feelingly by being inappropriately reluctant to withhold or withdraw care. Recognition of these parental feelings may create a perceived need among health professionals to state overly pessimistic prognoses in order to help parents "overcome" these protective feelings that unduly influence decision making. These parents may be more likely to show the symptoms of previous overly pessimistic prognoses of mistrust, skepticism, and seemingly impaired decision making.

RECOMMENDATIONS

Overly pessimistic prognoses are an under-recognized form of deception. Using intentionally overly pessimistic prognoses as a tactic to protect patients and other decision makers should require the same high thresholds as those required for invoking therapeutic privilege. Therapeutic privilege holds that health professionals can withhold information only when they believe such information would be significantly injurious to the patient. Therapeutic privilege is not to be used simply to shield people from unpleasant or undesirable news. In other words, the belief that parents will be better able to handle the emotional distress of losing a child if they are falsely prepared for the occurrence, or that parents will be harmed by explaining the intricacies of a situation including the slim but true thread of hope, is not a sufficient reason to use overly pessimistic prognoses. Health professionals need to recognize when they unintentionally slide toward the "benign" practice of hanging crèpe in the mistaken belief that they are providing necessary support for parents. Explaining the full truth, with all its inadequacies, is more likely to be appreciated and less likely to cause problems in the long run.

Bring-along crèpe deserves specific consideration. A more appropriate way to address decision makers' state of denial would be to maintain an open and continuing dialogue that permits discussion and reinforcement of the appropriate prognosis. Although it is understandable that health professionals would want to limit inappropriate treatment for their patients, this legitimate desire does not supersede the obligation to be truthful.

Ethics consultants should be aware of the effects of overly pessimistic prognoses when faced with seemingly uncooperative or overly aggressive parents. Treating the effect of overly pessimistic prognoses requires regaining trust through acknowledging the existence, positing explanations for past abuses, and addressing the facts of the current situation. Changing views of end-of-life care and changing decision-making practices have diminished the utility of overly pessimistic prognoses, and have led to situations in which this practice is harmful. There are certainly other reasons for parents to persist with care that many might consider inappropriate, and other reasons for parents not to bond with their newborns. But overly pessimistic prognoses need to be recognized as a possible cause for these problems, a cause that can be minimized by proper awareness, attention to precise communication, and a greater trust in families' abilities to deal with heart-rending or ambiguous information.

NOTES


THE CASES

CASE 1: PRACTICING PROCEDURES ON THE NEWLY DECEASED

Staff nurses from a particular unit of this pediatric teaching hospital inform their nurse manager that newly deceased patients are being used to teach resuscitation procedures without the knowledge of the parents. This attempt at teaching is apparently occurring on an ad hoc basis; it is not part of an endorsed training sequence in any part of the hospital. Several senior staff physicians in the unit believe that newly deceased patients provide a valuable training opportunity with potential benefit to future patients and at no harm to the deceased. The nurse manager requests a formal review of this practice from the ethics committee.

CASE 2: INFORMED CONSENT FOR AUTOPSY

An on-call resident physician is delegated to obtain consent for autopsy from a parent following the death of his child. The parent grants permission without any written

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ETHICS COMMITTEES AND POLICY DEVELOPMENT

Policy review and development is a basic function of hospital ethics committees across the United States. However, the actual process of policy development by ethics committees, and the management of problems that are encountered along the way, have not been described. Compared to other committee functions, such as case consultation or education, policy review or development is typically a slow process with less immediate gratification. It is also a committee activity with the potential to generate significant enmity, as entrenched interests within the institution will potentially affect the entire institution. In the "ways things are done around here," yet, with appropriate study of the issues and feedback from interested parties, ethics committees can be uniquely suited to identify problems and develop policies that allow the institution to respond effectively to difficult issues before they arise. This article describes the anatomy of policy development by an ethics committee at a pediatric teaching hospital.

FANTASIES IN THE POLICY REVIEW PROCESS

Several difficulties encountered in these policy reviews serve as a warning for others who will undertake similar endeavors. A lack of authority from the appropriate governing body is preferred before the ethics committee undertakes a policy review that will potentially affect the entire institution. In the autopsy case, the ethics committee encountered early and persistent resistance to a policy review from one particular department, which challenged the legitimacy of an ethics committee conducting an institutional review that had not been administratively authorized. In retrospect, the absence of authorization for the autopsy policy review required the committee to expend significant capital in credibility in order to conduct and complete the review process. This could have been avoided if the committee had obtained the necessary authorization from the beginning.

For similar reasons, competing jurisdictions with other hospital committees must also be clarified early in the process. Although members of the ethics committee typically have a greater interest in the area of bioethics than their colleagues, the larger hospital community may not view a particular issue as exclusively (or even marginally) the concern of the ethics committee. Other standing committees or departments may view the issue as more appropriately under their jurisdiction. Early assessment of policy review requests by a senior member of the ethics committee who is knowledgeable within the institution will be necessary. The "hierarchy and culture can sort out issues of competing jurisdiction before they arise. This investment of "tragic time" will help ensure that the ethics committee is expending its energy and good will in an efficient manner. As ethical and legal dimensions often coexist in case consultations as well as policy reviews, our ethics committee has an established line of communication with hospital counsel. In the autopsy case, this potential conflict was avoided by an agreement with hospital counsel beforehand that the ethics committee would intervene only in the event of a request for consent. In this case, the ethics committee was not involved with the autopsy case, but would avoid any review or comment on the particular case cited above.

The ethics committee should seek early and wide consultation. Ample notification of all interested parties within the hospital of the committee's intention to review a policy is essential if the committee wishes to gain confidence in the policy review process. In the case involving the use of newly deceased patients for teaching procedures, the interested parties were easy to identify and invite into the review process because the conflict stemmed from practice in one particular unit within the hospital. In the review of autopsy policies, an unintended delay in notifying several senior physicians with particular interest in autopsy, compounded by those who were not disposed to appear or did not deign to appear out of deference or respect for the relatively junior member of the committee, generated a perception of secrecy. The ethics committee never fully overcame the significant mistrust that emanated from this relatively small administrative blunder. In addition, the committee had to hold more frequent and lengthy meetings (than would otherwise have been necessary in an atmosphere less pervasive with suspicion) in an attempt to reassure all sides of fairness.

The ethics committee's attention to word choice throughout the review process is an important determinant of the institution's perception of the committee's role and value. Like religion and politics, ethics engenders emotions and beliefs that are not lightly tampered with. Language can be unintentionally inflammatory to various interests in the larger hospital community. Repeating the damage done by poorly chosen words can be difficult, because once the perception of fairness is lost, it is difficult to retrieve. In the autopsy case, for example, positions hardened when an impassioned ethics committee member stated that another (noncommittee member) clinician's position was "unethical." For all ethics case consultation and policy review, tact and diplomacy are more important matters as much or more than thoughtful and prescient ethical analysis. The committee needs to anticipate how far its final recommendations will go in soliciting institutional leadership and change. Is the committee's investment of time and energy ultimately directed at writing a recommendation or mandating change? Will the final product be a vague effort to push the institution in a certain direction without directly confronting or offending powerful hospital interests? If so, the final guideline will reflect the committee's belief that there is discretionality latitude in what can be done through the choice of words as "may" or "should." Or is the committee prepared to write an unambiguous policy that firmly states a position regardless of the potential for resistence? Because a policy leaves less room for discretion (by use of such words as "must" and "shall," the ethics committee must engage in persuasive justification and lobbying to ensure that the policy is implemented and enforced. It may not always be possible for the committee to anticipate its final position, but clarification of the range of possibilities at the start may help to avert unrealistic expectations. In the case involving the use of newly deceased patients for practice procedures, the ethics committee's final recommendation required informed consent for practicing on newly deceased patients; committee members seemed satisfied that their efforts led to a policy with substance. In the autopsy case, however, the need to seek informed consent was accompanied by the requisite notification that the hospital led to a document that allowed for discretionary latitude in several areas. After nearly a year of work on this case, many committee members were disappointed with the ambiguity in the final recommendations. For ethics committees, deciding whether to settle for what can actually be achieved, or to recommend policies that leave little room for discretion will reflect fundamental internal goals and philosophy. Regardless of how a particular committee views compromise on ethical beliefs, frequent discussions about the goal of the committee's work may be an important step in gauging group morale and motivation.

GATHERING DATA

There is an often repeated saying that "good ethics begins with good facts." In both of the policy reviews discussed above the committee followed a similar

sequence. First, a small working group of three or four committee members performed an extensive literature review on the subject, and this step was followed by a cross-sectional, national survey to determine the scope of the practice and existing consent forms or policies. This data-gathering stage was followed by meetings with the institution's leadership as well as with other interested parties within the institution. The process culminated with the ethics committee's submission of a written policy recommendation to the committee's governing body (the medical staff executive committee).

Can gathering data and ascertaining the facts of a particular practice help inform or justify moral beliefs? Just because something is a certain way, ought it be? Or, in the context of these policy reviews, can determining the frequency of using newly deceased patients in teaching or practice actually affect the institution's policy of existing policies on autopsy help determine the ethical justifications for or against a particular practice? Nearly 220 years ago, the philosopher David Hume first questioned the relationship of it to ought, or facts to values; much of the philosophical inquiry of the 20th century is the history of the theories developed as responses to the fact-value problem. Aside from these philosophical concerns, there are several practical reasons for the ethics committee to gather its own data on an issue under review.

 Gathering data allows all committee members to feel more confident about their deliberations. Not all members of the ethics committee have a clinical background, and everyone will not be equally knowledgeable about the issue of concern. This uncertainty will feel more secure about voicing their opinion as a result of this self-education process and will not have to defer continually to clinician members for explanation and interpretation of information. Further, deliberations will progress more thoroughly and logically for all members, clinician and nonclinician alike, when they appreciate the strengths and subtleties of competing positions.

Seeking data from outside the institution can be especially helpful in subsequent deliberations on the merits of these results and with other interested parties in the institution. Often another institution has confronted the issue at hand and may well have a policy that can be adapted in some fashion. Moreover, by making an effort to collect and assemble data from various sources—as opposed to relying on others within the institution who may be unaware of, or uninterested in, compelling but contrary data—the ethics committee can more confidently challenge entrenched hospital interests.
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ETHICS COMMITTEES AND POLICY DEVELOPMENT

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PITFALLS IN THE POLICY REVIEW PROCESS

Several difficulties encountered in these policy reviews serve as a warning for others who will undertake similar endeavors. One is the lack of authority from the appropriate governing body preferred before the ethics committee undertakes a policy review that will potentially affect the entire institution. In the autopsy case, the ethics committee encountered early and persistent resistance to a policy review from one particular department, which challenged the legitimacy of an ethics committee conducting an institutional review that had not been administratively authorized. In retrospect, the absence of authorization for the autopsy policy review required the committee to expend significant capital in credibility in order to conduct and complete the review process. This could have been avoided if the committee had obtained the necessary authorization from the beginning.

For similar reasons, competing jurisdictions with other hospital committees must also be clarified early in the process. Although members of the ethics committee typically have a greater interest in the area of bioethics than their colleagues, the larger hospital community may not view a particular issue as exclusively (or even marginally) the concern of the ethics committee. Other standing committees or departments may view the issue as more appropriate in their jurisdiction. Early assessment of policy review requests by a senior member of the ethics committee who is knowledgeable and well respected within the institution or professional hierarchy and culture can sort out issues of competing jurisdiction before they arise. This investment of "crage time" will help ensure that the ethics committee is expending its energy and good will in an efficient manner. As ethical and legal dimensions often coexist in case consultations as well as policy reviews, our ethics committee has an established line of communication with hospital counsel. In the autopsy case, this potential conflict was avoided by an agreement with hospital counsel beforehand that the ethics committee would not participate in the process of a patient's decision to refuse an autopsy but that the committee would not comment on an issue of particular case cited above.

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Gathering data allows all committee members to feel more confident about their deliberations. Not all members of the ethics committee have a clinical background, and everyone will not be equally knowledgeable about the issues at hand. As the data become known, it will help members feel more secure about their opinion as a result of the self-education process and will not have to defer continually to clinician members for explanation and interpretation of information. Further, deliberations will progress more thoroughly and logically for all members, clinician and nonclinician alike, when they appreciate the strengths and subtleties of competing positions.

Seeking data from outside the institution can be especially helpful in subsequent deliberations on the merits of the issues vis-à-vis other interested parties in the institution. Often another institution has confronted the issue at hand and may well have a policy that can be adapted in some fashion. Moreover, by making an effort to collect and assemble data from various sources—such as reported in ethics committees can more confidently challenge entrenched hospital interests.
In the case involving practice procedures, the ethics committee independently and exhaustively reviewed the medical literature on this topic and, thus, was able to address the concerns expressed by our present physician consultants, the newly deceased patients to teach procedures. In the autopsy case, data from a cross-sectional, national survey that demonstrated substantial deficiencies in the care of residents' knowledge of autopsy procedures helped convince many initially reluctant resident physicians that a rigorous review of the consent process was not an overreaction to "another bad case."

Broad representation in the policy review process is also essential for success. No matter how large and diverse the ethics committee, wide consultation beyond the confines of the committee to all interested parties is crucial to the success of a policy review. In both case reviews presented here, noncommitte members provided additional information and raised practical concerns that strengthened the quality of the deliberations. In addition, the review process will be viewed more credibly if it starts with a large group and is not seen as the work of a select few deliberating behind closed doors.

ASSESSING VALUES

Over the course of both consultations, ethics committee members struggled for hours in scheduled meetings and impromptu discussions with the concept of the patient-physician interaction. Although the physician-patient relationship was a pervasive theme in nearly all deliberations, it was never set as an independent variable to be calculated and agreed upon. Rather, it was always in the background, and each committee member seemed to be constantly re-examining various models of the ideal patient-physician interaction as the strengths and weaknesses of one proposal were weighed against those of another. One classification scheme frequently cited in the literature is that proposed by Emanuel and Emanuel. They describe four types of patient-physician relationships: paternalistic, informational, interpretive, and deliberative.

1. The paternalistic model assumes that the physician can and should determine what is in the best interests of the patient. Although this model is still accepted for emergencies, it is no longer widely accepted; there is no evidence that physicians have unique insight or can decide without discussion what constitutes a benefit or a harm to a particular patient.

2. The informational model assumes that the patient has a clear concept of his or her own values, and what is lacking are the medical facts. Under this model, physicians -- from their professional, technical, and ethical training -- determine what is in the patient's best interests. The physician in this relationship does not participate in any discussion of what value to ascribe to these facts. This model is also not formal and attributed to frame the issues as a struggle between consequentialism and deontology or as a clash between the principles of autonomy, beneficence, nonmaleficence, and justice. No comprehensive list of values at stake was drawn up and then ranked after months of deliberation. In reality, the weighing of competing values and ethical theories occurred in a far less direct fashion. Drafts for both policies were generated early in the process by the small working groups assigned to each case. It was the dissection of each draft by the larger committee that provided the best glimpse into the evolving moral deliberation.

3. Recognizing that the patient-physician interaction is a fluid process often devoid of fixed values and unambiguous facts, the so-called interpretive model suggests that the physician is more of a facilitator for the patient. Here, the physician helps patients to "uncode" their values in the context of the medical facts and the available therapeutic options. But this model assumes that physicians have the time and skill to guide this process without exchanging their values for those of their patients.

4. Acknowledging that under different clinical circumstances different models may be indicated, Emanuel and Emanuel nonetheless promote a deliberative model as the ideal in patient-physician interaction. Here the physician counsels the patient in the medical facts and helps the patient "elucidate the values of these embodied in the available options. The physician actively include suggesting, why certain health-related values are more weighty than others, and should be scrutinized to the patient. The physician aims at no more than moral persuasion. The physician, in short, empowers the patient in "moral self-development."

For the ethics committee, these were not simply theoretical models. It became evident that a resolution of both policy dilemmas first required each committee member to settle individually or with colleagues -- on a particular model of the physician- patient relationship. It is only in retrospect, after reviewing comments made over the long process in both cases, that a pattern can be identified. It appears that most members unwittingly adopted the deliberative model. Embedded in the assessment of the ideal model of the physician-patient relationship was the committee's belief that trust remains a central element of the relationship. The loss of trust by the supreriorious use of the dead was seen as potentially more detrimental to the patient-physicians-family relation-ship than the feared loss of these procedures. The committee determined that it was important to take the necessary time to conduct a clear and empathetic discussion with grieving parents.

Just as there was an unspoken but pervasive search for an agreed-upon ideal patient-physician interaction, there was also no formal agreement to frame the issues as the struggle between consequentialism and deontology or as a clash between the principles of autonomy, beneficence, nonmaleficence, and justice. No comprehensive list of values at stake was drawn up and then ranked after months of deliberation. In reality, the weighing of competing values and ethical theories occurred in a far less direct fashion. Drafts for both policies were generated early in the process by the small working groups assigned to each case. It was the dissection of each draft by the larger committee that provided the best glimpse into the evolving moral deliberation.

"What information to disclose and how to disclose it was the most common expression of the moral conflict in both policy reviews. To what extent are physicians bound to disclose information when they believe that such disclosures are not likely to be helpful, and may even be harmful? How can we know what constitutes a benefit or a harm to grieving parents? The data gathered provided some of these answers. For example, some committee members' absolute position against using newly deceased patients for practice procedures gradually yielded to an acceptance that the practice does have a role in training physicians. Committee members were especially perturbed by the fact that certain resuscitation procedures are inherently limited because they are almost exclusively performed only during a resuscitation attempt. Thus, newly dead patients allow physicians-in-training to practice resuscitation techniques that are difficult or impossible to learn in other ways without exposing living patients to additional risk.

Conversely, the national survey about chief residents' knowledge of autopsy procedures also shaped committee members' opinions. The committee found that a significant proportion of respondents reported substantial deficiencies in knowledge about the technique of autopsy. As word of these findings became more widely known, evidence from attending physicians from all specialty backgrounds could be heard at numerous meetings questioning another one on what they really knew, or what they had ever stopped to consider, about the ultimate disposition of organs as part of a complete autopsy. This finding led one former chief resident to confess aloud, "If we aren't sure about the procedures for the disposition of organs in an autopsy, then how can we think the families are in- formed?" The results of a subsequent national sur-vey on autopsy procedures also influenced committee members' thinking. Despite advances in body art and in autopsy techniques, the rate of clinically significant but unexpected findings from autopsies has remained in the range of 25 to 30 percent. Thus, providing the option of removing a portion of an organ or organs rather than conducting a complete autopsy risks missing unsuspected disease in another location in the body. Also persuasive was the knowledge that a postmortem examination of the brain can only be performed after several weeks of tissue processing. Thus, removing organs and returning them to the body after a day or two is not feasible, which may lead to inaccurate conclusions.

In the end, both policies placed the burden of moral proof on practitioners who sought to abrogate the authority that the ethics committee determined rightfully belonged to the parents. Although there were strong moral considerations about protecting grieving parents from the potential harms of disclo- sure, these harms were all related to the process of how the information was disclosed rather than parents' right to expect disclosure. Parents under stress, especially the parents of a recently deceased child, function at less than their optimal level (for that matter, so do clinicians). Parents also vary in the amount and type of information they want, the manner in which they want to be told, and the extent to which they place on the available options. Under these circum- stances, obtaining the perfectly informed consent is probably impossible. Indeed, poor communication skills (such as insufficient explanations or language that promotes feelings of abandonment) are frequent complaints of patients and their families. Although conversations about practice procedures or organ disposal are difficult and awkward, committee members did not deem this fact to be a sufficient basis for denying grieving parents of the right to de- terminant what procedures are performed on their child's body. The consensus among committee members was that the institution must allocate resources to train and supervise clinicians to conduct such conversations with parents, precisely because these re- quests must be done well if they are to be done at all. Institutional support for training and supervising cli- nicians to conduct these conversations with parents.
In the case involving practice procedures, the ethics committee independently and exhaustively reviewed the medical literature on this topic and, thus, was able to make an independent judgment on an entirely new problem—whether the postmortem practice of using newly deceased patients to teach procedures in the autopsy case, data from a cross-sectional, national survey that demonstrated substantial deficiencies in chief residents' knowledge of autopsy procedures helped convince many initially reluctant surgeons that a rigorous review of the consent process was not an overreaction to "one bad case."

Broad representation in the policy review process is also essential for success. No matter how large and diverse the ethics committee, wide consultation beyond the confines of the committee to all interested parties is crucial to the success of a policy review. In both case reviews presented here, noncommittee members provided additional information and raised practical concerns that strengthened the quality of the deliberations. In addition, the review process will be viewed more credibly if it starts with a large group and is not seen as the work of a select few deliberating behind closed doors.

ASSessing values

Over the course of both consultations, ethics committee members struggled for hours in scheduled meetings and impromptu discussions with the concept of the patient-physician interaction. Although the physician-patient relationship was a pervasive theme in nearly all deliberations, it was never set as an independent variable to be manipulated and, agreed upon. Rather, it was always in the background, and each committee member seemed to be constantly re-assessing various models of the ideal patient-physician interaction as the strength of one proposal were weighed against those of another. One classification scheme frequently cited in the literature is that proposed by Emanuel and Emanuel. They describe four types of patient-physician relationships: paternalistic, informative, interpretive, and deliberative.

1. The paternalistic model assumes that the physician can and should determine what the proper course of action is, with minimal input from the patient. Although this model is still accepted for emergency situations, it is no longer widely accepted; there is no evidence that physicians have unique insights or can decide without discussion what constitutes a benefit or a harm to a particular patient.

2. The informative model assumes that the patient has a clear concept of his or her own values, and what is lacking are the medical facts. Under this model, physicians—faced with the intransigence of uncooperative medical experts—dispense medical facts but do not participate in any discussion of what value to assign to these facts. The weakness of this model is that the physician in this relationship devolves into a detached technician. Moreover, there is an accumulating evidence that patients do not have a stable set of values that guides them across all circumstances.

3. Recognizing that the patient-physician interaction is a fluid process often devoid of fixed values and unambiguous facts, the so-called interpretive model suggests that the physician is more of a facilitator for the patient. Here, the physician helps patients to "uncork" those values in the context of the medical facts and the available therapeutic options. But this model assumes that physicians have the time and skill to guide this process without exchange their values for those of their patients.

4. Acknowledging that under different clinical circumstances different models may be indicated, Emanuel and Emanuel nonetheless promote a deliberative model as the ideal in patient-physician interaction. Here the physician counsels the patient in the medical facts and helps the patient "elucidate the values of the options in the available options. . . . The physician's objectives include suggesting, why certain health-related values are more worthy than others and should be emphasized. . . . The physician aims at no more than moral persuasion." The physician, in short, empowers the patient in "moral self-development."

For the ethics committee, these were not simply theoretical models. It became evident that a resolution of both policy dilemmas first required each committee member to settle the question, generally or exclusively—on a particular model of the patient-physician relationship. It is only in retrospect, after reviewing comments made over the long process in both subcommittees, that a pattern can be identified. It appears that most members unwaveringly adopted the deliberative model. Embedded in the assessment of the ideal model of the physician-patient relationship was the committee's belief that trust remains a central element of the relationship. The loss of trust by the surreptitious use of the dead was seen as potentially more detrimental to the patient-physicians-family relation-ship than the feared loss of these procedures. The committee determined that it was important to take the necessary time to conduct a clear and empathetic discussion with grieving parents.

Just as there was an unspoken but pervasive search for an agreed-upon ideal patient-physician interaction, there was also no formal attempt to frame the cases as the struggle between consequentialism and deontology or as a clash between the principles of autonomy, beneficence, nonmaleficence, and justice. No comprehensive list of values at stake was drawn up and then ranked after months of deliberation. In reality, the weighing of competing values and ethical theories occurred in a far less direct fashion. Drafts for both policies were generated early in the process by the small working groups assigned to each case review. It was the dissection of each draft by the larger committee that provided the best glimpse into the evolving moral deliberation.

What information to disclose and how to disclose it was the most common expression of the moral conflict in both policy reviews. To what extent are physicians bound to disclose information when they believe that such disclosures are not likely to be helpful, and may even be harmful? How can we know what constitutes a benefit or a harm to grieving parents? The data gathered provided some of these answers. For example, some committee members' absolute position against using newly deceased patients for practice procedures gradually yielded to an acceptance that the practice does have a role in training physicians. Committee members were especially concerned that even those who have a positive role in training at the time of death to ensure that adequate teaching is available for training. Thus, newly dead patients allow physicians-in-training to practice resuscitation techniques that are difficult or impossible to learn in other ways without exposing living patients to additional risk.

10. The suasion of the general survey by the national survey of chief residents' knowledge of autopsy procedures also shaped committee members' opinions. The committee found that a significant proportion of respondents reported not knowing what the approximate knowledge about the autopsy. As word of these findings made more widely known within the institution, attending physicians from all specialty backgrounds could be heard at numerous meetings quizzing another one on what they really knew, or what they had ever stopped to consider, about the ultimate disposition of organs as part of a complete autopsy. This finding led one senior clinician to confess aloud, "If we aren't sure about the procedures for the disposition of organs in an autopsy, then how can we think the families are in favor of it?" The preparedness by our present policy review on autopsy procedures also influence committee members' thinking. Despite advances in body donation and other patient care options, the rate of clinically significant but unexpected findings from autopsy has remained in the range of 25 to 30 percent. Thus, providing the option of removing a portion of an organ or organs rather than conducting a complete autopsy risks missing unsuspected disease in another location in the body. Also persuasive was the knowledge that postmortem examination of the brain can only be performed after several weeks of tissue processing. Thus, removing organs and returning them to the body after a day or two is not feasible at the moment, which may lead to inaccurate conclusions.

In the end, both policies placed the burden of moral proof on practitioners who sought to absolve the authority that the ethics committee determined rightfully belonged to the parents. Although there were strong moral considerations about protecting grieving parents from the potential harms of disclosure, these harms were all related to the process of how the information was disclosed rather than to parents' right to expect disclosure. Parents under stress, especially the parents of a recently deceased child, function at less than their optimal level (for that matter, do clinicians). Parents also vary in the amount and type of information they want, the manner in which they want to be told, and may not even place on the available options. Under these circumstances, obtaining the perfectly informed consent is probably impossible. Indeed, poor communication skills (such as insufficient explanations or language that promotes feelings of abandonment) are frequent complaints of patients and their families. Although conversations about practice procedures that are protocols or organ disposal are difficult and awkward, committee members did not deem this fact to be a sufficient basis for denying grieving parents the right to determine what procedures are performed on their child's body. The consensus among committee members was that the institution must allocate resources to train and supervise clinicians to conduct such conversations with parents, precisely because these requests must be done well if they are to be done at all. Institutional support for training and supervising clinicians to conduct these conversations with parents.
is also important because autopsy and the use of newly deceased patients for practice procedures help to achieve other worthy institutional goals (such as teaching and research).

**POLICY PROPOSALS**

The ethics committee recommended the following policy for the use of newly deceased patients to teach resuscitation procedures:

Non-inulating procedures may be taught and practiced on newly deceased patients, provided informed consent is first obtained from the deceased patient's parent or appropriate surrogate decision-maker. Informed consent should be documented in the medical record and should include a description of the procedure(s) to be performed. Non-therapeutic procedures may not be performed on patients who are potential Medical Examiner cases until the Medical Examiner declines the case.

The committee recommended the following revisions to the approach to informed consent for autopsy:

Physicians should receive a new curriculum that addresses: (i) the autopsy procedure; (ii) limitations to the procedure; and (iii) the storage, use and disposition of organs, so that they are able to discuss in a sensitive manner the details of the procedure that the grieving family may consider relevant and important. Rather than seeking to impose a uniform approach of multiple cultures, we suggest that the clinician learn to ask open-ended questions, such as: "What are the most important results you would hope to receive from an autopsy?" "What are the most important concerns that you have about autopsy?" Educational materials for the physician should be attached to the consent form in order to promote recurrent self-education prior to obtaining consent. We also recommend that the attending physician, who is typically the teaching physician, take renewed personal responsibility for the autopsy consent process. The teaching physician should assure that the resident approaches a family about an autopsy only after the resident has demonstrated competence in the autopsy consent. Teaching physicians must also guarantee that the requesting physician has earned the right to request an autopsy by virtue of his or her involvement in the care of the patient and his or her relationship with the family. Finally, the hospital should rewrite the autopsy consent form to more clearly explain the general procedures that will be followed as well as to heighten the awareness of the possibility for requesting restrictions to the autopsy, while also making clear that limitations will increase the likelihood of incomplete information.

**FOLLOW UP**

The ethics committee submitted both recommendations for changes in institutional policy to the committee's governing body, the medical staff executive committee. Both recommendations engendered impassioned debate at every step of the process, from policy review to implementation. The recommended policy for practice procedures was less contentious within the institution and was accepted. In part, this seemed to be related to the dichotomous choices that were available. One is either supportive or not supportive of this teaching technique, and one thinks either that it must be preceded by consent or that consent is not indicated. An equally plausible explanation for the relative lack of contention surrounding the recommendations for practice procedures was that fewer people were affected by this change in policy. The autopsy consent policy review was significantly more contentious. As noted earlier, a number of senior physicians believed that the ethics committee lacked the necessary authority, knowledge, and representation to make recommendations about the process of consent for autopsy. Although this view was not broadly shared throughout the institution, it led to a prolonged process with considerable lingering animosity on both sides. In retrospect, many members of the ethics committee suggested that this policy review may have been a case study in institutional political compromise rather than in moral deliberation. Many committee members were critical of the "moral incrementalism" that resulted from the process of compromise adopted by senior committee members in order to ensure that at least some of the final recommendations would be approved by the medical staff executive committee. For example, many but not all of the recommendations to change the autopsy consent form were ultimately approved by the medical staff executive committee. Another issue of contention among ethics committee members following final action by the medical staff executive committee was the issue of responsibility for implementing changes in the institution's teaching curriculum on the issues of autopsy consent. Some ethics committee members believed that, because the committee had acquired unique insight into the subtleties of the autopsy consent process, the committee was obligated to ensure institutional change in this area by organizing teaching conferences and implementing a new curriculum. An equal number of committee members, while agreeing on the inherent need for better education about these issues, vigorously opposed the further expenditure of the committee's time and effort in this area. Those who held this view believed that the committee had fulfilled its mandate by responsibly reviewing a difficult problem and making recommendations for institutional change, and that it was up to the institution to provide the resources and moral leadership to implement this change.

Ultimately, the extent to which the policy recommendations resulting from these reviews are persuasive will be for others to judge. Believing that others may benefit from the time and effort expended here, individual committee members later published an analysis of both cases. However, no systematic quality performance review of the ethics committee's work on these two cases was performed. This may be a neglected aspect of ethics committee work. Others have advocated that quality review of committee work must be a regular function of an ethics committee that makes case or policy recommendations.  

**NOTES**

2. Ross, see note 1 above.
3. Font and Crawford, see note 1 above.
9. See note 6 above, p. 2222.
is also important because autopsy and the use of newly deceased patients for practice procedures help to achieve other worthy institutional goals (such as teaching and research).

POLICY PROPOSALS

The ethics committee recommended the following policy for the use of newly deceased patients to teach resuscitation procedures:

Non-inulating procedures may be taught and practiced on newly deceased patients, provided informed consent is first obtained from the deceased patient’s parent or appropriate surrogate decision-maker. Informed consent should be documented in the medical record and should include a description of the procedure(s) to be performed or practiced, in writing, by the person who will be involved. Non-therapeutic procedures may not be performed on patients who are potential Medical Examiner cases until the Medical Examiner denies the case.

The committee recommended the following revisions to the approach to informed consent for autopsy:

Physicians should receive a new curriculum that addresses: (i) the autopsy procedure; (ii) limitations to the procedure; and (iii) the storage, use and disposition of organs . . . so that they are able to discuss in a sensitive manner the details of the procedure that the grieving family may consider relevant and important. Rather than seeking to proffer the perspective of multiple cultures, we suggest that the clinician learn to ask open-ended questions, such as: “What are the most important results you would hope to receive from an autopsy?” “What are the most important concerns that you have about autopsy?” Educational materials for the physician should be attached to the consent form in order to promote recurrent self-education prior to obtaining consent. We also recommend that the attending physician, who is typically the teaching physician, take renewed personal responsibility for the autopsy consent process. The teaching physician should assure that the resident approaches a family about an autopsy only after the resident has demonstrated competence in the autopsy consent. Teaching physicians must also guarantee that the requesting physician has earned the right to request an autopsy by virtue of his or her involvement in the care of the patient and his or her relationship with the family. Finally, the hospital should rewrite the autopsy consent form to more clearly explain the general procedures that will be followed as well as to heighten the awareness of the possibility for requesting restrictions to the autopsy, while also making clear that limitations will increase the likelihood of incomplete information.

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