# *From the Editors*

Recently in the United States, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued its new guidelines for accreditation of hospitals (*Accreditation Manual for Hospitals*). Written in an atmosphere created by the Patient Self-Determination Act (PSDA), the guidelines, for the first time, devote a chapter to the protection of patients' rights. While incorporating the goals of the PSDA (and providing scoring for measuring success in implementing the mandate of the PSDA), the new JCAHO guidelines go beyond the dictates of the PSDA in creating new and far-reaching standards for protecting patients. The scope of the Commission's work will have a major impact on the ethical duties of healthcare managers, the manner in which reviews will be conducted, and the role of all staff, particularly with regard to the professional demands on the ethics committee and ethics consult service, if there is one.

Among the new standards is a requirement that every accredited healthcare organization, including home healthcare, must have in place mechanisms "to consider and discuss ethical issues arising in patient care"; examples offered in the guidelines are "an ethics committee, ethics forum, consultation services, or a combination of such." Although appropriate mechanisms are left to each institution, the result of the new JCAHO standards is that most health organizations in the United States will have ethics committees.

The guidelines also make clear that it is not enough for health organizations to simply establish a process for addressing ethical concerns regarding patient care. Patients or their designated representatives must have *access* to that mechanism. And because for most institutions an ethics committee will be the mechanism of choice, the issue of access throws light on a shadowy area in the historical development of ethics committees.

The Commission's position is that patients or their representatives should be able to contact the ethics committee to trigger a consultation, and if triggered by someone else, the patient's voice or the designate speaking for the patient should be heard at the consultation. Compliance with this section of the guidelines will require radical changes for many ethics committees. Most of the committees (77%) responding to a nationwide survey by Kushner and Gibson in the late 1980s indicated that patients were *not* routinely advised of the committee's existence or activities. "Oversight" was offered most frequently as the reason for this. Although some said they "never discussed it as a possibility," others said they wanted to first establish themselves and maintain credibility and authority "before opening up the committee to an anticipated increased workload." The JCAHO has now changed all that. By professionalizing the ethics committee and its role of protecting patient's rights and auton-

*Cambridge Quarterly of Healthcare Ethics* (1992), 4, 287-288. Printed in the USA.

omy *and* opening that process to patients, the ethics committee will enter the mainstream of the institution's commitments and mission. Kudos to the JCAHO for instituting long-overdue procedures. In subsequent issues, we will address the long-term implications of the new requirements.

On a related note, this issue includes the announcement of the Center for Healthcare Ethics Committees, a project of the International Bioethics Institute supported by the Walter & Elise Haas Foundation of San Francisco. The Center will further education and research useful to healthcare ethics committees around the world.

Increasingly, healthcare ethics committees are facing dilemmas created as new technologies press the edges of accepted practice, blurring distinctions between clinical care and research. In some of these gray areas, the treatment-oriented ethics committee interacts with the Institutional Review Board (in the United States) and the largely research-oriented ethics committees in other countries press into areas of experimental medical practice. Interdisciplinary interests in this boundary will be increasing in the years to come.

In this issue, we address problems of organ transplantation and research, and as the articles demonstrate, the cultural and personal assumptions enjoyed by advancing research and practice are wonderful candidates for further exploration.

Organ transplant technology creates dilemmas on many levels. In this issue's Special Section on Organ Ethics, Professor Marco Segre recounts the first consultation of an ethics committee on the ethical propriety of using a living donor for liver transplantation. Recognized as a pioneer of bioethics in Brazil, Dr. Segre was invited by Dr. Silvano Raia, head of the surgical team at the University of São Paulo Medical College Hospital and Clinics, to participate in the decision making. (An interesting historical footnote is that the first American surgeon to perform the same operation trained with Dr. Raia in Brazil.) Important autonomy questions are raised by liver donor treatment technology. Because regeneration occurs in both donor and recipient, it becomes possible to take only part of the organ for transplant. Are families today "coerced" by the technical possibilities into consenting to this procedure to save the life of a loved one? International responses to this important procedure are offered, as are articles on the general issue of the ethics of treatment technology.

We are also privileged to present three reports arising from crises around the world—a report from Russia, where change in the entire social structure is coming at a dizzying pace, with profound implications for healthcare; a unique story of an ethics committee's preparations for war in the Persian Gulf; and an urgent plea for assistance from war-torn Croatia. These contributions highlight the common purpose of all people working in healthcare and bioethics, however diverse the setting may be.