirton & Kissell, 2002).

The legal system has endorsed the use of ethics committees and various rulings have shown that courts are inclined to accept the rulings of HECs without reservation (Wilson, 2002). Lately, a major shift has occurred in several states, including Alabama, Florida, Georgia, Hawaii, Maryland, Montana and Texas, where HECs are no longer adjunctive to the courts but rather the HEC decisions hold legal weight (Wilson, 2002). The acceptance of HEC decisions is based upon the assumptions that it is quicker, easier, cheaper and more effective to use an HEC than the courts and that decisions made by HECs are correct.

No one can argue the importance and influence of HECs, but care should be taken to understand that HECs have the same potential flaws as any committee and the decisions rendered are equally vulnerable. While we tend to think of ethics committees as free of internal and external bias this is probably an unrealistic view. Committees are composed of human beings and human beings are by definition influenced by their view of the world and others around them. For example, consider that many committees are composed of institutional representatives who may find it hard to argue against the institution or its policies (DeVille & Hassler, 2001).

Hospital Ethics Committees, Decisions and Decision Makers

Until the last half of the 20th century patients, families, and/or physicians easily, and often paternalistically, solved the ethical problems in health care. Technology changed the playing field making it increasingly difficult to know the right solution in any given situation. For the first time in history, individuals could be kept alive with machines or donated organs. The questions posed as a result of these technological changes became so complex that the individual decision maker was no longer enough. Hospital committees emerged as a mechanism to review the individual circumstances of ethical dilemmas and provide assistance and safeguards for patients and providers. Since their inception, HECs have been endorsed by most major health-related groups including the

Department of Health and Human Services, American Nurses Association, American Medical Association and American Hospital Association.

Although HECs began as a voluntary effort, they now serve a quasi-legal function. Hospitals use the judgments of HECs to avoid asking courts to make decisions on patient care and courts accept the HEC decisions as being in the best interests of the patient. In most states, HECs are not required, although as of 1992 the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO) does require hospitals to have a mechanism to resolve ethical issues. HECs obviously fulfill the JCAHCO requirement. Some states, such as New Jersey and Maryland, have a legal requirement for HECs (Scheirton & Kissell, 2001). As a result of these endorsements, mandates, and requirements the nationwide percentage of hospitals with HECs has risen from 10% in the 1980s to 90% today (Guo & Schick, 2003).

Ethics committees are generally composed of interested professionals, including physicians, hospital administrators, nurses, clergy, lawyers and community members. Guo and Schick (2003) surveyed over 500 HECs and found that 40% of HEC members were physicians, 20% nurses, 13% clergy, with the other 25% divided among ethicists, administrators, social workers, attorneys and others.

There are no standards for HEC composition. The expectation appears to be that the ideal committee will have a representative sample of interested parties plus an ethicist knowledgeable about moral discourse and ethical reasoning, although less than half of all committees do (Wilson, 2002). Wilson (2002) notes that it is not unusual for an ethics consult to be provided by an HEC member with no ethical training at all.

Some, but not all hospitals, require ethics training. For example the University of Washington system requires that HEC members learn the technique of ethical analysis and be familiar with the ethical commonplaces of autonomy, beneficence, non-maleficence and justice (University of Washington: <http://eduserv.hscer.washington.edu/bioethics/topics/ethics.html>). Others require an ethicist to be a member of the HEC. However, in general, expertise and ethical training are ideal rather than required. More often than not, all that is required to serve on an HEC is an expressed interest.

The assumption by courts is that HEC decisions are expert decisions. However, decision making, like all human enterprise, is fraught with potential problems, including error. Contrary to popular opinion, expertise may not necessarily improve decision-making, nor does committee membership require expertise (Shanteau, 1992b)

Expertise is defined as a special skill or knowledge representing mastery of a particular subject (Merriam-Webster, 1994). Some consider years of experience to be synonymous with expertise, but not all experienced people become experts. Some are just more experienced (Shanteau, Weiss, Thomas, & Pound, 2002). Weiss and Shanteau (2001) write that the two characteristics that represent expertise are the ability

to discriminate among informational clues and to be consistent in decisions. Shanteau (1992b) says that the information experts use is different in quality not quantity. Generally speaking both experts and non-experts use a small number of cues in making a decision (Shanteau 1992a). Shanteau (1992a) reports that different types of experts from physicians to stockbrokers use from one to seven cues to make decisions. He notes that experts sort the more relevant information from the irrelevant. Knowing what to ignore may be as important as knowing what to consider. Irrelevant information can be problematic for both experts and non-experts (Gaeth & Shanteau, 1981). Thus, the quality and quantity of information are both important to decision-makers.

Weiss and Shanteau (2001) also propose that there are at least four different types of experts.

They are:

1. Expert judges who are able to look at the information provided and make an expert judgment.
2. Expert predictors who are able to use the information provided to predict outcomes.
3. Expert instructors who are to use information to teach others.
4. Performance experts who use information in order to provide an expert performance.

All experts need the ability to evaluate the information provided for the decision. However, the qualities that make an expert diagnostician (judgment expertise), or surgeon (performance expertise) are not necessarily the same as those required to teach or to predict the future.

According to Weiss and Shanteau (2001) the knowledge domains of experts are specific and not generalizable across disciplines. Thus an expert in one discipline is not necessarily an expert in another. A lawyer will only bring legal expertise to the table not medical expertise; a surgeon will bring surgical expertise but not necessarily moral expertise, and so forth. Interestingly, it has been shown that experts within a field do not necessarily agree with one another when given the same information. Agreement by experts on any given topic, from animal husbandry to the stock market, can run at 50% or less (Shanteau, Weiss, Thomas & Pound, 2002). So even a committee composed of ethical experts might not agree with one another.

While the presence of experts can be helpful, there are also downsides. Shanteau (1992b) says that the presence of an expert can lead to premature closure when non-expert members too quickly agree with the decisional lead of the expert. When premature closure occurs, not all information available is considered before a decision occurs. Quick decisions can have a disproportionate and sometimes negative effect on results as no new information is allowed that might change the behavior or the outcome.

Thus the decision can easily be made without consideration of important facts and figures.

When individuals follow the lead of others, regardless of the information involved, the imitative behavior is called herd mentality or rational herding. Sushil Bikhchandani, Hirshleifer and Welch (1998) write that herding is seen when individuals converge on similar behavior without thinking. Imitative herd behavior can lead to an informational cascade. In an informational cascade information ceases to be important to the decision, people just follow or agree with one another regardless of what they individually think. Cascades are defined as a situation where every subsequent person based on the observations of others beforehand, makes the same choice independent of his/her private signal (Bikhchandani, Hirshleifer & Welch, 1998). Avery & Zemsky (1998) write that this behavior can impede the flow of information because individuals make decisions sequentially rather than concurrently.

Obviously, cascades can cause premature closure as people ignore the discrepant information that they or others bring to the decision making table. As a result, there can be massive social imitation sometimes leading to the wrong direction. The recent stock market internet bubble is an example of a large scale informational cascade brought on by herd behavior (Surowiecki, 2004).

The ideal of rational thinking, where perfect answers come from perfectly thought through alternatives, is rampant in many disciplines. Unfortunately, most thinking is not completely rational, nor can it be. All decisions are based upon less than perfect information and are made by less than perfect human beings. Decision-makers cannot rely on others to be perfect and volumes of information, while comforting, usually increase the possibility of error rather than decreasing it (Kosko, 1993). The difficulties with rationality led economists to create a new label called bounded rationality. This label refers to people who act nearly optimally, but not perfectly optimally (Simon, 1955; Gigerenzer & Selten, 2001).

A recent book summarized research about group decision-making. According to Surowiecki (2004), wise groups have four things going for them; 1) diversity of opinion, 2) independence, 3) decentralization and 4) aggregation of private judgments into group decisions. Each of these four elements helps to create good decisions. First, independence of thought is important. Diversity of opinion helps to ensure that all the relevant aspects of the situation are considered. It is too easy for a homogeneous group to make a decision without consideration of opposite points of view. In fact it is far too easy for like-minded people to be formed into decision-making groups in the first place.

Diversity of membership is important to good decisions and to overcoming the effects of the herd (Surowiecki, 2004). Differences in disciplines and people bring a broader array of information to the table when decisions are required. This richness of information helps to ensure that as many alternatives as possible are considered (Page & Hong, 2001). Diversity also helps to ensure that committees remain open to new information. It

is too easy for a long standing committee, composed of homogeneous members, to fall back on previous decisions as template for future action (March, 1991). Such groups lose their independence.

The work on informational cascades and herd-like thinking points out the importance of valuing individual thought in the decision-making process. If everyone agrees with the leader, or the first to form an opinion, than the decision is based upon one person, not the group. Broadening the decision-making base, and making it more decentralized helps ensure that an expert or powerful leader does not unduly influence the results. And finally the aggregation of information into decisions helps ensures that all relevant information is considered.

The above discussion points out a few of the problems that could influence the decisions made by HECs. It is worth considering the role of an expert in an HEC. While experts can and should bring an added dimension to ethics committees, the members must be cognizant of the narrow scope of most experts expertise, the lack of agreement between experts on any given topic, and the untoward consequences when non-experts follow an expert without thinking. Second, committee members should consider the quality and quantity of information used in the decision-making process. It is clear from the literature that most decisions are formed from a small numbers of cues. If the information used to form those decisions is misinterpreted, or erroneous than the decision also may be flawed. While too much information may not improve decisions made, too little may result in a failure to consider all important elements. Third, HECs should consider the importance of each committee member in adding diversity of thought, independence, decentralization and aggregation to the decision-making process.

Summary

What lessons can HECs take away from the work on decision-makers and decision-making? First, HECs should be formed from not only from diverse professional groups but also by individuals with diverse opinions. Second, experts have a role to play but that role should be considered no more important than roles played by other committee members. Third, the information used by the group is important. Every decision will be different so the information required by the group to form its opinion should be tailored. Fourth, the group should be very aware of imitation and group thinking of herd behavior. To avoid over-influence by one or more members, groups may consider the use of balloting or other means of allowing all members to be heard.

The presence of HECs strengthens the ability of the health care system to provide care that is not only medically superior but also of the highest ethical standards. However, committee composition and the decision-making process should be considered as potential sources of error.

To strengthen HECs and their decisions, the following suggestions are offered:

1. Ensure that HECs are composed of diverse professions, as well as diversity of gender and ethnicity. Diversity strengthens decisions by expanding the knowledge and opinion base (Smith, Bisanz, Kempfer, Adams, Candelari, & Blackburn, 2004).
2. Include community representation so that not all members are institutionally based. Diversity of institutional information is also important. Institutional allegiance may also influence decisions in unknown ways (DeRenzo, Silverman, Hoffman, Schwartz, & Vinicky, 2001; Deville & Hassler, 2001).
3. Make sure that the professionally powerful voices, for example physicians and lawyers do not override the other committee members' opinions. DeVille & Hassler (2001) note that when lawyer members of HECs speak, other members may not feel any further discussion is needed. HECs might consider the technique of the military where some military tribunals vote in reverse order of seniority.
4. Consider the pooled opinion technique described by Surowiecki (2004) in the *Wisdom of Crowds*. Within the HEC meetings opinions might first be gathered on a paper ballot allowing each voice to be heard as an individual before pooling. As Surowiecki (2004) notes no one expert is consistently right and pooled opinions are on average better than the individual.
5. Require ethics training for all members (Wilson, 2002). Exposure to the techniques of ethical analysis gives a common frame of reference for all committee members.
6. All information provided to HECs should be adequate in volume and organized in such a manner as to be interpretable by the committee. Clinical evidence should follow standard guidelines and reflect the best evidence available. Decisions should occur only after all relevant information is considered. However, committees should be aware that more information may not be better; it may only increase error (Kosko, 1993).

References

- Avery, C. & Zemsky, P. (1998). Multi-dimensional uncertainty and herd behavior in financial markets. *American Economic Review*, 88(4), 724-748.
- Bikhchandani, S., Hirshleider, D. & Welch, I. (1998). Learning from the behavior of others: Conformity, fads, and informational cascades. *Journal of Economic Perspectives*. 12, 151-170.
- DeRenzo, E., Silverman, H., Hoffman, D., Schwartz, J., & Vinicky, J. (2001).
- Maryland's ethics committee legislation- A leading edge model or a step into the abyss? *HEC Forum*, 13(1), 49-58.
- DeVille, K. & Hassler, G. (2001). Healthcare ethics committees and the law: Uneasy but inevitable bedfellows. *HEC Forum*, 13(1), 13-31.
- Gaeth, G.J. & Shanteau, J. (1984). Reducing the influence of irrelevant information on experienced decision makers. *Organizational Behavior and Human Performance*, 33, 263-282.
- Gigerenzer, G. & Selten, R. (2001). *Bounded rationality: The adaptive toolbox*. Cambridge: MIT Press.
- Guo, L. & Schick, I.C. (2003). The impact of committee characteristics on the success of healthcare ethics committees. *HEC Forum*, 15(3), 287-299.
- Kosko, B. (1993). *Fuzzy thinking: The new science of fuzzy logic*. New York: Hyperion.
- March, J.G. (1991). Exploration and exploitation in organizational learning. *Organizational Science*, 2, 71-87.
- Merriam-Webster's collegiate dictionary (10th ed.). (1994). Springfield, MA: Merriam-Webster.
- Page, S. & Hong, L. (2001). Problem solving by heterogeneous agents. *Journal of Economic Theory*, 97, 123-163.
- Scheirton, L.S. & Kissell, J.L. (2001). The leverage of the law: The increasing influence of law on healthcare ethics committees. *HEC Forum*, 13(1), 1-12.
- Shanteau, J. (1992a). How much information does an expert use? Is it relevant? *Acta Psychologica*, 81, 75-86.
- Shanteau, J. (1992b). Competence in experts: The role of task characteristics. *Organizational Behavior and Human Decision Processes*, 53, 252-266.
- Shanteau, J., Weiss, D.J., Thomas, R., & Pound, J. (2002). Performance-based assessment of expertise: How can you tell if someone is an expert? *European Journal of Operations Research*, 136, 253-263.

- Simon, H.A. (1955). A behavioral model of rational choice. *Quarterly Journal of Economics*, 69, 99-118.
- Smith, M.L., Bisanz, A.K., Kempfer, A.J., Adams, B., Candelari, T.G. & Blackburn, R.K. (2004). Criteria for determining the appropriate method for an ethics consultation. *HEC Forum*, 16(2), 95-113.
- Surowiecki, J. (2004). *The wisdom of crowds*. New York: Doubleday. University of Washington School of Medicine; *Ethics in Medicine* (n.d.). Retrieved August 28, 2004 from the University of Washington School of Medicine Web site: <http://eduserv.hscer.washington.edu/bioethics/topics/ethics.html>.
- Weiss, D.J. & Shanteau, J. (2001). The vice of consensus and the virtue of consistency. Retrieved August 30, 2004 from the Kansas State University CWS Web site: http://www.ksu.edu/psych/cws/library_present.htm.
- Wilson, R.F. (2002). Rethinking the shield of immunity: Should ethics committees be accountable for their mistakes. *HEC Forum*, 14(2), 172-191.