The hospital ethics committee (HEC) is an entity that arose relatively recently, in the 1980s, in response to various concerns about how to choose the ethically correct path in dealing with a wide range of novel situations being brought about by the advances of medicine. This article recounts the hospital ethics committee's historical background, briefly defines its nature, describes the Argentine experience with it to the present, reviews existing guidelines for organizing and operating an HEC, and makes a number of recommendations designed to heighten awareness of the HEC’s potential and promote its use.

Hospital ethics committees (HECs) are interdisciplinary bodies that perform teaching, research, and consultative functions dealing with the ethical problems that arise during the practice of hospital medicine. These bodies emerged in response to problems posed by new medical technologies and a new social awareness oriented toward evaluation of prolonged treatments, decisions not to treat newborns with serious malformations, and other deliberations of an ethical nature.

In 1982, only 1% of the hospitals in the United States had committees of this kind, but in 1988 the percentage had risen to 60% for hospitals with more than 200 beds (1). Today’s reality in Latin America, however, continues to show little such development. This article presents a historical analysis of HECs’ legal basis, describes their structure and Argentina’s experience with them, and makes some recommendations.

THE PRAXELOGIC-ETHICS COMMITTEE

In his decision of 31 March 1976, Judge Richard Hughes of the U.S. State Supreme Court of New Jersey responded to a request to suspend the artificial respiration of a young woman in a deep coma by noting that the ethics committee of the institution where the woman was a patient should be consulted. In his decision, Hughes cited a recent article by the pediatrician Karen Teel (2) in which she proposed having an ethics committee composed of physicians, social workers, lawyers, and theologians serve as an instrument for evaluating different therapeutic options applicable to a given patient.

The Morris View Nursing Home, the institution where the young woman, Karen Quinlan, was in a coma, formed an ethics committee composed of two representatives of the clergy, the institution’s director, a social worker, a physician who was not treating Karen Quinlan, and its own legal representative. The committee, which was not the envisaged panel of experts, went beyond the framework of prognostic review proposed by the judge to consider ethical aspects involved in making decisions about the
case. In this way, without awareness of the principal actors, Teel's critical article, the unfortunate Karen Quinlan, the informed Judge Hughes, and the determined Morris View Nursing Home gave forward impetus to the most recent chapter in a fascinating human history.

Extensive publicity surrounding the Quinlan case called attention to the ethics committee, an entity almost nonexistent until then (3), and prompted its formal consolidation; but it was the March 1983 report (4) of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research that gave a decisive boost to such committees by proposing their organization and use in making decisions about terminal patients. This report provided a model for establishing such committees, a list of already existing ones (only 1% of the hospitals in the United States had them at that time), and a survey of their activities.

When a baby with Down's syndrome and esophageal atresia was born at Bloomington, Indiana, in the spring of 1982, a year before the presidential report, another key event in the history of HECs began. The life of the newborn depended upon an operation that would allow it to be fed. The baby's parents refused treatment; and the infant, abandoned to its fate in a home, died of starvation in six days while the medical team tried without success to get a court to intervene in the case (5). The following year the U.S. Department of Health and Human Services proposed a regulation to evaluate the treatment of disabled children and suggested government intervention in such cases (6). The American Academy of Pediatrics responded to this by proposing the creation of specialized ethics committees, each of which would be specifically designated an "Infant Bioethical Review Committee" (7).

Then, on 11 October 1983, the child who would be known as "Baby Jane Doe" was born at Port Jefferson, New York (8). This infant was born with multiple neurologic deficits, spina bifida, microcephaly, and hydrocephaly. The medical team caring for her to prevent infections but not to treat her malformations indicated the baby might benefit from surgical intervention. Her parents, preferring conservative treatment, rejected the intervention proposal, but a court ruled that the operation should be carried out. The decision was reversed by the New York State Court of Appeals, and Baby Doe was taken home without treatment. Confronted with this situation, in February 1984 the U.S. Department of Health and Human Services ordered an investigation of parental decisions about the treatment of disabled babies and opened a telephone hot line for reporting cases of negligence.

On 23 May of that year, U.S. District Court Judge Charles L. Brieant of the Southern District of New York, Manhattan, summarily vacated the federal "Baby Doe rules" for violating the medical duty of confidentiality and the parents' right to privacy. Brieant thus dealt with the complaints of the American Medical Association, American Hospital Association, and other societies. The Department of Health and Human Services accepted the decision in part, and although it adhered to Washington's prevailing guidelines and emphasized the possibility of investigating such cases, it offered great freedom of action to hospitals having infant care review committees. Within this context, debate over decision-making revolved about three alternatives: leaving decisions to parents and physicians, establishing direct government intervention and control, or taking cases to court (8). Another strong alternative confronting these three was the option of utilizing HECs, an option that was to undergo major development.
THE LEGAL-SCIENTIFIC COMMITTEE

An earlier chapter of the story began 30 years before the Quinlan case. On 1 October 1946 an international tribunal at Nuremberg, Germany, sentenced 22 members of the Nazi Party for crimes against humanity. The following year, after having uncovered atrocious experiments carried out on prisoners of war, the tribunal proclaimed the Nuremberg Code, which established a set of principles that should be respected in conducting medical experiments on human subjects.

The code’s influence was immense: It was discussed at a national conference in Chicago in 1958 (9). It provided the basis for a Draft Code of Ethics on Human Experimentation that was drawn up by the World Medical Association in Geneva in 1961 (10) and developed into the World Medical Assembly’s Declaration of Helsinki of 1964 (11). It was also contained in the Twenty-ninth World Medical Assembly’s amendment of that declaration in Tokyo in 1975, which expressly recommended that each phase of experimentation with human subjects, after being defined in an experimental protocol, be submitted for consideration to an independent committee specially formed to advise and render an opinion on it, so that the basic recommendations of the Nuremberg Code could be more thoroughly applied.

In this way research ethics committees, which have since functioned in various health institutions including hospitals, were consolidated globally under the basic concept of human responsibility. That same year, 1975, saw the publication of the previously noted article by Karen Teel (2).

Six years later, in 1981, the World Health Organization disseminated its "Proposed International Guidelines for Biomedical Research involving Human Subjects." This proposal sought to point up the usefulness of applying the Declaration of Helsinki, revised at Tokyo, to developing countries (12). Particular attention was drawn to Latin America as a region that seemed especially suitable for establishment of ethics review committees.

THE DEONTOLOGIC-TECHNICAL COMMITTEE

The origins of our story’s first chapter are lost in the mists of time. It is believed that toward the end of the fifth century B.C. or the first half of the fourth century B.C., the shortest and most influential of known medical texts took shape in Greece. Its author is unknown.

Physicians found that the text offered a set of standards enabling them to practice their profession morally, and also established the basis for powerful social action through the universality of its language (13). Reproduced through the centuries from times when men worshipped Aesculapius, the Greco-Roman God of Medicine, considered by Erotian a work about techné, prescribed by Pope Clement VII’s bull Quod jusiurandum in 1531 to all those graduating as physicians, used as their standard by the Asclepiads in K. Deichgräber’s view (14), and as the Pythagorean manifesto in L. Edelstein’s (15), the Hippocratic Oath has influenced medical ethics until today. The World Medical Association’s General Assembly adapted it for its Declaration of Geneva in 1948 and International Code of Medical Ethics in 1949. Moreover, by invoking professional commitment and a code of ethics, the Oath made itself the major antecedent of

The international codes cited in this article are reprinted in full or in part as Appendices to this issue, beginning on p. 599.

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the ethics committees serving medical associations, colleges, and schools of medicine, institutions that often extended this model to hospitals.

HEC ORGANIZATION ACCORDING TO THE THREE MODELS PRESENTED

A distinction established between the three models just presented is useful in enabling us to define the concept of the "praxeologic-ethics committee" with greater precision. That is because the praxeologic-ethics committee's worth resides in the fact that it is charged with making ethical decisions involving both facts and values—scientific concepts, technical rules, and philosophic ideas.

The commission or delegation of authority which falls to the committee, though proposed by some person or group, must in any case come from the hospital itself. It should be borne in mind that a legal-scientific or deontologic-technical committee is deferring to one or another sort of outside entity (government, universities, associations, etc.), whereas the HEC serves as the "conscience of the institution" (26). The definition of Cranford and Doudera (27), who describe this committee as "a multidisciplinary group of health professionals at a health institution who carry out the function of managing the ethical dilemmas that occur within the institution," makes this clear.

Our concept seems even clearer if we compare the legal and deontologic options with the ethical one. As Diego Garcia (18) observes, this shows that HECs need to have a methodology for analyzing the moral problems they confront. He suggests that this methodology should include the following phases: initial evaluation of the problem; analysis of the proposed act's correctness; analysis of its goodness; and decision-making. In turn, Kieffer (19) proposes the following phases: presentation of the problem; identification of alternative courses of action; analysis of the results of each course of action; ordering of existing values; and selection of a course of action based on the analysis. Other authors have proposed different approaches (20).

In any case, it seems evident that useful tools for the committee's work are clinical ethics protocols, including that of Bochum (21). For the committee is not merely applying already established moral standards geared fundamentally to maintaining professional decorum or carefully noting the legal consequences of a bold scientific undertaking; instead, its aim is that of providing a truly ethical process.

We can also say that HECs are eminently praxeologic (oriented to human behavior) rather than scientific or technical, because they concentrate primarily upon the multiple implications of particular actions and decisions (22, 23). This is the point, we believe, at which we should ask ourselves, "What is an HEC's ethic?" and at which we will inevitably encounter metaethical issues.

Bearing in mind that everyone involved in the ethical dilemma is represented, Bertomeu (24) believes it possible to employ a communication ethic like that of Apel and Habermas which excludes the strategic negotiating interests of the parties in order to initiate a true moral process. For this to happen it is necessary, irrespective of any objections (25), that philosophers be able to enter hospitals and ensure the probity and rigor of the moral debate among health professionals and laymen at the same time (as Toulmin posits—26) that they establish their own status. In any event, clinical ethics requires special training (27, 28).

In addition, it is necessary to note the multidisciplinary nature of an HEC compared to a committee of experts (a legal-
scientific committee) or a committee of notables (a deontologic-technical committee). At the same time, the HEC's functions will be much more varied—since the existence of any conflict in values may convoke it, while the other two types of committees have more limited domains.

**THE ARGENTINE EXPERIENCE**

In recent years a few ethics committees have been created in Argentina; and because they have arisen during the great resurgence of interest in bioethics, they may be considered immersed in this subject.

More specifically, on 5 December 1984 the Ethics Committee of the University of Buenos Aires' Hospital de Clínicas was created as a result of a few episodes of medical malpractice and certain clinical investigations that had not been evaluated from an ethics standpoint. Among the deeper considerations motivating the hospital's decision was its need for an agency capable of overseeing research and malpractice, channeling complaints by patients and family members, providing ethical education for students and graduates, and defining standards of medical activity. Members were chosen from among physicians of "recognized ethical stature associated with the hospital." This ethics committee, which stopped operating a few years later, was basically of the deontologic-technical type, though it may also have considered dealing with legal-scientific matters.

Elsewhere in Buenos Aires, an HEC was created at the Italian Hospital.

In Tucumán, two ethics committees were created in 1988. One, the Bioethics Society of the Medical College of Tucumán, is devoted to the study of reproductive technologies and contraception. The other, the Ethics Committee of the Faculty of Medicine, is composed of 10 members, three of them physicians; it has been assigned advisory and consultative duties. There are no hospital ethics committees in Tucumán.

In Mendoza, the Central Hospital created a bioethics committee in October 1987. This multidisciplinary body, which has been going through a formative period, holds meetings every 15 days.

Elsewhere, a bioethics committee is being organized at the Lagomayor Hospital. The Psychiatric Hospital of Sauce has appointed a coordinator and plans to organize an HEC. And in Mar del Plata the Deontothanatology Committee of the Community Hospital, created in 1984, may become an HEC.

Within this context, the Ethics Committee of the Oncologic Center of Excellence of Gonnet was created under our direction in 1987 in response to the mounting moral problems being encountered in the health care field. A result of extensive previous work in the field of medical humanities and bioethics, the committee consists of six to 12 professionals from a variety of disciplines and is designed to perform educational, normative, and consultative tasks. In general, its purpose is to make recommendations that are not binding upon the parties involved.

During the first two years of its existence the committee engaged mostly in research and instruction. However, since December 1988 it has come to devote itself increasingly to care-oriented consultative work. Its present membership includes an anthropologist and a priest, though a majority of the members are physicians or philosophers. The committee's weekly meetings are devoted to reading and discussing cases. All hospital personnel participate in the committee's plenary meetings. The greatest shortcoming of this approach encoun-
tered to date is difficulty in simultaneously achieving effective group integration and methodologic progress.

The main questions that the committee has dealt with to date fall into the following areas: theoretical and practical aspects of ethical decision-making; understanding and adaptation of clinical ethics protocols; analysis of the professional-patient relationship; health care; new technologies; experimentation involving human subjects; and death and dying. From the standpoint of its composition, functions, and methodology, the committee may be considered a unique example of the praxeologic ethics type. It has come increasingly to serve as a reference center for hospitals in the area, to which it provides advice and instruction, and its educational role has grown steadily.

RECOMMENDATIONS ON HEC ORGANIZATION

On a daily basis, HECs are the most efficacious tool available for working in the field of biomedical ethics, from three standpoints: theoretically and conceptually in terms of ethics communication; methodologically, for bringing to bear a clinical approach intermediate between casuistry and situation ethics; and administratively, by providing a sound basis for prescriptive action. This suggests that a good share of our ideas for stimulating bioethics in our countries may come to crystallize around HECs, despite the fact that it is not easy to guide their organization.

In its guidelines for ethics committees, the American (U.S.) Academy of Pediatrics asserts that a hospital’s management should appoint the HEC’s individual members, who should include a staff physician, a hospital administrator, an ethicist or member of the clergy, a legal representative (lawyer or judge), a representative of the disabled, a member of the community, a member of the medical staff, and a nurse. The hospital should provide the necessary resources for operation of the committee, which should meet regularly or upon request.

The guidelines further state that the committee should be charged with developing standards to deal with both general issues and specific cases, should retrospectively review clinical histories considered morally questionable, and should review specific cases by holding meetings open to all the affected parties, said meetings to be called on 24 hours’ notice at the request of members of the HEC, hospital administration, or patient’s family. The committee should keep a record of all its deliberations and of the specific cases considered, but should also maintain institutional confidentiality, its records being available to outsiders only on court order or at the special request of an accredited organization.

The American Hospital Association’s recommendations for hospital biomedical ethics committees hold that their functions should be oriented toward managing biomedical ethics education programs, providing forums for discussion between physicians and other professionals within or outside the hospital community about topics in biomedical ethics, providing consultative services for people involved in biomedical decision-making, and evaluating institutional experiences through review of decisions with biomedical ethics implications. Such committees should not concern themselves with review of professional conduct; their reviews should not substitute for legal or judicial reviews; and they should not make decisions about biomedical ethics problems. (That is, the committees should in no way supplant
traditional decision-making authorities in such matters.)

These recommendations also indicate that committee members should be chosen with the committee’s foregoing aims in mind and should encompass a broad spectrum of views and experiences. This multidisciplinary membership should be drawn from the ranks of physicians, nurses, administrators, social workers, clerics, trustees, lawyers, ethicists, and patient representatives. A hospital’s legal adviser may take part in the meetings and should review the committee’s recommendations.

For greater efficiency, the committee should have the hospital’s support and should operate as a stable entity meeting regularly and when necessary. As a general rule, no one personally involved in a case the committee is deliberating may participate on the committee while the case is being considered. The recommendations of the committee should be regarded as valid for the entire team intervening in the treatment. The patient’s privacy and the confidentiality of patient information must be respected. The circumstances under which the committee’s recommendations may appear in clinical histories should be determined by each hospital.

Veatch (29) identifies four general types of HEC: those that review ethical or other values in decisions about an individual patient’s care (the kind proposed by Karen Teel); those that deal with ethically more general decisions and policies (distribution of resources, hospital readiness to deal with given problems, etc.); those that consult (their function is to provide advice—especially in cases involving terminal patients); and those dealing with prognoses (as was proposed by Judge Hughes in the Quinlan case).

Spinsanti (30) adds a fifth model, characteristic of institutions with religious sponsorship, wherein the committee takes special account of the need to reconcile activities with religious morals.

John Robertson (31) has suggested four possible HEC models: optional-optional, in which there is no obligation to consult the committee or to follow its recommendations; imperative-imperative, in which consultation and adherence to the committee’s recommendations are mandatory; imperative-optional; and optional-imperative.

In any case, we believe it suitable for an HEC to be able to advance progressively (32) from formative development through retrospective review of cases to establishment of general standards to adoption of an active consultative role. It is hard for us to believe that the organization of an HEC should be a perfectly standardized matter. Each hospital, each group, each individual will have its unique experience within very general lines.

But ethics is a philosophic discipline, not a categorial science. Its knowledge is enshrouded, approximate, and based on denial of the "nonethical." An HEC’s first step is therefore Socratic—identification of ethical sensitivity, concern for good, eagerness for instruction. Initially, therefore, the need is to find similarities; and, to facilitate this process, it is our "recommendation" that a course on hospital ethics committees be organized in which these sensitivities and concerns can be developed. This course should be designed to provide the minimal theoretical and practical elements appropriate for such development.

Beyond this, he who views ethical issues through the eyes of the HEC will be able to see the multiform faces of all his past and present patients, the long corridors of life and death, hope and anguish. He will see the respirators and the beds and the eyes, the scalpel that bleeds over open flesh, the agony of Jane Doe and the resigned gesture that Karen
Quinlan made when, in a wink, there was no more air. He will also see laws, codes, and the masses of people maltreated in the name of health and the glory of scientific research. He will see the centuries pass by, and, in the timeless bottom of a land worked by men of all nations, on the eroded hill of centuries, the yellowed and indestructible stone of the Temple of Aesculapius.

REFERENCES

Medical Specialty and Malpractice

A study of medical malpractice claims in Florida (U.S.A.) suggests that a small proportion of physicians generates a large part of insurance settlements. Among specialties considered to be low-risk (such as internal medicine and pediatrics), in which claims were relatively infrequent, 3% of the doctors accounted for 85% of total malpractice compensation payments and legal costs. Such payments were less concentrated among gynecology/obstetrics, anesthesiology, and surgical specialties, areas in which claims were more frequent. The study showed no relationship between claims against a physician and the type of medical school or country in which he or she studied. However, title of the degree awarded was positively related to a higher number of malpractice suits for some specializations, and previous claims against a physician were a good predictor of future claims.