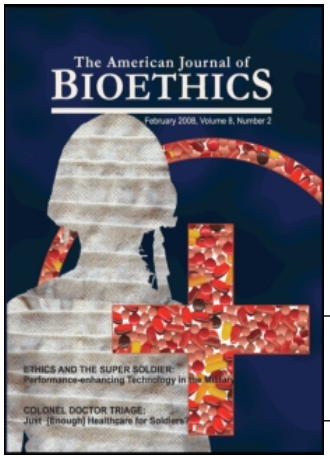

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Multi-Institutional Ethics Committees: For Rural Hospitals, and Urban Ones Too

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urban setting. By bringing urban and rural healthcare professionals together with diverse beliefs and values, we avoid the type of relativism that leaves us believing that universality of moral values cannot be achieved. Granted, there are repercussions for not upholding the values and beliefs of a community, such in the case of the impaired physician, who may leave the community or stop referring patients to the hospital if challenged by someone with moral courage. Nevertheless, the most basic and common value of all healthcare professionals is patient care, and when this value is compromised by politics, community beliefs, and emotions, then we need to take a step back and weigh the risks and benefits, determining whether personal or community beliefs should take precedent over the potential risks of acting on those beliefs. The final step in moral courage training, according to Kidder (2005), involves practice and persistence "where learners can discipline themselves through direct, incremental skill building that increases their ability to apply moral courage" (213–214). Positive change can happen when rural and urban healthcare providers, through practice and persistence, find some common ground where moral courage is embraced rather than feared. ■

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Multi-Institutional Ethics Committees: For Rural Hospitals, and Urban Ones Too

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Cook and Hoas (2008) have identified and illustrated serious shortcomings in rural bioethics and healthcare decision-making. Some of the problems that the authors discuss are unique to the rural context. Others are not. This commentary addresses deficiencies common to one of the most important ethics instruments in both rural and non-rural healthcare facilities: their hospital ethics committees. Specifically, this commentary focuses on the problems of insufficient resources, competence, and independence.

Distressingly, none of these three problems is unique to rural hospitals, although failings may be comparatively more common among rural facilities. Indeed, recognizing just such challenges, the American Hospital Association (Washington, DC) once refused even to endorse ethics committees for rural hospitals (Rettig 1990, 122–123). But it is now widely recognized that most urban and suburban facilities suffer from these same three problems. Indeed, for more than half the time that ethics committees have existed, scholars have constantly and severely criticized their inadequate composition, training, methods, and resources (Hoffman and Tarzian 2008, Wilson 1998).

THE ADVANTAGES OF MULTI-INSTITUTIONAL ETHICS COMMITTEES

While hardy a one-stop, fix-all solution, the multi-institutional ethics committee (MI-HEC) can significantly ameliorate deficiencies regarding resources, competence, and independence. Basically, a MI-HEC is comprised of members from more than one institution. For example, if each of three rural Montana hospitals were individually too small to support its own ethics committee, they could pool their efforts. Each could contribute one-third of the committee's members and pay one-third of CME and other costs. In short, shifting to "inter-institutional activities" can achieve "economies of scale and economy" (Cook and Hoas 1999).

The MI-HEC can help each institution overcome its lack of ethics resources in that each hospital benefits from the

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input and deliberation of a large multidisciplinary body, yet must contribute only a fraction of the membership and a fraction of the cost. With respect to competence, the MI-HEC can harness more disciplinary expertise, include more disciplinary perspectives, and support more formal training than an individual intramural ethics committee (Nelson 2007).

With respect to independence, the MI-HEC will be less beholden to the peculiar social relationships at any one institution. For example, Cook and Hoas (2008) describe several futility cases in which the provider's decision whether to accede to the surrogate's request for continued treatment was materially influenced by the family's money and influence. In contrast, a MI-HEC would presumably be less willing to accede to an 86-year-old terminal cancer patient's request for surgery because he "was influential, well-known, and well respected in the community" (Cook and Hoas 2008, 52). After all, the majority of the members would be from other institutions in other communities. At the same time, since the committee's functions are not entirely outsourced and the referring institution has some representation on the committee, relevant community norms and values can still be considered.

There is a substantial basis to believe that MI-HECs could offer some material benefits to rural healthcare institutions. They have long been endorsed and encouraged for those institutions unable to create effective HECs individually. For example, freestanding dialysis clinics in some regions have collaborated to form MI-HECs (Miller 2002). Similarly, Maryland state law specifically anticipates that a nursing home ethics committee may function: "(1) solely at that related institution; (2) jointly with a hospital advisory committee; or (3) jointly with an advisory committee representing no more than 30 other related institutions" (Maryland Health-General Code 1990, 19–371). And further examples of and models for MI-HECs are described in the academic and professional literature.

Importantly, the MI-HEC can improve not only the quality of rural ethics but also the perception of that quality by both providers and the public. If rural healthcare providers were confident that the MI-HEC could handle an issue and effect positive change, they would be more likely to use the committee. More positive experiences will lead to more usage and more usage will lead to more positive experiences. United, MI-HECs create consistency among institutions, increasing public understanding and trust in committee functions.

THE RISE AND PROMISE OF TELEETHICS

While the concept of a MI-HEC has been around for 20 years, there is an utter dearth of either implementation or scholarly analysis. Space does not permit a complete explanation for this neglect. But I want to address perhaps the most common objection to the MI-HEC: that because rural facilities are separated by great distance, a cooperative venture such as an MI-HEC would be impractical. It would, the objection states, be very difficult for the members from the different constituent institutions to get together for ethics education, policy development, or case consultation (Niemira et al. 1989).

This may have been true just a decade ago. But it is not true today. Technology already available or soon available in rural healthcare institutions can effectively facilitate the necessary communication. Telemedicine is proving its feasibility and usefulness in the clinical context, for example, allowing a rural family physician to instantly consult with an urban specialist through live interactive videoconferencing (US Office of Technology Policy 2004).

Just as telemedicine is addressing the lack of rural physicians, "teleethics" can address deficiencies in rural bioethics. For example, nearly 15 years ago, the University of Missouri (Columbia, MO) developed the Missouri Telehealth Network to enhance access to care to more than 40 underserved Missouri counties. More recently, over the past 3.5 years, the University of Missouri Center for Health Care Ethics has incorporated this very same telemedicine technology for use by ethics consultants to provide services to ethics committees and providers at rural health facilities where such ethics consultation services are not available. At the 2007 American Society for Bioethics and Humanities (Glenview, IL) annual meeting, David Fleming and Donald Reynolds reported that the accessibility and feasibility of providing teleethics services have proven to be very effective.

CONCLUSION

Unfortunately, material advances in bioethics are often made only in response to crises. Since rural healthcare facilities may most acutely feel the need to fix problems with their ethics mechanisms, they may serve a sort of sentinel or bellwether function. They may serve as the spark to the Joint Commission (Oakbrook Terrace, IL), state regulators, or others to give definition to the composition and operation of HECs. And they may serve as the laboratory in which to test solutions that may later be adapted more broadly.

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