CLINICAL ETHICS

Hospital ethics committees in Israel: structure, function and heterogeneity in the setting of statutory ethics committees

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Objectives: Hospital ethics committees increasingly affect medical care worldwide, yet there has been little evaluation of these bodies. Israel has the distinction of having ethics committees legally required by a Patients' Rights Act. We studied the development of ethics committees in this legal environment.
Design: Cross-sectional national survey of general hospitals to identify all ethics committees and interview of ethics committee chairpersons.
Setting: Israel five years after the passage of the Patients' Rights Act.
Main measurements: Patients' rights and informal ethics committee structure and function.
Results: One-third of general hospitals have an ethics committee, with committees concentrated in larger facilities. Hospitals without committees tended to lack any structure to handle ethics issues. Committees tend to be interdisciplinary and gender-mixed but ethnic mix was poor. Confidentiality is the rule, however, legal liability is a concern. One-third of patients' rights ethics committees never convened and most committees had considered fewer than ten consults. Access to the consultation process and the consultation process itself varied substantially across committees. Some patients' rights ethics committees attempted to solve cases, others only rendered decisions. Informal committees often refused to consider cases within Patients' Rights Act jurisdiction.
Conclusions: Despite statutory requirement, many Israeli patients and clinicians do not have access to ethics committees. The scant volume of cases shows serious discrepancies between practice and Patients' Rights Act regulations, suggesting the need for education or revision of the law. Heterogeneity in committee function demonstrates need for substantial improvement.

Ethics committees in hospitals are a relatively new phenomenon. Such bodies have been in existence for less than 40 years worldwide and their precise roles and methods of functioning continue to evolve. Ethics committees are particularly new to Israeli hospitals.[1] Until recently few hospitals in Israel had functioning ethics committees, and the role of such committees has not been well defined.[2] Such nascent development of hospital ethics committees in Israel is ironic because Israel may be the only country that has a statutorily prescribed role for ethics committees.[3] According to the Patient's Rights Act passed by the Israeli Knesset in May 1996, ethics committees have four legal functions:

1. To allow provision of treatment against a patient's will: "Should the patient be deemed to be in grave danger but reject medical treatment, which in the circumstances must be given soon, the clinician may perform the treatment against the patient's will, if an ethics committee has confirmed that all the following conditions obtain: (a) the patient has received information as required to make an informed choice; (b) the treatment is anticipated to significantly improve the patient's medical condition, and (c) there is a reasonable grounds to suppose that, after receiving treatment, the patient will give his retroactive consent."

2. To allow withholding of information important for informed consent from a patient: ". . .the clinician may withhold medical information from the patient concerning his medical condition if an ethics committee has confirmed that giving this information is likely to cause serious harm to the patient's mental or physical health". Similarly, ethics committee consultation is required to withhold medical records from a patient.

3. To allow disclosure of medical information against a patient's wishes to protect public health or the health of a third party.

4. To review documentation in a case handled by the control and quality committee.

The Patients' Rights Act prescribes the form of the ethics committee as follows: "The Director-General (of the Ministry of Health) shall appoint ethics committees: each such committee shall comprise five members as follows: (1) a person qualified to be appointed District Court Judge . . . [as] Chairman of the Committee; (2) two specialist physicians, from different specializations; (3) a psychologist or social worker, and (4) a representative of the public or person of religious authority".

Thus, in terms much clearer than those setting out the requirements of the charge for any other nation's ethics committees, the Israeli statutory ethics committee is a multidisciplinary committee that has decision making authority. Many other aspects of the committee's structure and function are not prescribed, however, including organisational placement of the committee and the form of deliberations. Furthermore, five years after the initiation of the Patients' Rights Act, no evaluation of the functioning of these ethics committees has been performed. We undertook to describe the current form and function of hospital ethics committees in Israel and the cases that they hear.

METHODS

We performed two cross-sectional surveys: first we surveyed all acute care general hospitals in Israel to identify all ethics committees. Then we interviewed the chairperson of each ethics committee.

Table 1 hospital ethics committees in Israel by hospital size

Number of hospital beds	No ethics committee	Informal ethics committee	Patients' rights ethics committee	Both informal and patients' rights ethics committees
<100	13	0	0	0
101–200	7	1	0	0
201–300	3	0	0	0
301–400	1	0	2 (1 Never met)	0
401–500	2	0	0	2 (1 PR never met)
>500	2	1	6 (1 Never met)	2 (1 PR never met)
Total	28	2	8	4

Includes all acute care hospitals as of January 2001. Paediatric, women's and geriatric hospitals are excluded. The three regional patients' rights ethics committees are not included in the table.

We contacted by telephone in January and February 2001 the hospital director's office of each acute care general hospital in Israel in order to identify whether the hospital had an ethics committee. Paediatric, maternity, geriatric, and mental hospitals were not included. Specifically we asked about ethics committees under the Patients' Rights Act (patients' rights ethics committees (PRECs)) or "informal" ethics committees of any other sort (IECs). Respondents indicating that the hospital had no ethics committee were asked how the hospital dealt with ethical issues that arose in the care of patients. Responses to the item varied, including having a respected physician act as ethics consultant, having a rabbi or social worker fill this role, desiring to start an ethics committee, or not having ethical problems that needed attention. To check whether all PRECs had been identified, an investigator met with a representative of the Ministry of Health to review all appointed committees. The ministry identified three additional regional committees that are responsible for the ethics of community care.

We developed survey instruments to collect information from committee chairpersons on the following topics: (1) structure of the ethics committee, including committee duration, composition, formulation, preparation, staff, funding, reporting, organisational alignment, and whether the committee had a public representative; (2) function of the ethics committee, including meeting schedule and activities, and (3) consultation process and experience, including method of consultation, who may consult the committee, whether patients are notified about consultation, and the volume of consultation throughout the life of the committee and during the past 12 months.

If the committee performed prospective consultation, the chairperson was asked to present, in generic terms, the three most recent consultations. Chairpersons presented the elements of the case, the presenter's views, processes undertaken, whether the committee tried to solve the case (by carrying out processes to reach a resolution of the ethical problem), or simply rendered a decision, and follow up. Patients' rights ethics committee chairpersons were asked to categorise the statutory basis on which each case was handled and whether they had been presented with cases that did not fall within their statutory realm. Chairpersons of IECs were asked whether they had been presented cases that fell within the PREC jurisdiction and how they handled such cases.

In-person face to face interviews with chairpersons were performed in English between March and May 2001; all interviewees spoke fluent English. Three chairpersons each chaired two PRECs. For one PREC the chairperson position was in flux; the hospital director and a physician on the committee were interviewed. One IEC chairperson refused to be interviewed. Data on this committee are missing from this report. A second IEC, consisting of six physicians, has no chairperson; the responsible hospital administrator was interviewed. Interviews concerning committees that had never met were performed over the telephone. On average, 90 minutes was dedicated to each committee interview.

RESULTS

Of the 42 acute care hospitals in Israel, 14 (33%) have at least one ethics committee. Four hospitals have both a PREC and IEC, eight hospitals have only a PREC and two have only IECs. However, four of the 12 PRECs have never met. Having an ethics committee is related to hospital size. Only one (4%) of the 23 hospitals with 300 or fewer beds had an ethics committee. This unique committee is a religious body with rabbinical decision making authority. Among hospitals with 301–500 beds, four of seven (57%) have at least one ethics committee. Nine of the 11 hospitals (82%) with more than 500 beds have at least one ethics committee (table 1).

Among the eight hospitals with 200 or more beds that have no ethics committee, two indicated that they have been unable to locate a qualified chairperson for a PREC, one hospital claimed liability concerns, and the other five had no plans to develop an ethics committee. In two of the eight hospitals, individuals in hospital administration perform a form of ethics consultation.

In addition to the hospital-based committees, three regional PRECs have been assembled. One has never met. Thus, nationwide 15 PRECs exist, of which five (33%) have never convened. Hospital directors, a hospital lawyer, and chairpersons explained that two of these committees had never met because of concerns about potential liability for committee decisions, one committee had never received a case referral that fitted the legal mandate, and for the other two committees the hospitals had no structure for consultation. Six IECs exist. The remainder of this report presents data on the 10 PRECs and four IECs. For the religious ethics committee and one additional IEC no data were collected.

ETHICS COMMITTEE STRUCTURE AND FUNCTION

All PRECs were formed in 1997 or later; the IECs convened earlier. Patients' rights ethics committees and IECs had a majority of male members, but 45% and 35% were women, respectively. Three PREC members were non-Jewish (two Arab physicians and one sheik) and one IEC member was non-Jewish (an Arab physician), yielding a 4% non-Jewish membership overall. While the structure of PRECs is prescribed by law to be five individuals (with additional alternates), IECs tended to be larger, with one committee containing 16 members. Three of four IECs had a community member. All PRECs had staff support from the hospital, usually in the form of an administrator whose job it was to field consultation requests and to convene the committee. Half of IECs had such support. No ethics committee had a budget and no member received financial compensation for participation (table 2).

All but one of the ethics committees conducted meetings in a confidential fashion. There was much disagreement concerning whether ethics committee members were protected from liability for committee decisions. Four of 10 PREC chairpersons thought committee members were covered,

Table 2 Structure and function of patients' rights ethics committees and informal ethics committees

	Patients' rights ethics committees	Informal ethics committees
N	10	4
Year started	8 in 1997, 1998, 1999	1987, 1995, 1995, 1996
Structure		
Number of members	5 set by law (with 5–6 alternates)	16, 9, 6, 6
% Female	45%	35%
% Non-Jewish	5%	3%
Public representative	Required by law	75%
Staff support	100%	50%
Budget support	0%	0%
Confidential proceedings	100%	75%
Signed assurance	0%	0%
Protected from legal liability	40%	75%
Function		
Member education	80%	75%
Studied Patients' Rights Act	80%	75%
Regularly scheduled meetings	0%	50%
Activities		
Prospective consultation	Required by law	100%
Retrospective consultation	20%	75%
Develop policy	0%	50%
Educate hospital staff	0%	75%
Educate community	0%	25%
Consultation		
Requestor may be:		
Any provider or patient	60%	75%
Only physician	0%	25%
Don't know	40%	0%
Patient informed of consult	80% yes; 20% sometimes	50% yes; 25% no; 25% DK
Report of consult produced	100%	50%
Placed in patient's chart	50% yes; 20% no; 30% DK	25% yes; 75% no
Compulsory or Advisory	100% Compulsory by law	100% advisory
Handles PREC content cases	N/A	25% yes; 50% no; 25% DK
Number of consultations		
Total	0, 2, 2, 2, 3, 3, 4, 7, 15, 21	10, 15, 25, 60
Past 12 months	0, 0, 0, 0, 1, 1, 2, 2, 4, 10	2, 3, 5, 10

DK=Don't know, PREC=Patients' Rights ethics committee.

although several respondents stated that there might be a liability concern if committees handled cases outside their jurisdiction. One chairperson attributed the lack of consultations to the hospital administration's liability concern. Two chairpersons emphatically denied any liability concerns.

Most ethics committees conducted self education at the initiation of the committee and had reviewed the Patients' Rights Act. No committee had an educational programme for members joining after committee inception.

Patients' rights ethics committees met only for consultation. In addition to prospective consultation, two of the PRECs also considered cases retrospectively. Two of the IECs conducted regularly scheduled meetings and one other had had such meetings in the past. While all IECs performed prospective consultation, three performed retrospective consultation and educated hospital staff, two developed policy, and one undertook community education.

ETHICS COMMITTEE CONSULTATION

The IECs, which had existed longer, had convened for more prospective consultations, ranging from a low of 10 to the ethics committee with the most experience in Israel having considered 60 cases. One of the PRECs, despite meeting for an educational session and receiving a case request, had never performed a consult. Six of the PRECs had conducted two to four consults over about five years with the most prolific patients' rights committees completing seven, 15, and 21 consultations (see table 2).

Sixty per cent of PRECs and 75% of IECs considered cases from any health care worker or patient at the institution. One IEC would accept only cases requested by physicians. Four of 10 PREC chairpersons were unaware of whether patients and families could bring cases. Eighty per cent of PRECs and half of IECs stated that patients were always informed of cases affecting them (except cases to do with withholding information from the patient). Two PREC chairs stated that cases from outside their institution fell beyond their committee's jurisdiction, several chairpersons were uncertain, and one committee had fielded a case directed from a hospital that did not have a PREC. Because of the impracticality of convening the committee at the distant location or moving the ill patient, this case was redirected to court. While PRECs, according to the law, make binding decisions, all IEC decisions were advisory. Two IECs will not handle cases within PREC jurisdiction (although one had no functioning institutional PREC), one will handle such case, and one chairperson was unsure.

Each chairperson was asked to describe three cases for which the committee had convened. For four committees, the interviewee could not describe three cases and for two committees more than three cases were reported. Among PRECs, the most common topic was treatment against a patient's will. Three cases involved a limb amputation, two haemodialysis, and four other surgeries (tracheostomy, removal of purposely swallowed material, subdural evacuation, and bowel obstruction). In each case, the physicians bringing the case desired to perform the procedure. For PRECs the second most common topic was disclosure of information without patient's consent. Of seven reported cases, six concerned HIV infection. Two cases concerned withholding of

Table 3 Topics of cases presented to ethics committees

Topic of case	Patients' rights ethics committees (N=21)	Informal ethics committees (N=13)
Withholding information from patient	0	0
Withholding medical record from patient	2	0
Disclosing information without patient consent	7	0
Treating against patient's will	10	4
Quality control committee appeal	0	–
End of life treatment plan	1	3
Handling genetic information	1	0
Triage and custody issues	0	2
Intra-provider conflict	0	2
Treatment standards issues	0	2
Case involved non-Jewish patient	1	2

Table contains information obtained on 21 of 56 consults conducted by 10 Patients' Rights ethics committees and 13 of 110 consults conducted by 4 Informal ethics committees.

Table 4 Processes of ethics consultation and case resolutions

	Patients' rights ethics committees (N=18)	Informal ethics committees (N=10)
Ethics consultation processes		
Met with provider bringing case	18/18 (100%)	10/10 (100%)
Met with patient	14/14 (100%)	3/4 (75%)
Met with family	6/8 (75%)	4/6 (67%)
Suggested medical consult	1 (6%)	0
Suggested clergy	2 (11%)	0
Suggested psychiatric consult	1 (6%)	2 (20%)
Tried to resolve case	12/17 (71%)	2/9 (22%)
Case resolution		
Compulsory or advisory decision	15 compulsory, 3 advisory	9 advisory, 1 no decision
Decision agreed with perspective of provider presenting case	12/15 (80%), 3 presenter perspectives unknown	8/8 (100%), 2 presenter perspectives unknown

Table contains descriptions for the 18 patients' rights ethics committee consults and 10 informal ethics committee consults for which full case data were available.

medical records. No cases of withholding information from a patient or quality control committee issues were described. Patients' rights ethics committees convened for two advisory consultations in cases that were not on topics specified by law (table 3).

Informal ethics committees convened most often for cases of treating a patient against his or her will: an amputation, two haemodialysis cases, an abdominal surgery, and three cases to develop an end-of-life treatment plan. Two of these cases fell within the jurisdiction of a PREC; one at a hospital with a non-functional PREC. In six of these seven cases, the physician bringing the case did not desire to perform the procedure but felt the need for approval not to provide life-sustaining care. Consultations also were performed for triage, and child custody issues, conflicts between providers, and disagreements about standards of care (see table 3).

Overall, three (9%) of the 34 ethics committee cases presented involved non-Jewish patients. An additional two cases that were presented to PREC chairpersons, but not considered by full committees, involved Muslim patients, with religious themes playing a prominent role.

The process of ethics committee consultation was similar for PRECs and IECs. The provider who brought the case met directly with the committee and in most cases the committee met with available patients or family. In a minority of cases, medical, clergy, or psychiatric consultation was recommended. Patients' rights ethics committees tried to resolve 71% of cases without needing to render a decision. Five PRECs always tried to resolve cases prior to a decision and four PRECs never did so. Informal ethics committees tried to resolve 22% of cases they considered. When the position of the case presenter was known, PRECs rendered an opinion contrary to this view in 20% of cases. In all cases, the IEC agreed with the case presenter's perspective (table 4).

CHAIRPERSONS' SUGGESTIONS TO IMPROVE ETHICS COMMITTEES

Chairpersons of PRECs described many factors hampering committee function. Meetings were difficult to convene at short notice, which resulted in several cases being referred to court. Several chairpersons suggested expanding PREC membership, others recommended inclusion of only on-site personnel. Four chairpersons were concerned with a lack of rules to direct the committee function, but one chairperson pointed out specific patients' rights regulations concerning committee application, timing and documentation[4] of which many chairpersons apparently were unaware. Also of concern was a lack of specification about the ethical basis on which cases were to be solved and legal liability issues. Patients' rights ethics committee and IEC chairpersons were concerned that few of the cases that should be tackled were referred to the committees, suggesting that many ethical conundrums received inadequate attention.

DISCUSSION

This first comprehensive analysis of ethics committees in Israel shows that while the number of committees is small and, in most cases, activity levels are low, ethics committee work is accelerating. Most committees began functioning in the past five years, spurred by the passage of the Patient's Rights Act; more than one-third of all PREC cases were considered in the past year. While evaluating the quality of

ethics consultation is beyond the scope of this analysis, the findings suggest that several committees have availability and consultation processes in place to provide effective ethics consultation. Overall, however, ethics committee access is poor and many aspects of ethics committee consultation are inadequate.

Patients admitted to two-thirds of the hospitals in Israel and their clinicians have no access to ethics committee advice. While hospitals without ethics committees tend to be smaller and care for less ill patients, no system links these facilities to available committees, nor is it clear that a referral system is a good way to handle ethical issues. Ethics committees derive much of their meaning from local control and the process of ethics consultation requires proximity.[5] Most small hospitals without committees reported not having any structured method of providing ethics consultation. This void almost ensures that ethics issues will not receive adequate attention. Furthermore, without forces promoting medical ethics within the institution, clinicians are unlikely to grow in this area. Studies show that ethics consultation is valued by clinicians,[6 7] often—but not always—found helpful by patients and families,[7 8] and may be beneficial in terms of stewarding resource use.[9 10] A study of American physicians found that half requested an ethics consultation in a 2 year period.[11] Ethics committees can also provide useful advice to institutions.[12] It is likely that ethical issues deserving of attention are inadequately addressed in these Israeli hospitals without ethics committees.

Of greater concern may be the obstacles to ethics committee formation perceived by one-third of the 15 larger medical centres in Israel. These facilities with more than 400 hospital beds perform complex procedures and care for critically ill patients who must, at times, generate ethical problems. While the level of need for ethics consultation remains to be empirically studied, we found that legal and administrative issues impeded formulation or activation of PRECs at these facilities, thus interfering with the handling of ethics issues. Furthermore, establishment of an IEC in these institutions that would handle cases enumerated in the Patients' Rights Act would be a violation of that act. This situation demands revision of the Patients' Rights Act.

These data and direct statements of PREC chairpersons identify several problems that derive from the legislative origins of PRECs. The lack of specificity regarding procedures such as whether cases may emanate outside the institution, and whether patients need be informed that their case is to be considered produces significant heterogeneity among PRECs. Other issues troublesome to some PREC chairpersons appear to be covered in a set of regulations about which better education is needed. More problematic is the variation among PRECs concerning the goals of ethics consultation. Contrary to classic ethics consultation,[13] the consultations of four of nine active PRECs aim "to render a judgment" rather than to "solve the case".[14] As might be expected of groups chaired by judges, these committees function as courts rather than carrying out the "work of ethics"[15] in which investigation, communication, mediation, and serial discussions aim to develop a plan of care that is best for the patient. Confusion about liability, a serious impediment for some PRECs, is not addressed in the act. Finally, no resources were dedicated to support the function of these committees. Many of these issues might be traced back to lack of oversight provided by the Israeli Ministry of Health. A first step might be to bring together the chairpersons of the PRECs and the IECs to begin a dialogue, to learn the procedures, and to build on common experiences to improve the function of these committees.

The data collected also point out the incompatibility of the requirements of the Patients' Rights Act with the realities of clinical practice. Although we examined less than half of all cases considered by the PRECs, it is likely that PRECs have heard few—if any—cases of withholding information from patients since the law was passed. Indubitably, withholding information from patients occurs commonly in Israeli hospitals. A more practical definition of what sort of omission should require an ethics consult is critically needed. The findings also reveal the need for education at the institutional and clinician level concerning the Patient's Rights Act as a whole, and specifically about reasons for required ethics committee consultation.[16] The incidence of these issues must be much higher than the number of consults received by the PRECs. A significant obstacle to case referral may be the binding nature of the committees' decisions. A process that arrives at decisions which must be followed, extremely atypical in ethics consultation, may frighten away clinicians (or patients) who might desire the consultation process or just advice or reassurance.[17]

Committee ethnic composition also deserves comment. Only one committee included non-Jewish clergy. In a country that is 20% Arab, cultural sensitivity in ethics consultation requires that more than 4% of ethics committee members be non-Jewish. Furthermore, at least three of the reported consultations involved non-white Jewish patients. Attention should be focused on committee composition and cultural competence in consultation.

This small study has several limitations. The number of committees described is small and data from one committee were unobtainable. However, the chairpersons interviewed dedicated substantial time and effort to ensure the thoroughness of this process, at times spending a half-day with the interviewer, and combing through years of consultation reports, requests and correspondence. The number of consultations reported is small, and because several could not be retrieved, the sample is not representative of all consultations performed by ethics committees in Israel. Lastly, these data report a snapshot of the state of ethics committees in Israel. The number, composition, and even structure and function will change over time. Perhaps the findings of this report will stimulate swift improvement so that patients and clinicians in Israeli hospitals will have access to skilled, ready ethics consultation in the near future.

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