CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

| VOLUME 1: GOVERNANCE & ADMINISTRATION | Effective Date: 12/13 |
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| CHAPTER 20 | Revision Date(s): |
| POLICY 1.20: HEALTH CARE ETHICS COMMITTEE | Attachments: Yes ☒ No ☐ |

## I. POLICY

The California Correctional Health Care Services (CCHCS) shall maintain an Ethics Committee at Headquarters to support clinicians and improve patient care by:

- Consulting on and reviewing cases where ethical dilemmas have been identified and staff, patients, or surrogates have questions or are in conflict.
- Educating health care staff and patients using the wide body of literature in bioethics and published legal decisions related to clinical ethics.

## II. PURPOSE

CCHCS Ethics Committee shall provide multidisciplinary consultation, guidance, and education about the ethical aspects of providing health care within the California prison system. The Ethics Committee supports ethical reflection, respectful dialogue, and critical analysis based on standard practices from the ethics literature to facilitate resolution of bioethical dilemmas.

Organizational benefits from the Ethics Committee include:

- Enhancing patient care
- Conserving resources/avoiding unnecessary costs
- Improving accreditation reviews
- Reducing risk of lawsuits
- Sustaining organizational integrity
- Encouraging professionalism of all staff within the organization

## III. PROCEDURE

### A. Ethics Committee Membership

1. Chair and Vice Chair
   a. Chairperson shall be a clinician (or nurse) from headquarters or the field appointed by the Director of Health Care Operations or designee.
   b. Vice Chair shall be a clinician (or nurse) administrator from headquarters appointed by the Director of Health Care Operations or designee.
2. General Membership
   a. Members will be nominated by leaders of disciplines which support the Ethics Committee. Individuals nominated should have an interest in the area of health care ethics, be willing to serve a minimum of one year on the Ethics Committee, and attend monthly meetings on a regular basis. Membership is composed of approximately 20 members of a multidisciplinary group of CCHCS and California Department of Corrections and Rehabilitation (CDCR) representatives. Each of the

following disciplines/groups shall be invited/encouraged to appoint a member to the Ethics Committee:

- Medical Services
- Nursing
- Mental Health
- Dental
- Custody
- CCHCS legal
- CDCR legal
- Chaplaincy
- CDCR Division of Adult Institutions
- Community members

b. Ethics Committee members shall be geographically designated throughout the state.

3. Members with expertise in issues relevant to a referred case will be specifically invited to attend meetings where these issues will be discussed (i.e., a mental health representative for a mental health issue, a dental representative for a dental case, etc.).
4. Consult Team – As time and support permit, a subset of committee members will be trained to serve as clinical ethics consultants.
   a. Selected individuals will be among those who have expressed interest and possess the clinical knowledge necessary to triage consult requests.
   b. These identified individuals will receive additional training and mentoring including attending a comprehensive ethics course, if possible, at least once during their first year of service.
   c. Attempts will be made to designate Consult Team members geographically.
   d. Designated trained and qualified Consult Team members will triage Ethics Committee consultation requests from institutions and obtain additional information on each case as needed. In addition, these members may provide ethics education to the referring institution and further guidance if/when an Ethics Committee consultation is deemed not appropriate. Pending the formation of a Consult Team, the Ethics Committee Chairperson, Vice-chair, or designee will perform these functions.
   e. Consultations provided by Consult Team members will be reviewed at scheduled Ethics Committee meetings.

**B. Meetings**

1. The Ethics Committee shall meet no less than quarterly.
2. A quorum shall exist when at least six members are present. Each member shall have one vote.
3. Members of the Ethics Committee in any discipline may vote on Ethics Committee recommendations.

4. Ethics Committee action is approved with a majority vote. A record of Ethics Committee proceedings shall be kept in a secure location, in which all Ethics Committee actions and recommendations are described.

### C. Ethics Committee Meeting Activities

1. The Ethics Committee consults on and reviews institutional cases referred by individuals from throughout the organization to the Ethics Committee wherein staff has identified ethical dilemmas and when staff, patients, or surrogates have questions or are in conflict.
2. Participation of referring individuals is encouraged when discussing referred, institutional cases.
3. The Ethics Committee also reviews and discusses cases reviewed by Consult Team members.
4. Meeting agenda includes:
   a. New active case consultations, presentations, and discussions.
   b. Consults managed in the past month by a committee member are reviewed by the Ethics Committee.
   c. Review of recommendations and topics of interest.
   d. Journal club, ethics related topics.
5. The Ethics Committee may use the four-box method of ethics consultation for all recommendations. (See Attachment I).
6. The Ethics Committee does not make health care treatment decisions – these are between providers and their patients. The suggestions presented by the Ethics Committee to the referring institution are not institutionally binding, nor are they legally binding. The Ethics Committee will make recommendations in specific cases in a prospective manner, but is not available to judge the 'ethics' of past events or decisions.
7. The Ethics Committee provides relevant education and training on ethics topics to Ethics Committee members and to staff via webinar or other appropriate distribution methods.

### D. Confidentiality

The proceedings and records of the CCHCS Ethics Committee shall be confidential and protected from discovery to the extent permitted by law.

## IV. APPLICABILITY

The Ethics Committee is accountable to and reports to the Governing Body or a subcommittee which reports to the Governing Body.

## V. REFERENCES


- California Civil Code Section 56, et seq., Confidentiality of Medical Information Act
- Albert Jonsen, Mark Siegler, William Winslade; *Clinical Ethics, A Practical Approach to Ethical Decisions in Clinical Medicine*, 4th Edition.
  McGraw-Hill, Inc., New York, 1998

Attachment I

# Four Box Method of Ethics Consultation

| Medical Indications | Patient Preferences |
|---|---|
| **The Principles of Beneficence and Nonmaleficence**<br><br>1. What is the patient's medical problem? History? Diagnosis? Prognosis?<br>2. Is the problem acute? Chronic? Critical? Emergent? Reversible?<br>3. What are the goals of treatment?<br>4. What are the probabilities of success?<br>5. What are the plans in case of therapeutic failure?<br>6. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided? | **The Principle of Respect for Autonomy**<br><br>1. Is the patient mentally capable and legally competent? Is there evidence of incapacity?<br>2. If competent, what is the patient stating about preferences for treatment?<br>3. Has the patient been informed of benefits and risks, understood this information, and given consent?<br>4. If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision-making?<br>5. Has the patient expressed prior preferences, e.g., Advance Directives?<br>6. Is the patient unwilling or unable to cooperate with medical treatment? If so, why?<br>7. In sum, is the patient's right to choose being respected to the extent possible in ethics and law? |
| **Quality of Life** | **Contextual Features** |
| **The Principles of Beneficence and Nonmaleficence and Respect for Autonomy**<br><br>1. What are the prospects, with or without treatment, for a return to normal life?<br>2. What physical, mental, and social deficits is the patient likely to experience if treatment succeeds?<br>3. Are there biases that might prejudice the provider's evaluation of the patient's quality of life?<br>4. Is the patient's present or future condition such that his or her continued life might be judged undesirable?<br>5. Is there any plan and rationale to forgo treatment?<br>6. Are there plans for comfort and palliative care? | **The Principles of Loyalty and Fairness**<br><br>1. Are there family issues that might influence treatment decisions?<br>2. Are there provider (physicians and nurses) issues that might influence treatment decisions?<br>3. Are there financial and economic factors?<br>4. Are there religious or cultural factors?<br>5. Are there limits on confidentiality?<br>6. Are there problems of allocation of resources?<br>7. How does the law affect treatment decisions?<br>8. Is clinical research or teaching involved?<br>9. Is there any conflict of interest on the part of the providers or the institution? |

Albert Jonsen, Mark Siegler, William Winslade; *Clinical Ethics, A Practical Approach to Ethical Decisions in Clinical Medicine*, 4th Edition. McGraw-Hill, Inc., New York, 1998