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Editorial

Clinical ethics committees: a worldwide development

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Clinical ethics committees (CECs) are well established in North America where they are known as hospital or health care ethics committees. Similar groups and other kinds of clinical ethics support are now developing in Europe. This supplement to the *Journal of Medical Ethics* provides an overview of the issues arising from the provision of clinical ethics support services, and clinical ethics committees in particular. Its primary focus is the UK but contributors from North America and continental Europe provide an international perspective.

Clinical ethics committees are an emerging feature of UK health care. This supplement's first paper provides an overview of the current provision of clinical ethics support in the UK and an assessment of the way in which CECs are developing. Personal perspectives from five UK CECs provide insight into some of the issues that those considering setting up a committee in their own trust will need to address.

In Germany CECs are at a similar stage of development to the UK. However, a "top down" impetus, as in the committee described by Simon, is more common than in the UK. Simon describes the work of a CEC in case consultation. A different model of case consultation using individual ethicists is described by Reiter-Theil.

Danis and colleagues have found that requests for ethics case consultations, either to a committee or an ethicist, are more likely to be triggered by conflict than by cognitively based concerns. They conclude that those involved in ethics consultation will need skills in mediation as well as ethical analysis.

Should ethics case consultation be by committee or individual ethicist? A committee has the advantage of bringing a broader range of views and expertise to the ethical problems, but an individual ethicist can be more responsive to a request for an urgent consultation. Eiser and colleagues describe ways in which some advantages of both methods can be combined by using electronic communication between CEC members to facilitate case consultation in two hospitals in Chicago. Electronic communication is already having an effect on clinical medicine and is likely to have implications for ethics support services. Parker and Gray discuss some of these wider issues in their paper on e-ethics.

In the Netherlands CECs (known as institutional ethics committees) are more widespread than in the UK. Meijburg and ter Meulen have been involved in developing and training such committees for several years and their paper provides advice for health care institutions considering establishing a CEC. The wider issue of educating all health professionals within the institution is discussed by Tweeddale in his account of his experience as a member of a CEC in Vancouver.

Doyal considers the role of a CECs as a forum for collective debate in order to provide coherent ethicolegal institutional policies. Any CEC influencing institutional policy or clinical care will need to be aware of legal as well as ethical principles and will need to ensure that its constitution and procedures stand up to legal scrutiny. These issues are discussed more fully by Hendrick.

The position of CECs in the context of clinical governance is discussed by Campbell, who argues that CECs have the potential to improve the quality of clinical care within the NHS.

This supplement provides a firm reference point from which to consider the future development of clinical ethics support services in the UK. There is evidence of demand for such a service, but there is also experience of the limitations that such a service can face. Do CECs, or other ethics support services, deliver the support that clinicians and institutions need, when they need it, and of appropriate quality? Do they, in short, promote the quality of health care? The promise of CECs is clear, and the experience recorded in this supplement of the journal makes us optimistic for their future. It remains now to be seen whether CECs can make good this early promise.

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Clinical ethics support services in the UK: an investigation of the current provision of ethics support to health professionals in the UK

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Abstract

Objective—*To identify and describe the current state of clinical ethics support services in the UK.*
Design—*A series of questionnaire surveys of key individuals in National Health Service (NHS) trusts, health authorities, health boards, local research ethics committees and health professional organisations. Interviews with chairmen/women of clinical ethics committees identified in the surveys.*
Setting—*The UK National Health Service.*
Results—*Responses to the questionnaires were received from all but one NHS trust and all but one health authority/board. A variety of models of clinical ethics support were identified including twenty formal clinical ethics committees (CECs). A further twenty NHS trusts expressed an intention to establish a CEC within the next twelve months. Most CECs in the UK have been in existence less than five years and are still defining their role. The chairmen identified education of committee members and contact with other ethics committees as important requirements for committee development. Problems were identified around lack of support for the committee and with raising the profile of the committee within the institution. There has been little evaluation of clinical ethics support services either in the UK or in other countries with longer established services. What evaluation has occurred has focused on process rather than outcome measures.*
Conclusions—*Clinical ethics support services are developing in the UK. A number of issues have been identified that need to be addressed if such support services are to develop effectively.*

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Keywords: Clinical ethics committee; health professionals; ethics support; health care ethics committees

Introduction

In recent years, consideration of ethical issues has become an important and frequent part of discussions around health care within the UK, both at the level of the individual patient and at a population level. A number of factors have contributed to this increase in the discussion of ethics. The mapping of the human genome, techniques for assisted reproduction and improved life-support mechanisms offer new opportunities for treatment but also raise ethical concerns. The development of effective but expensive treatments, an increase in chronic disease and an ageing population raise new questions of priority setting. The recent inquiries into paediatric cardiac surgery at Bristol, and the removal of the organs of dead children at postmortem examination without parental consent at Alder Hey, have focused as much on the ethical integrity of clinicians and health care institutions as they have on clinical competence.

Within this framework of raised ethical awareness and demand for public accountability, how can individual health professionals and health care institutions ensure high ethical standards in all aspects of patient care? Some support for health professionals on ethical issues in clinical care already exists in the UK in the form of guidelines from national bodies and professional organisations.[1 2] However, local support services may be needed to provide support that is responsive and relevant to local circumstances. There is some evidence to suggest that such support services would be welcomed by clinicians.[3]

Clinical ethics committees (CECs), also called hospital or institutional ethics committees (HECs), have been a feature of health care in North America since 1971,[4] and their number increased dramatically in the 1980s.[5] Clinical ethics committees have also developed in Europe and Australia although they are less widespread than in North America.[6–9] Ethics consultation services provided by individual ethics consultants or teams have also developed, sometimes in association with a CEC and sometimes separately.[10 11] The methodology for the assessment of clinical ethics support services is poorly developed. A few studies have tackled this issue, primarily focusing on process rather than outcome measures.[12] In the UK research ethics committees are well established but there are few data on CECs. There have been published reports on five different CECs,[13–15] and anecdotal evidence suggested that there were other CECs developing within the UK as well as other methods of clinical ethics support. The aims of the study reported in this paper were:

1. To identify all ethics support services relating to clinical practice currently provided for health professionals working in the UK.

2. To investigate the perceived need for such a service among senior managers and clinicians within the health service.
3. To describe in detail the structure and function of established CECs in the UK.

Method

The investigation comprised two main types of study:

1. A number of closely related questionnaire surveys.
2. Structured interviews with the chairmen of CECs identified in the questionnaire surveys.

1. QUESTIONNAIRE SURVEYS

Several brief questionnaire surveys of the following groups were carried out:

- chief executives, chairmen, medical directors, directors of nursing and directors of operations (ambulance trusts) in all NHS trusts in the UK;
- chief executives, chairmen, directors of public health and, where applicable, directors of primary care services in health authorities and health boards in the UK;
- chairmen of all local research ethics committees (LRECs) and,
- senior officers in identified professional organisations.

In addition, written requests for information were sent to identified individuals in university departments of medical ethics.

Sampling

All NHS trusts, health authorities and health boards, and professional organisations were identified using the medical directory, and the names of individual postholders were recorded. Chairmen of LRECs were identified using the national database of LRECs held at King's College, London.

All subjects were sent a brief questionnaire accompanied by a letter explaining the nature of the study and the fact that the study focus was on clinical ethics and excluded information about research ethics. Two postal reminders were sent. For trusts and health authorities where no postholders replied a further telephone request was made to the medical director or director of public health. Between the initial questionnaire mailing and the first reminder there was a significant change in NHS trusts, with some trusts merging and new trusts forming. Therefore, following the first reminder a confirmatory check was made to ensure the database included all current trusts using the NHSE website (England), the Welsh Office (Wales), the Northern Ireland health and personal social services website, and the Scottish health organisations website. Trusts that no longer existed were removed from the database, new trusts were added and questionnaires were sent to the appropriate personnel. The final database included all NHS trusts active on the first of April 2000.

The questionnaires developed for each group were slightly different to reflect their different health care roles but each questionnaire was designed to answer two main questions:

a) Did the trust/health authority/research ethics committee/professional organisation provide support on ethical issues relating to clinical practice as opposed to research?
b) Did the person completing the questionnaire perceive a need for clinical ethics support for health professionals in his or her organisation?

2. INTERVIEW STUDY

Interviews were conducted with the chairmen of all clinical ethics committees in NHS trusts identified in the questionnaire survey. The interviews lasted between 30 and 60 minutes and were tape-recorded. Four interviews were not recorded for technical reasons but contemporaneous notes were taken. A topic guide was developed covering the following areas:

1. The structure of the committee (membership, terms of reference, experience/expertise of members, training).
2. The functions of the committee (case consultation, policy development, education, other functions).
3. The development of the committee (reason for development, profile of the committee within the trust, achievements, problems).
4. The views of the chairmen on the future development of the committee.

The interview transcripts were analysed to obtain factual data, and to identify themes relating to the specific topic areas.

A full description of the methods is given in the study report.[15]

Results

QUESTIONNAIRE SURVEYS

Response rates

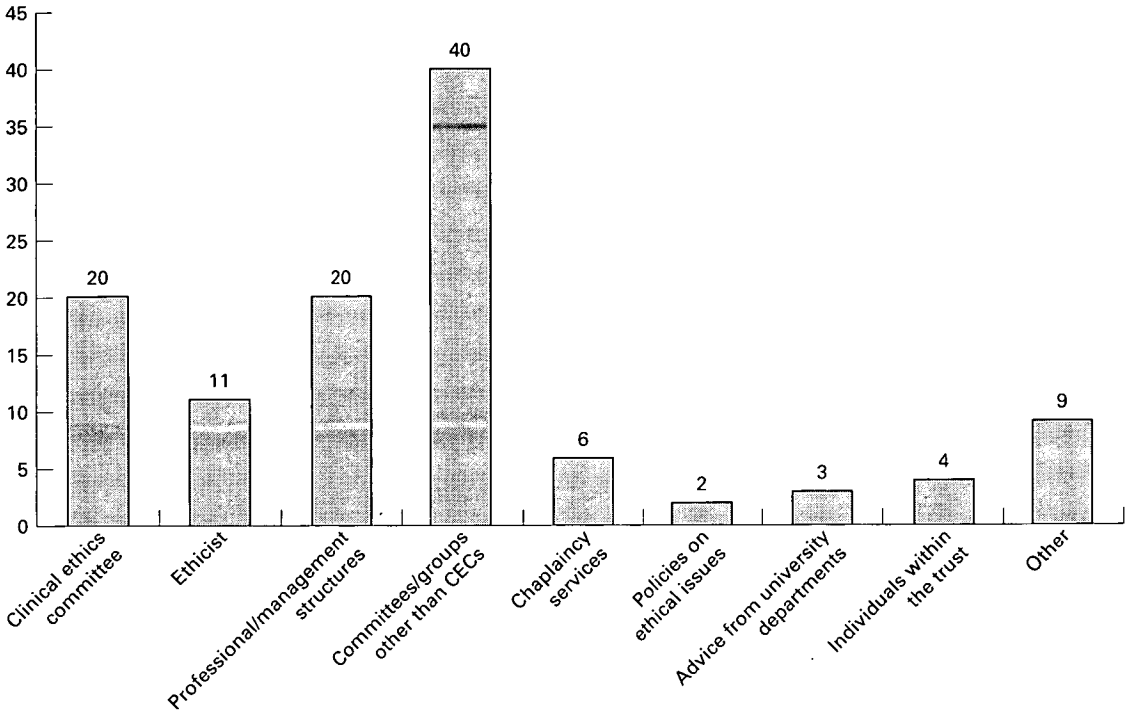
A total of 2,363 questionnaires were sent. Responses were received from:

- 99.8% (455/456) of all NHS trusts (71.3% (1273/1784) of individual postholders);
- 99.2% (123/124)of all health authorities/health boards (78.8% (238/302) of individual postholders);
- 90.0% (208/231) of chairmen of LRECs;
- 95.0% (20/21) of those national professional organisations surveyed.

Level of ethics support currently provided

1. **NHS trusts**: Of those NHS trusts active on April 1st 2000, 18% (84/456) have already identified some formal method of addressing ethical issues arising from clinical practice within the trust. These vary from specific services dedicated to the provision of clinical ethics support to the incorporation of ethics into existing trust structures such as a clinical governance committee or professional advisory committee. (See figure 1.)
2. **Health authorities and health boards**: A resource allocation or priority setting committee

Figure 1: number of NHS trusts reporting different models of formal clinical ethics support. Some trusts have more than one model



that addresses ethical issues was reported in 14% (18/124) of health authorities and health boards.

3. **Local research ethics committees (LRECs)**: Some health professionals see LRECs as a source of advice on ethical issues relating to clinical practice. Forty-two per cent (88/208) of responders to the LREC questionnaire stated that their committee had been asked for advice on clinical ethical issues and 25% (52/208) stated that the committee had provided such advice.
4. **Professional organisations**: Of the responders to the professional organisation questionnaire, 57% (23/40) stated that the organisation had some form of clinical ethics support for members. (See table 1.)
5. **University departments of medical ethics**: Of the eighteen individuals in departments of medical ethics approached for this study responses were obtained from fifteen (82%), and 60% (10/15) of those responders stated that they had been approached by clinicians for advice on ethical issues relating to patient care. Of those who had been approached, 50% received requests at least once a month and 50% received requests infrequently. Those individuals who received requests at least once a month were personally involved in a clinical ethics committee or an assisted conception ethics committee.

Table 1 Type of formal support on ethical issues in clinical practice provided by professional organisations

Type of support	*Number of organisations with such support*
Ethics committee	15
Written guidelines	14
Telephone advice	11
Education	7
Other	7

Perceived need for clinical ethics support

- Of those respondents to the trust questionnaire who answered the question on perceived need for a clinical ethics support service, 89% (557/620) agreed or agreed strongly that the trust should have such a service. The respondents represented 80% of all trusts. A clinical ethics committee was favoured by 62% (365/587) of these responders, 26% (152/587) favoured an ethicist and 12% suggested another model of service.
- Of the responders to the health authority questionnaire, 50% (120/238) felt that a clinical ethics support service would be useful in the health authority, and 84% (199/238) thought that the health authority had a role to play in providing support or advice to primary care groups/trusts on ethical issues relating to clinical practice and/or resource allocation.

- Of the responders to the LREC questionnaire, 85% (177/208) thought that there was a need for ethics support on clinical issues within the NHS organisations that referred research proposals to the LREC.
- Of the responders to the professional organisation questionnaire, 57% (12/21) thought that the ethics support provided by their organisation to health professionals should be improved.

General comments on clinical ethics support

The questionnaires administered to the trusts and health authorities/boards provided space for general comments. Comments were made by 12% (208/1713) of trust respondents and 24% (56/238) of health authority/board responders. The majority of comments indicated recognition of the need for a mechanism to raise awareness of ethical issues within the institution. One respondent wrote: "I feel very strongly that there are circumstances in practice, and our relationships with patients and their families, which could be handled better if we had access to individuals or processes which support ethically based decision making."

However, just under 20% of those commenting in the trust questionnaire expressed a clear opinion that any form of clinical ethics support was unnecessary within individual NHS trusts. They felt that ethical decisions were an intrinsic part of a clinician's work and support from senior colleagues was more appropriate than external mechanisms. One respondent wrote: "I am somewhat alarmed at the growth of quasi formal/regulatory committees and much prefer sensible informed decisions between colleagues."

Some health professionals within trusts, including those in favour of clinical ethics support, expressed concern about the feasibility of providing such support in general, and concern with doing this through clinical ethics committees in particular. These concerns included:

- the cost of setting up such a service;
- the need for a rapid response to requests for advice in urgent clinical situations;
- the establishment of yet another committee, increasing bureaucracy within the trust;
- that the clinical autonomy of health professionals would be compromised.

There were also positive suggestions on what form, other than an ethics committee, a clinical ethics support service should take. These included:

- small groups or individuals within the trust;
- an extension of current clinical supervision arrangements;
- regional committees covering more than one trust.

Table 2 Membership of committees

Group	*Number of committees with members of this group*
Consultant/Medical Director	20
Junior doctors	3
Nurse managers	17
Junior nurses	1
Other clinical professionals	10
Non-clinical manager	10
Chaplain	11
Lawyer	4
Ethicist/philosopher	10
Lay/patient representative	15
General practitioner	6
Trust Board member	11

INTERVIEW STUDY

Development of the committees: Only four (20%) of the twenty clinical ethics committees had been established for more than five years. Most of the committees had been established because of concern by clinicians about difficult cases or issues they had encountered. Two committees developed from a trust research ethics committee (not from a LREC) when it became clear there was a need to consider ethical issues other than those arising from research within the trust. One committee was established on the initiative of the trust board and one on the initiative of the chief medical officer in the health authority

Committee membership: All committees were multidisciplinary but the mix of disciplines and the presence of lay members differed between committees. (See table 2.)

Some committees' terms of reference made allowance for other people to be co-opted on to the committee for discussion of specific issues. Seventy per cent (14/20) of committees had a senior doctor as the chairman.

Funding: Fewer than half of the committees had access to funding. Sources of funding included the trust board, education and training budgets, specific grants and local research ethics committee funding. Some committees had funding for more than one purpose. (See table 3.)

Except where specific funding had been allocated, administrative support for the committee was usually provided by the chairman's secretary, and in at least one case the chairman wrote the minutes of committee meetings.

Functions of the committee: The terms of reference of the established CECs identify three main functions of the committees: support for individual clinicians; input into trust policy and guideline formation, and education of health professionals within the trust.

Table 3 Funding available for clinical ethics committees

Type of funding	*For education/ training*	*For an ethicist*	*Administrative*	*Total with no funding*
Number of committees with access to funding	5 (25%)	2 (10%)	4 (20%)	11 (55%)

Some committees have funding for more than one purpose.

Table 4 Guidelines and policy issues reported as being addressed by clinical ethics committees

Do not resuscitate (DNR) guidelines
Consent policy
Advance directives
Rights and duties of relatives
Confidentiality
Consent to participate in undergraduate education
Withholding and withdrawing of treatment
Guidelines relating to HIV
Policy for dealing with the media
Commercial use of tissue
Consent for DNA testing
Total parenteral nutrition
Use of restraints
Elective ventilation
Possession of illicit drugs
Abuse of services by members of the public

The role of committees in guideline and policy development covered three main areas:

- consideration of both existing and developing hospital policies, and advice on the ethical issues arising from them;
- identification of areas of concern, where a policy or set of guidelines may be required and then input into their subsequent development;
- development of guidelines on specific ethical issues by the committee for consideration and ratification by the trust board.

A range of policies and guidelines have been considered by the currently established committees in the UK. (See table 4.)

Most committees used retrospective case discussion as a form of self-education for the committee members. Several of the chairmen commented that issues arising from individual cases often highlighted a need for the development of a policy or guidelines. Eight committees have engaged in discussion of active cases and provided advice and support in these cases. The frequency of requests for advice on active individual cases is low (usually less than two per year) although one committee in an acute trust had received thirteen requests over the two years that it had been functioning. Three acute trusts have an ethicist on the committee who also gives advice and support to individuals and care teams within the trust. These ethicists are attached to local university departments and are not funded by the trust. (See table 5.)

Table 5 Some issues raised in 'active' case consultations conducted by CECs

Confidentiality around HIV testing
Refusal of life-saving treatment
Refusal of spouse to give permission for life-saving treatment because of patient's previously stated views
Request from relatives not to divulge distressing information to a person with learning disability
Use of restraint to allow appropriate treatment
Relatives requesting information about patients
Conflict between medical team and parents over use of CPR in severely disabled children
Withdrawal of treatment
Advance directives

Table 6 Models of educational initiatives by clinical ethics committee

Grand rounds
Seminars or workshops on specific issues
Educational document on consent
Inclusion of ethics in postgraduate seminar programme
Teaching of specific groups by individual member of committee

All committee chairmen highlighted the importance of education on ethical issues for all health professionals within the trust, and agreed that one role of the committee may be to initiate or facilitate such education. Education was seen as one way of raising the profile of both the committee and clinical ethics in general across the trust. However, few of the committees were actively involved in education in a regular or structured manner. There were various reasons for this, most commonly lack of resources (time and money) and a lack of confidence among ethics committee members in their ability to educate others when they were still learning. (See table 6.)

Evaluation: Only one clinical ethics committee had so far undertaken any formal evaluation of its process or function. Most committees produce an annual report describing the work of the committee.

Issues arising from the interviews

A number of issues were raised in the interviews.

1. **The professional status of the committee chairman**: It was generally felt that the chairman did not need to be a doctor and that the position could be held by another health professional or a lay person. However, there was a view that the chairman needed to be someone with authority and respect within the trust in order that the committee was perceived as important by employees of the trust. The support of the medical staff was seen as essential for the useful functioning of the committee and resistance from them as a potential barrier to the committee's effectiveness. Therefore, from a pragmatic viewpoint it was widely thought that a senior doctor as chairman is desirable in the early development of the committee.
2. **Does the committee need an ethicist?** The views of the chairmen on the need for an ethicist or philosopher on the committee were sought. Some thought that an ethicist, or someone with a qualification in ethics, was essential to the effective functioning of a clinical ethics committee. One chairman said: "I think that the idea of having a committee like this without appropriate expertise all round is absurd."

   Others thought it was more important to have clear thinking, articulate people with an interest in ethics and an ability to place the issues in a practical context, rather than a designated expert with no practical experience. "I think many of the people with expertise in this area are theoreticians rather than practitioners."

   One chairman expressed concern about bringing in someone from outside the trust who would not have practical experience of the trust.

3. **Training for committee members**: All chairmen thought some training for committee members was desirable. The two main barriers to achieving this were lack of funding and lack of suitable courses. Six committees had arranged training for their members, which ranged from attendance at a specific course to "in house" training by the committee's ethicist. Initial training was usually organised when the committee was established but no committee had established a programme of updating members or training new members. Two main approaches to training were identified: training in ethical theory and training in the process of ethical deliberation. Committees with ethicists were more likely to receive education around moral theories and principles, and specific issues such as consent or confidentiality. Several chairmen put forward the view, however, that education aimed at improving critical ethical thinking, and learning to work through issues as a group was at least as important as a detailed knowledge of ethical theories. One chairman said: "An initial introduction for members may be useful, a short two-day course may be helpful in that at least people can reflect on the approach to medical ethical problems. But one should stress again that an effective committee may be one that actually develops its own expertise as it goes along."
4. **Clinical ethics committees and clinical governance**: The relationship between clinical ethics committees and clinical governance was commented on by many chairmen. Most chairmen of established CECs viewed consideration of the ethical issues as an integral part of providing high quality patient care. They also considered it important, however, for the clinical ethics committee to be seen as separate from the monitoring process of clinical governance. One chairman said: "I think it needs to be seen to be functioning with, but not simply as part of, clinical governance."
5. **Potential hindrances to the effective functioning of clinical ethics committees**: All chairmen felt that clinical ethics committees could potentially offer a model for raising ethical standards of patient care in NHS trusts. However, several obstacles were identified that could impede their successful development and their effectiveness. (See table 7.)

Table 7 Obstacles to the successful development and effectiveness of a clinical ethics committee

Resources (financial and human)
Availability of training for members
Appropriate expertise on the committee
Reluctance of clinicians (particularly doctors) to recognise and use the committee
Difficulties in raising the profile of the committee

Discussion

Clinical ethics committees (CECs) are developing within UK NHS trusts and their number seems likely to increase rapidly in the next few years. Most established committees have developed as a result of clinicians identifying a need for clinical ethics support, ie there has been a "bottom up" approach. However, with the advent of clinical governance CECs may also develop in a more "top down" manner with the impetus coming from management. Models, other than CECs, of providing ethical support to clinicians have been adopted in some trusts, and are preferred by some health professionals. Results of this study also suggest that many senior clinicians and managers, as well as trust and health authority chief executives, believe that some form of ethics support service is desirable.

The high response rate to the questionnaire surveys ensured a comprehensive coverage of NHS trusts and health authorities. The interviews with the chairmen of all identified CECs also provided comprehensive coverage of this model of clinical ethics support, as well as providing a more in-depth view of the processes and functions of these committees. However, the study had some weaknesses. It was clear from the questionnaire responses that not all senior clinicians and managers were aware of what support was available in their organisation. We may therefore have missed some ethics support services in our questionnaire surveys. This risk was minimised by sending the questionnaire to several people in the same organisation. The perception of a need for a clinical ethics support service in this study is limited to senior professionals only. Other health care workers may not have the same views.

The results of this study raise a number of issues. There are many models, or potential models, for providing clinical ethics support within the UK NHS. Eighty-eight trusts reported some mechanism of providing clinical ethics support other than CECs. It is not possible to say from this study how active or effective these forms of support are, or whether it is just wishful thinking on the part of the respondents that these mechanisms could be used for ethics support. The findings raise the possibility that existing structures in trusts could be developed to provide support and guidance on ethical issues in clinical care as an alternative to a CEC. Health authorities and health boards have a role in providing clinical ethics support to primary care groups and trusts. They too will need to consider appropriate models of providing such support. Although some evaluation of such services has taken place in North America there has been little rigorous evaluation of outcomes, with most research looking at process data such as satisfaction of health professionals and patients.[17–19] In general satisfaction is high among users of CECs but this accounts for only a small percentage of any professional group within the institution.[20] Longer term evaluative studies using outcome as well as process data are needed.

Whatever models of clinical ethics support are found to be most suitable, either for individual trusts and health authorities, or more generally within the health service, many of the issues

identified in the interviews with chairmen of CECs will be relevant. There was broad agreement between the chairmen of CECs in many areas. A fundamental point arising from all the interviews was that CECs should be advisory, offering support but not issuing decisions. For the committee to be successful, it must have recognition and support from within the institution at all levels, including administrative and financial support. Many CEC chairmen identified the need for appropriate training or education of committee members as important. The areas identified as important in such education include basic moral theory, ethical analysis, critical thinking, and knowledge of national ethical and legal guidelines. All committee chairmen commented that they were unaware of other CECs and that contact between CECs would be an important method of providing support and education for developing CECs. The sharing of experience and specific guidelines through some form of network would avoid each committee having to "reinvent the wheel".

There was less consensus about the various functions of CECs. Although most committees have concentrated on guidelines and policy formation, some committees see case consultation as the main function of the committee. Most chairmen agree that education of health professionals within the institution and raising awareness of ethical issues is important but there are concerns about how the committee can provide this service. Similar problems were faced by CECs developing in North America.[21 22]

Several of the CECs in the UK are not yet clear about their exact role in the institution and there are concerns about how effective the committees are. Comments from the questionnaire surveys also raise concerns about the effectiveness of a clinical ethics support service, even among those who are very much in favour of raising ethical awareness in clinical practice. It is therefore imperative that any services have clearly stated objectives, and that there is a rigorous evaluation of both process and outcome during their development.

In conclusion, clinical ethics support services, and particularly CECs, are in the early stages of evolution in the UK. There is the opportunity, through good liaison between the existing services, and continuing evaluation, to ensure the development of effective ways of providing such support.

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Snapshots of five clinical ethics committees in the UK

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Abstract

Each of the following papers gives an account of a different UK clinical ethics committee. The committees vary in the length of time they have been established, and also in the main focus of their work. The accounts discuss the development of the committees and some of the ethical problems that have been brought to them. The issues raised will be relevant for other National Health Service (NHS) trusts in the UK that wish to set up such a committee.

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The development of Peterborough Hospitals NHS Trust clinical ethics committee

DEVELOPMENT OF THE COMMITTEE

The first clinical ethics committee meeting at Peterborough Hospitals NHS Trust was held in September 1999. The concept of a clinical ethics committee was first raised the previous year independently by doctors, nurses and professions allied to medicine– Professions Allied to Medicine– (PAMS) within their own professional groups. It was then discussed collectively by the trust's clinical management board in response to recommendations within the clinical governance agenda.

As a result of this discussion it was proposed by the clinical management board, whose members are multiprofessional, that a practice development nurse should look into the background of such committees and submit a formal proposal to the board. A proposal supporting the need for, and viability of, an ethics committee that would provide a multidisciplinary forum for the discussion of ethical issues affecting the delivery of patient care in Peterborough Hospitals NHS Trust, was submitted and accepted by the clinical management boards in May 1999.

MEMBERSHIP

The practice development nurse who submitted the proposal was invited to configure the committee and recruit members. It was decided at the outset that the committee should be multidisciplinary and would comprise 15 to 20 members. Membership is as follows: two nurses, two PAMS, two lay members, a solicitor, a philosopher, a chaplain, two to four doctors, a midwife, a representative from an ethnic minority and a general practitioner (GP). The aim was to have a broad representation of views, while keeping the committee manageable. Membership could be extended to include other areas of expertise required for a particular issue that the committee addressed. Although the committee met for the first time in September 1999, full membership was not achieved until June 2000.

The committee members were a group of people who were interested in ethics, but few had any formal training in ethics. One member had an MA in ethics and another had a postgraduate diploma in health care ethics and was currently studying for an MA in medical and health care ethics. The philosopher on the committee taught the master's programme of ethics at Northampton College University.

DEVELOPING THE AIMS OF THE COMMITTEE

The terms of reference of the committee were kept general rather than specific, as this was a new development, for which there were no specific guidelines. The committee decided that the main functions of the committee would be to educate and act as an ethics resource for trust staff. The committee would also undertake the provision of ethical advice on the development of institutional policies. It would also provide a forum for objective, interdisciplinary review of trust policies. The terms of reference were to be reviewed approximately one year after its formation. It was felt that as members became more knowledgeable about ethics, they would be able, in the future, to define the terms of reference of the committee more specifically.

The committee has had much discussion about whether it should be involved in case consultation. The consensus is that the committee is not yet well enough established for this, and that a significant number of staff might feel this would constitute interference in their clinical judgment.

Meetings are held monthly in the evening. Initially meetings were held alternately in the day and in the evening. However, membership attendance during the day was poor because of members' other commitments.

Funding to support the committee was secured in April 2000 from the Cambridgeshire and Northwest Anglia Education and Training Consortium. The funding, for two years, supports the payment

of the philosopher for attending meetings, four hours of secretarial time each month and resource purchases such as the medical and nursing ethics journals and training costs for committee members.

ETHICAL ISSUES AROUND THE TRUST'S GUIDELINES AND POLICY

The committee has critiqued various hospital policies and guidelines from an ethical perspective as a method of self education. These have included the trust's advance directive and CPR policies, which include do-not-resuscitate orders. Comments and observations made by the ethics committee were sent to the resuscitation committee, and the ethics committee then discussed their response.

The trust's strategy has also been looked at in some depth. Comments have been sent to the chief executive suggesting ethical perspectives that the committee feels should be included in the forthcoming update of the strategy. One broad comment is whether it should be the trust strategy to promote the availability of complementary medicines to staff, which on the whole are not evidence-based, whilst advocating in the same strategy that the trust should strive to provide research and evidenced-based care. Another question raised is: if complementary care is being made available to staff, should it not also be offered to all patients. The ethical principles of equity and justice were used as arguments against the strategy, to promote such a stance.

RESPONDING TO SPECIFIC CONCERNS OF TRUST STAFF ON ETHICAL ISSUES

Eight months after its formation the committee moved from its learning stage into its active stage. The clinical management board asked the committee to look at the issues surrounding media intervention in patient care and to make recommendations if appropriate. The request was as a result of concern among trust staff that the setting of priorities in surgical waiting lists was being influenced by pressure from the local media. The committee invited the communication manager to the committee meeting to discuss the issue.

The discussion centred on a case in which some staff felt that a patient had received care because the patient's case had received media attention. However, a broader discussion of equity among patients ensued. Committee members raised, as examples, the issue of patients who call consultants' secretaries frequently, or who persistently visit their general practitioner (GP). In some cases such patients have their appointments brought forward at the expense of other less "demanding" patients. However, the time taken by staff in resisting such demands could be even more unjust to other patients because it might mean their treatment was delayed even more.

In some situations there was a conflict between providing the treatment being demanded and the best care that could be delivered.

The conclusion of the discussion was that patients have a right to be treated justly, but not to make demands for better treatment than could be given to all patients in a similar clinical situation. However, the greater good was sometimes achieved by meeting the demands of the occasional patient. The communication manager said only 20% of press coverage of the trust was in fact negative.

Confidentiality of patient information in the context of media coverage was also discussed. The conclusion from this discussion was that unless a patient gave specific permission no information could be given to the media.

The ethical discussions have been full and lively and some changes to the trust's media and patient complaint policies and distribution of those policies have been recommended. We currently await the clinical management board's response to our recommendations.

The committee feels that this request has been an important milestone in the development and acceptance of the committee within the trust. It has since been asked to advise on ethical aspects of admissions to intensive care.

RAISING THE PROFILE OF THE COMMITTEE

A year after the establishment of the committee we feel ready to advertise our existence more broadly. Members are accepting numerous invitations to talk about the activities of the committee at various trust meetings and educational events, and the committee is provisionally planning a regional ethics educational workshop.

Evaluation of the committee is essential, but will, we believe, be premature until the committee has been in existence for two years of more. We hope by then there will be information from other committees in the UK about how they have evaluated their effectiveness. The past year has seen the committee form, grow and plan for the future, in which its overall aim is to contribute to the provision of high quality care within Peterborough Hospitals.

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A clinical ethics committee in a district general hospital

INTRODUCTION

It became apparent in the early 1990s that our hospital had no forum for debating the increasing range and complexity of ethical dilemmas faced in routine clinical practice. By analogy some consultants felt that if ethics committees were needed to review research ethics why not clinical ethics commitees too? There is less consensus in clinical ethics than in research ethics, and many clinical ethical dilemmas are arguably more complex than those in research. Consequently a group of interested clinicians introduced the concept of a clinical ethics committee to the consultant medical board. While some consultants felt there was no need for such a forum, most supported the initiative. Acknowledging the dearth of experience in the United Kingdom[1-3] a group of 17 interested people was recruited after consultation with the medical board

Table 1 Inaugural membership

6 clinicians	
2 physicians	
1 general surgeon	
1 psychiatrist	
1 obstetrician	
1 paediatrician/neonatologist	
3 Members of the nursing profession	
1 chief nurse	
1 midwife/midwifery manager	
1 oncology ward sister	
Head physiotherapist	
Principal pharmacist	
Radiology services manager	
Hospital chaplain	
General practitioner	
3 lay members:	A senior police officer
	A personnel director
	An executive of a public company

chairman and the prospective clinical ethics committee chairman and began work, taking advice from ethicists at our local university and medical school.

SETTING, MEMBERSHIP AND ROLE

The Wirral Hospital is a 1250-bed hospital providing secondary care services to a population of 360,000. It is physically located with, but managerially distinct from, the regional oncology centre. The inaugural committee was multidisciplinary (see table). We were keen to recruit assertive lay members. The elected chairman was a senior clinician with extensive management experience and a longstanding interest in ethics dating from the London Medical Group in the 1970s. We felt it important to have a chairman of sufficient standing to have the confidence of both management and senior clinical staff. The elected vice-chairman was a paediatrician with an MSc in health care ethics and is chairman of the local research ethics committee.

A junior doctor was added to the inaugural group. A psychiatrist, because of pressure of time in his role as medical director, was replaced by a consultant in palliative care. An intensive care anaesthetist subsequently joined the committee. We decided against having legal representation, but the trust solicitors have been consulted, as appropriate, over several issues. We have been helped by the fact that the trust chairman, a solicitor, has a strong interest in ethics and has attended the committee as an observer. The committee reports to the trust board and also to the medical board (all local hospital consultants).

We expected to be asked to consider dilemmas involving individual patients. In fact our major role has been in advising on the ethical aspects of policies produced elsewhere in the trust or instigated by the committee itself. We have used working groups which have reported back to the full committee. Educational activities have so far been self directed but we are beginning to address the education of junior doctors and other professionals. We have not formally undertaken individual case review, although committee members, especially the chairman, have been informally consulted over such cases.

SPECIFIC ISSUES

The clinical ethics committee has been pivotal in the development of trust policies, including the "do not resuscitate policy", patient confidentiality in relation to the hospital computer information system, a contract for patients admitted with alcohol misuse and the local application of the British Medical Association's (BMA) guidelines for withholding and withdrawing medical treatment. We have also debated the eligibility of patients for renal replacement therapy, and issues around late termination of pregnancy.

The most recent dilemma discussed was the increasing number of requests from clinicians for a specific blood test, the CD4 lymphocyte subset, as a surrogate marker for HIV infection. It appeared that clinicians, when faced with the personal and practical difficulties of discussing HIV testing with patients, were bypassing these by requesting CD4 measurement instead. The test was also being requested by clinicians as part of a range of tests for patients with undiagnosed prolonged infections and wasting diseases, again without appropriate information being given to the patients.

The laboratory personnel were uneasy with this practice and felt it conflicted with their professional responsibility to perform investigations as requested. Their advice was that a low CD4 count was a specific indicator of HIV infection and thus the committee felt that doing the test without appropriate counselling of patients was unjustified. Also the CD4 measurement was not sufficiently sensitive to exclude HIV infection confidently. There was a danger, therefore that a normal result might be falsely reassuring. The request for the CD4 test without counselling was held to be an infringement of the patient's rights. It was also considered to be an infringement of the rights of the laboratory staff, who had a duty to uphold good medical practice and ensure adherence to guidelines. In other immunodeficiency states where HIV infection was not strongly suspected, other lymphocyte markers or tests for immunodeficiency could be done without infringing the patient's rights or compromising the laboratory staff.

The committee advised, therefore, that the laboratory staff could refuse to do the CD4 measurement unless the requesting clinician had given appropriate information to the patient.

As a result the consultant haematologists will now not sanction the CD4 test without the specific consent required.

CHALLENGES

While the committee has been generally welcomed, the greatest difficulties encountered have related to perceived threat to individual clinicians when dilemmas have been presented to the committee by other professionals in their clinical team. These difficulties have not yet been resolved. Perhaps the

most valuable role of clinical ethics committees is to emphasise the difficulties inherent in clinical ethical dilemmas, not just provide simple answers.[4]

Another challenge has been to persuade professionals of the importance of involving patients and families in decision making. This was highlighted when we debated the hospital's "do not resuscitate policy". Some committee members, and other clinicians involved in devising the policy, were reluctant to involve patients and families fully in the information disclosure necessary to make "do not resuscitate" decisions. Debate in committee succeeded in developing a policy which emphasised that patients should be involved in making such decisions, unless there were exceptional grounds for not doing so. Recent media publicity has vindicated the committee's stance.

In discussing withholding and withdrawing medical treatment in incompetent patients, we recognised that doctors might leave themselves vulnerable legally, despite making ethically justifiable decisions. After preparing local modification of the BMA document on this issue, we sought trust legal advice. This was necessarily defensive in pointing out that doctors might leave themselves vulnerable to charges of attempted murder or manslaughter if withholding or withdrawing such treatment, and recommended an approach in favour of continuing treatment. This approach could require doctors to act against the best interests of their patients in starting or continuing treatment that might prolong suffering. The committee was charged with producing, and did produce, advice which steered a middle road between protection of the trust and doctors, and a regard for patients' best interests.

The educational challenge has been to persuade staff, particularly the junior medical staff, that ethical issues carry as much weight as purely didactic clinical teaching. Medical trainees are more set upon gaining factual clinical knowledge than debating the ethical issues surrounding them.

CONCLUSIONS AND OBSERVATIONS

The committee is still learning and developing. We have yet to achieve universal acceptance among clinicians and need to develop our educational role. We expect to become more involved in resource issues, and probably in individual case review. There are undoubtedly further challenges, but we believe that clinical ethics committees will play a pivotal role in delivering clinical governance and in mediating partnership between clinicians and patients.

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The ethics of clinical practice committee in Nottingham

Recognition by the medical director and members of the medical staff committee that ethical problems were playing an increasing role in clinical practice led to the formation of the committee at the City Hospital in June 1994. The title of ethics of clinical practice committee (ECPC) was chosen to emphasise its multidisciplinary nature; there was representation of medical and nursing staff from within the hospital and a hospital chaplain represented a multi-faith religious centre in the hospital. There are currently twenty-two representatives, eight of whom are from outside the hospital, including a professor of social studies, a senior lecturer in law, a deputy director of public health and three general practitioners (two retired).

The terms of reference for the committee are shown in the table.[5] Minutes are circulated to all consultant staff and to the hospital nursing forum. The committee meets monthly and in 1999 was expanded to represent both the City and University Hospitals in Nottingham as it is hoped to develop common policies in the new spirit of cooperation between trusts.

CASE DISCUSSION

In 1994 the committee discussed a problem of treatment for a patient with metastatic cancer, which was referred by the department of clinical oncology. The patient had been informed by medical relatives that there was a newer treatment, by injection, as opposed to the standard irradiation therapy. Injection therapy was very costly but apparently more effective. However, the use of the new treatment would soon exhaust the department's budget if it was available to all relevant patients. Guidance was sought from the clinical unit on the following five questions.

(1) If patients ask about treatments available for their disease should they be told of treatments that are available elsewhere but not in our department?

Committee members thought patients should be given as much information about treatment options as was available to the medical staff involved in their care. The availability of the treatment and its considered effectiveness should also be discussed fully with the patient.

Table 1 Terms of reference for ethics of clinical practice committee

General ethical issues arising from established policies in connection with patient treatment and care.
Ethical issues associated with new initiatives in patient treatment and care.
Items of ethical import concerning individual patients.
Advice on moral conflict issues where the clinician or other professional asks for such assistance.
Issues of conflict between the wishes ++of the purchaser and provider in terms of patient care.

(2) If the patient requests an expensive treatment do we provide that treatment for this one patient knowing that the treatment could not be afforded for other patients who could benefit from it?

Member felt that patients should be offered treatments that were considered to be of proven benefit for their symptoms. The question was whether the new injection treatment had been shown in properly controlled trials to be superior to the current treatment that was available. There needed to be an agreed policy within the department as it was recognised that directorates needed to keep within their budget allocations as well as considering the needs of all patients they treated.

(3) Should we offer to treat this patient as a National Health Service (NHS) patient if he were to pay for the cost of the drug alone but not for the full cost of being treated privately?

It was considered by the committee to be highly unethical for a patient to pay for the cost of the drug alone and to receive the remainder of his treatment as an NHS patient. Private and NHS treatment should always be kept strictly separate. The committee felt the ability to pay should not determine who receives a specific treatment within the NHS.

(4) Should we advise this patient to try and obtain the treatment from another centre in the UK?

A few centres are offering the treatment that this patient requested but those centres use various selection processes. The committee advised that patients should be informed of centres in the UK for this particular treatment if that information was requested. The possibility of referral from the patient's health authority within NHS funding would have to be considered. If the patient was too ill to travel and the treatment was essential, the general practitioner (GP) fundholder or health authority should be approached for funding for the treatment.

(5) Should we offer to treat the patient as a private patient?

If the patient were to be accepted as a private patient then this would require appropriate re-referral from the GP or other medical person.

FURTHER COMMENTS

The above case shows the close relationship between ethical and legal issues. The legal expert on the committee subsequently reported on the issue of the patient being treated as an NHS patient and paying for the cost of the drug alone without any handling or administrative charges. The suggestion was that it would not be illegal to enter into such an agreement but it would be risky to do so on the basis of mixed liability. A proper contract would need to be drawn up with the patient, and this would probably need specialist legal advice. If one supplied the drug to the patient on this basis then one could not force the patient to pay if he/she then refused. Such an arrangement appeared to be outside the spirit of the NHS and there did not appear to be a case precedent or reference in the published literature in this area.

It is interesting to note that the subject of rationing of health care due to limited resources has been the focus of attention for the committee on a number of occasions.[6] The director of public health is a member of the ECPC. In 1997 there was increased pressure upon public health directors to sanction expensive individual packages of care at a time of major cash restraints with the purchaser/provider split. Inequalities of health care delivery had also been exacerbated in some instances by the issue of general practice fundholding. The ECPC also discussed the setting up of a forum in Oxford as a means of providing advice on rationing decisions in health care.[7]

A SECOND CASE DISCUSSION

The question of whether a patient with advanced cancer should pay for an expensive drug not available on the NHS while being treated in an NHS hospital arose once more, in 1999. The drug in question was licensed and may have had limited benefit in prolonging the patient's life. However, the drug was still regarded as of marginal benefit (it was assumed that any drug of proven efficacy would have been funded and made available to all NHS patients). Five years after the first case discussion members expressed some uncertainty about whether the principle of respecting the autonomy of the fully-informed patient, who wants to try every last avenue of treatment at whatever expense, overrode the principle of justice, with patients on an NHS ward receiving differential access to treatment.

Members are increasingly aware that there are examples of supplementation of state provision by private care within the NHS. There are also examples of patients commencing care in the private sector and then being admitted to NHS facilities with complications. Oncology patients having private treatment outside the NHS are an example of such a group of patients. It was felt that so long as there is no direct intermingling of patients receiving private and NHS care on the same ward, then some of the ethical dilemmas are avoided but it still raised the overall problem of equity of access.

On this occasion there was a 50/50 split in the viewpoints of members of the ECPC, with many of the doctors stating that the patient should be allowed to spend his own money on a drug even if it is only of marginal benefit. Many of the nursing staff felt such action was fundamentally against the principles of the NHS. Others pointed out that the core question may not be one of the patient's right to choose a treatment believed to be of marginal benefit, but whether the NHS or any other entity has a duty to make this treatment available. The NHS provides its services essentially on the basis of citizenship: by living in the country and paying taxes people are entitled to receive its services. The essence of citizenship is that like cases are treated alike and access and entitlement to treatment does not link to ability to pay. Patients using a particular

service should be treated equally in relation to their clinical needs. This is the only morally legitimate way to proceed.

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To test or not to test: that was the question: the first challenge for a novice clinical ethics group

Two years ago a clinical ethics advisory group (CEAG) was established at the James Paget Hospital. It has adopted a "bootstrap" approach to its development and slowly determined its role and activity. The membership includes consultants, nurses, the hospital chaplain, a speech therapist and a lay person. Recruitment of a GP has been unsuccessful as attendance at the meetings does not carry remuneration. Meetings are held bimonthly or more frequently as the need arises.

The group has debated local case studies in order to develop skills in the analysis and management of ethical issues. Outside educational courses have also been attended. Links with the faculty of law at the University of East Anglia have been established.

The CEAG determined that it should be an independent body and act only in an advisory capacity. The first substantial case where its advice was sought is presented.

CASE REPORT

A health care worker sustained a needlestick injury during a surgical procedure on a patient who was potentially at risk of HIV infection. The health care worker had followed the protocol for universal precautions and, following the injury, sought to follow the recommendations laid down by the trust. A starter pack for postexposure prophylaxis against potential HIV infection was provided. However, the health care worker was reluctant to begin treatment because of previous drug sensitivities, the complexity of the treatment and the other possible side effects. The health care worker asked whether the treatment would be necessary if the patient was found to be HIV negative. Following recovery from the general anaesthetic, the patient was seen and counselled by a health advisor. Unfortunately, consent for HIV testing was refused on the grounds that the patient felt unable to cope if there was a positive diagnosis. The plight of the health care worker was explained to the patient who felt it was unfair that he should have to be tested because of the needlestick injury. It was noted that a sample of the patient's serum had been saved prior to the surgical procedure for cross matching.

The consultant in genito-urinary medicine (GUM), who was also a member of the CEAG, was asked to become involved. He met with the patient, who again declined to consent to testing. He suggested that the opinion of the CEAG be sought. As prophylaxis needed to be taken within 48 hours of the injury, an emergency meeting of the CEAG was called on the evening of the event, some four to five hours after the needlestick injury.

Prior to this advice was also sought from the General Medical Council and legal experts.

The General Medical Council has produced guidelines on HIV testing in exceptional circumstances. In situations where prophylactic treatment is available, an existing blood sample taken for other purposes may be tested. However, this could then be challenged in the courts or be the subject of a complaint to the employer and the General Medical Council. This would then require the hospital staff to justify their action.[8]

Legal advice suggested there was no right or wrong decision in testing or not testing, as long as the case had been discussed with peers and employers.

Discussions were also held with other genito-urinary physicians at local, regional and national level. They were sympathetic to the plight of the health care worker, but they all considered these were not the sort of exceptional circumstances that would justify testing without consent.

THE FIRST CEAG MEETING

Five members of the CEAG, including the GUM physician, met at very short notice to discuss the case. The problem was identified as whether or not the clinicians could test a blood sample of a patient for HIV without consent when a health care worker had suffered a needlestick injury. A structured approach was taken and the facts of the case were examined. The individuals involved were identified as:

The healthcare worker
The patient
The partners and family of both the health care worker and the patient
Other patients that the health care worker might become involved with, who could then be at risk of cross infection

The right of the patient not to be tested without consent was considered, as well as the right of the health care worker to know the HIV status of the patient. The main discussion focused on the utilitarian argument of weighing the consequences of each course of action. The argument in favour of not testing was based on the distress a test would cause the patient. The argument in favour of testing was that the uncertainty of infection would cause considerable psychological stress to the health care worker and could put other members of the health care worker's family at risk. In addition, the worker might have to be restricted in clinical activity thereby affecting the delivery of care to other patients (for example, cancelled operating lists, clinics etc). Significant career effects might also occur. The potential physical harm from the prophylactic drugs was also taken into account. Most of the members of the meeting could person-

ally identify with an equivalent situation that they might encounter in their own everyday practice.

The committee concluded that the balance of arguments supported the blood testing without the patient's consent. However, as there was some time before a final decision needed to be taken, it was agreed to reconsider the issues at a larger meeting of the CEAG the next morning.This would also allow time for further counselling of the patient.

THE SECOND CEAG MEETING

At the second meeting, seven members reviewed both the case and the outcome of the first meeting. Two members who were present at the first meeting were unable to attend. In the subsequent debate the rights of the patient were seen as paramount. There was an opinion that all health care workers must subordinate their own rights to those of their patients. The decision on prophylaxis was for the health care workers to take as they were aware of the risks they took in the course of their work. The utilitarian arguments were seen as less persuasive in this context. The consensus view of the meeting was that testing without the patient's consent should not take place.

THE SUBSEQUENT EVENTS

As no testing took place, the health care worker took the prophylactic medication, became unwell and developed a rash. The worker felt aggrieved at a perceived lack of support from the CEAG.

THE LESSONS LEARNT

At the next bimonthly CEAG meeting, there was a review of the case consultation and various points emerged.

1. The complexity and unusual nature of the case had been a serious challenge to the CEAG and had revealed weaknesses in its operation. No formal plan had been established for the management of emergency ethical dilemmas. Organisation of the emergency meetings was difficult and documentation of the discussions was therefore limited. The time available was very limited for considered debate.
2. The leadership of the CEAG was not clear during this episode because the chairman was on leave.
3. The GUM clinician acted in his capacity both as a consultant providing clinical advice on the case and as a CEAG member in debating the ethical issues. It was later agreed that this could lead to a conflict of interest.
4. The two meetings had come to different conclusions based on two different approaches to the problem (utilitarian and deontological). Those who attended both meetings found their opinions changed as the debate developed. This demonstrated that there was no method for the resolution of such disagreement within the CEAG, beyond consideration of a further debate.
5. The health care worker had expected an executive decision for testing and had misunderstood the advisory role of the group. This showed that the role of the CEAG was unclear in the minds of hospital staff. Many staff still perceived the role of the ethics committee as being to make difficult decisions.
6. The CEAG had not established a mechanism for formal discussions with any of the parties, during the assessment of the ethical situation. However, most of the committee was agreed that their presence during a meeting would constrain debate. There was no mechanism either for formally debriefing the parties afterwards about the decisions that the CEAG had reached.
7. The visceral response of most clinicians ("test") was in stark contrast to the opinion of the GUM specialists nationally ("don't test"). The CEAG were disappointed that the GMC guidelines and advice from other national bodies failed to give direction and support in this area of conflict. It was difficult to see where a developing ethics group could go to obtain such support.

CONCLUSION

It was unfortunate that such a difficult case was the first real test of the CEAG. As a result of this episode the group is looking at its operational policy and the way in which it presents itself to the rest of the trust's staff. The issue of a lack of national guidance and support on difficult ethical issues should be debated. Perhaps a national or regional ethics advisory group may be required for help with issues where a local group feel out of their depth.

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This paper has been a case study in which there was substantial contribution from all members of the CEAG. The authors have merely written the report.

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The clinical ethics committee at St Mary's

The clinical ethics committee (CEC) at St Mary's was established by the trust medical advisory committee (TMAC) in 1997. It was inspired by the Imperial College Medical School (ICMS) course in medical ethics that several members of the TMAC attended. The only stipulation of TMAC was that the chairman should be a trust consultant and that the professor of medical ethics at ICMS should be a member of the committee.

The CEC was developed following the model published by Henry J Silverman in 1994, describing how such a committee had been established then revitalised in Maryland and New Jersey.[9] An account of three UK ethics committees was also helpful.[3] Members were selected because of their

Table 1 Original membership of the committee

Consultant physicians	2
Nurses	6
Professor of medical ethics	1
Reader in medical ethics	1
Physiotherapist	1
Paediatric social worker	1
Medical student	1
Lay member	1
Hospital chaplain	1

enthusiasm for clinical ethics and not as representatives of their discipline or department. However, the committee membership was similar to those of other hospitals on which we had modelled ourselves.

Since then, there have been some changes in membership. The vice-chairman is now a senior nurse and the chaplain currently fulfils the role of secretary. The trust does not provide secretarial facilities. Since the advent of clinical governance the committee, while still reporting regularly to TMAC, also reports to the clinical quality steering group. This group is responsible for the circulation of any guidelines that the CEC produces and for communication with the trust board.

ETHICS CASE CONSULTATION: THE CHOSEN FOCUS OF THE COMMITTEE

The committee has chosen to focus on assisting the clinical staff of the trust in the management of cases when difficult ethical issues arise. The modus operandi is that requests for a clinical opinion come either directly from a consultant to the committee chairman, or through the usual request path for a specialist consultant opinion. The patient is then seen at the earliest opportunity by any clinical member of the CEC, who then summarises the case. The summary is circulated to those members of the CEC who are available, or who may have specialist knowledge relevant to the case, for example palliative care. The chairman is contacted, or in his absence the vice-chairman, who decides whether an opinion can be offered immediately or whether an emergency committee meeting should be called. The opinion of the member of the CEC who sees the patient is always written in the case notes and the case is always discussed at the next meeting of the CEC. If the opinion of the committee differs from that originally entered in the case notes, then the amended opinion is also documented in the notes.

CASE EXAMPLES

Advance directives

Soon after the committee was established it was asked to give an opinion on the withholding of hydration and nutrition from a patient who was resident overseas and who had been admitted with a severe intracerebral haemorrhage that rendered the patient unconscious, although the patient was still breathing spontaneously and there was no indication for neurosurgery. The patient had written an advance directive (AD) that was legally valid in the jurisdiction in which she was resident. The AD had been written five years previously after the death of a friend following a severe stroke, and the patient's clinical condition corresponded exactly to that stipulated in the AD. The directive stated that the patient did not want hydration, nutrition or any life-prolonging therapy in these circumstances.

This was the first time that a patient who had written an AD was being managed in the trust. If the AD was followed then the unconscious patient would be transferred to a ward with no intravenous line or nasogastric tube inserted. All nutrition, hydration and life-sustaining treatment would be withheld, in a patient who was not necessarily irreversibly close to death. The patient's spouse and children, who were anxious that the AD was complied with, had accompanied the patient from overseas. The consultant in intensive care asked the CEC for guidance on how the patient should be managed.

The CEC members were unanimous in supporting adherence to the AD. They thought the patient's condition corresponded to one of the situations specified in the AD, that the AD had not been written under duress and that there was no strong reason to suggest that the patient had changed her opinion since writing the AD. However, the committee thought the opinion of an English court should be sought as a matter of urgency. The CEC's opinion was written in the hospital notes and communicated to the patient's family, who appeared much relieved by it. However, while an application to the court was being prepared the patient died.

Subsequent to this case the CEC has been asked to advise on another case of an overseas patient who suffered a severe stroke while in the UK and who had an advance directive. In this case the AD did not clearly apply to the patient's clinical state and the CEC did not advise compliance with the AD. The patient recovered sufficiently to be flown home.

GIVING ADVICE IN EMERGENCIES

The ability of the CEC to respond in an emergency is illustrated by the case of a patient with an imminently life-threatening condition who was refusing treatment which would be life-saving, on the grounds that he had suffered a reaction to previous treatment. The treatment needed to be given within a few hours or the patient would suffer irreversible brain damage. The patient's disease had resulted in moderate hypoxia but he did not appear confused. The consultant caring for the patient asked the advice of the CEC on whether it would be ethical to treat the patient against his will. The chairman and the other consultant physician on the committee were on annual leave so the vice-chairman, a senior nurse, consulted with the professor of medical ethics. They felt that the degree of hypoxia was enough to lead to a degree of confusion that would impair decision making capacity in the patient. They

established that the patient had not been given information about the consequences of refusing treatment before the hypoxia had developed. Therefore, their advice was that it would be ethical to treat the patient against his wishes, on the assumption that if the patient was not hypoxic he would consent to life-saving treatment, even if there was a risk of a reaction to the treatment. The treatment was given, the patient had a moderate reaction but survived. Following recovery the patient expressed gratitude that his wishes had been overruled. The ethics advice was available to the clinicians within two hours of being sought.

COMMITTEE ADVICE TO TRUST MEMBERS

Apart from helping with the management of cases, the CEC has advised various members of the trust on a variety of subjects including the following:

The ethical issues raised by limb transplantation.
The ethical problems involved in the treatment of staff and students in the accident and emergency department.
The ethical issues around providing prophylactic treatment for staff members who receive needlestick injuries, but not for partners of HIV-positive patients after intercourse.

When such subjects are discussed, the member of staff who has requested the advice is invited to attend the committee meeting and take part in the debate.

GUIDELINE DEVELOPMENT BY THE COMMITTEE

The CEC has produced three documents or guidelines for the trust staff: guidelines on the management of patients in a persistent vegetative state; guidelines on the withholding and withdrawing of treatment in adult patients who are not dying and who have not written an advance directive, and the committee has contributed to the development of a pro-forma to be kept in the hospital case notes, for patients who are not for cardiopulmonary resuscitation (CPR).

There has been no audit of the CEC's contribution to patient management but there is a perception within the trust that the staff are better informed on the problems of managing incompetent patients. There are now fewer requests for guidance on these issues than there have been over the last two years. The CEC recognises that appropriate audit is essential to the proper functioning of a clinical ethics committee but there is currently no consensus in the committee as to how this should be carried out.

Dr Richard Lancaster, PhD, FRCP, is a Consultant Physician and Chairman of the Clinical Ethics Committee.

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Support for ethical dilemmas in individual cases: experiences from the Neu-Mariahilf hospital in Goettingen

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Abstract

Prompted by a recommendation of the two Christian hospital associations in Germany, the Neu-Mariahilf Hospital in Goettingen set up a health ethics committee in autumn 1998. It is the committee's task to give support to staff members, patients and their relatives in individual cases where ethical dilemmas arise. The following article descibes the committee's work by means of three cases.

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Keywords: Ethics consultation; health ethics committees; case review

Health ethics committees in Germany

In March 1997 the two Christian hospital associations, the Katholischer Krankenhausverband Deutschland, and the Deutscher Evangelischer Krankenhausverband, recommended that every hospital within the associations establish a health ethics committee (Klinisches Ethik-Komitee).[1] These are quite distinct from the institutional review boards, which examine research proposals, and which have been in existence in Germany for about twenty-five years.

One of the factors which has led to this development is the clear gulf between what is medically feasible and what can be afforded. This gulf leads to conflicts for health professionals who wish to do the best they can for each individual patient but are not always able to do so. Health ethics committees, it is hoped, will provide a forum for open and free discussion, thus giving support to health professionals in coming to a decision as to how best to resolve ethical conflicts.

These committees will not only focus on issues arising from the limitations on resources. They will provide doctors, nurses and other health professionals with an opportunity to discuss any ethical problem which arises in their practice. Furthermore, the committees will be available to patients.

In addition to being a forum for discussion these committees may also give specific advice. On some issues a vote may be taken on which course of action is thought to be best. The committee's advice, however, will only be one factor in coming to a decision. In the end, the decision will remain with the health professional.[2]

The health ethics committee at the Neu-Mariahilf hospital in Goettingen

The Neu-Mariahilf hospital in Goettingen was one of the first to take up the recommendation of the two Christian Hospital Associations; it established a health ethics committee in the course of putting into practice the hospital's new mission statement.[3] The establishment of the committee was supported by the Academy for Ethics in Medicine as regards content and organisation.[4]

Members of the ethics committee include an ethicist (as the chairman), a teacher of religious education, a jurist, a citizen, three physicians, two nurses, a teacher of nursing care, the managing director of the hospital and the matron (as spiritual adviser and representative of the supporting order). The individual members were appointed by the board of directors for two years. It is not their task to represent the interests of the profession. Rather they should play a part in the forming of a joint opinion through their own personalities, and on the basis of their professional experience and professional competence.

Along with consultation in situations of ethical conflict, the committee offers discussion evenings, which take place every three months. The individual events are announced publicly in the hospital. Everyone interested in the topic, whether they are staff, patients or relatives, may participate.

The introduction of the ethics committee was prepared carefully. After the first preliminary talks, an in-house series of events on various ethical topics (for example, informed consent, withdrawal of treatment, dealing with dying people and their relatives) was held during the autumn of 1997. A booklet with articles on the individual events was distributed free of charge among interested staff members. The concept of the committee was presented in January 1998, in the course of a public information day on the various projects involved in the realisation of the hospital's mission statement. Staff members were encouraged to take an active part in four preparatory seminars in order to work out the standing orders of the committee and to rehearse and try out how it might work, by means of case examples. In June 1998, the standing orders were passed and the members selected. After the first session in July, the members of the committee introduced themselves to the staff and took up work in September.

In the following, the work of the health ethics committee at Neu-Mariahilf hospital is to be delineated with three examples. The first example describes an initiative which developed from the first public discussion evening organised by the ethics committee, the other two show clearly the ways in which the committee tries to support people in situations of ethical conflict.

Case 1: Handling stillborn children with dignity

In Germany, about 4,000 children are stillborn each year. If their birthweight is less than 500 g they do not have to be buried. As a rule, the bodies of these stillborn children are burned as hazardous waste.

Because of reports in the media, in summer 1998 1998, according to which the cinders of burnt miscarriages were used in road construction, the committee organised a discussion evening with staff members of the obstetrics department and parents concerned in order to talk about how to handle stillborn children with dignity and how to support their parents. As a result, the following initiative was launched, which in the meantime has been joined by the other two obstetrics clinics in Goettingen.

The bodies of stillborn children under 500 g are no longer disposed of as hazardous waste but are collected in the pathology department. Up to three times a year, the bodies are transferred to a coffin and buried in an anonymous burial ground in the municipal cemetery. The parents may learn the site of the burial ground on request. The obstetrics clinics agreed to pay for the burial and are supported in this by an annual collection in the parishes of Goettingen. Several days after the burial an ecumenical memorial service takes place. By means of a reply card, which they receive together with information about further possibilities for consultation and support when being discharged, the parents can make known their wish to be invited to the memorial service.

An additional result of the discussion evening is a new mode of expression at the hospital's obstetrics department. The discussion showed that some specialist terms in obstetrics, especially in connection with miscarriage and stillbirth, sometimes sound unfeeling and cold to the ears of parents concerned. Sensitised by this, staff members of the department have since tried to avoid such terms, both among themselves, and while talking to parents.

Case 2: Withdrawal of treatment in the final stage of a cancer disease

At the beginning of 1999, the ethics committee was asked by staff members of the intensive care unit to give its opinion on the question of withdrawal of treatment in patients in the final stage of cancer. A few days earlier, a patient had died in the intensive care unit who, on the eve of his death had received intensive medical treatment to prolong his life, although it had been clear that because of his disease he would die within the next few days.

In the preliminary talk between the committee's chairman and members of the nursing staff it became clear that the nursing staff were not so much interested in an evaluation of the case itself, as in the committee's position on the problem in principle, taking the case as a starting point. This could then serve as guidance in future cases. Three questions were crystallised as being very important in the course of the talk: how important is the patient's will concerning decisions on withdrawal of treatment and forgoing treatment? Who is to be included in the decision making process? How should the decision be documented?

After this preliminary talk, which clarified both the question and the committee's task, the inquiry was discussed at the committee's next meeting.[5] The proposers were informed personally about the result of the discussion by the chairman. Furthermore, the result was set down in a written statement, that may be seen by everyone in the hospital.[6]

In its statement the ethics committee first refers to the new principles relating to medical terminal care published by the German Medical Association,[7] according to which the patient's will and the discussion with medical and nursing staff are crucial to the question of withdrawal of treatment. Going beyond these professional guidelines, the committee stressed the necessity of documenting in the medical record the consent reached in the discourse between medical and nursing staff. This should be carried out, especially in case of end-of-life decisions, by the senior physician of the respective department by means of a clear entry in the patient's notes.

Furthermore, the ethics committee saw a need for discussion and further vocational training on this topic. Therefore it subsequently organised a public discussion evening on the topic of medical advance directives, and in-service training on the ethical and legal aspects of medical terminal care. Both offers were very well received by the staff.

Case 3: Operations with an increased risk for the patient

Another inquiry was made about a patient who, because of unbearable pain in the vertebral column, wished for an operation to alleviate pain. The attending physician was prepared to perform the operation although drastically increased risks for the patient were involved. When, after the operation the feared complications occurred, some staff members shook their heads or made critical or reproachful remarks. In this situation the physician asked the ethics committee to give its opinion.

The committee held the view that the therapy wish of a patient may be complied with even if an increased risk for the patient is involved. This requires, however, the patient to be sufficiently informed about these risks and that there are no less risky alternative treatments available. In this case, the patient had been clearly aware of the increased risk, particularly as the operation had initially been refused by the attending anaesthetist.

Also, an alternative analgesic drug therapy in maximum dosage had been suggested and tried out. As this therapy attempt failed, gaining no satisfactory alleviation of pain for the patient, the operation on the vertebral column was performed as a last resort.

With regard to the negative reactions of the staff, the ethics committee considered whether the decision in favour of the operation had been sufficiently discussed with the staff members involved. Possibly, many of the staff knew only little of the patient's urgent wish for an operation even at the risk of dying, and therefore after the operation reacted by shaking their heads. This could probably have been avoided by more communication and transparency with regard to medical therapeutic decision making.

Concluding remarks

Between October 1998 and June 2000, the ethics committee was asked by staff members (physicians or nurses from different wards) to give its opinion in seven cases. In one case, the proposers were referred to the managing director of the hospital as the problem involved was more of an organisational nature. All inquiries concerned cases that had happened only a short time earlier and had left those involved feeling uneasy. As even talks with colleagues did not result in satisfactory answers, those concerned turned to the ethics committee, hoping to find perspectives and guidance for their future actions. With the proposers' assent, some of the questions included in the inquiries were taken up as topics for the public discussion evenings. In this way the ethics committee tried to promote the general discourse of ethical issues, seeking for it to become a matter of hospital routine.

In summary, one can say that in the two years of its existence the ethics committee has proved worthwhile in dealing with questions and problems arising from the discrepancy, often very painful for hospital staff, between the ethical guidelines formulated in the mission statement and striven for by the staff, and the realities of the hospital. One should, however, take care not to measure success and failure of an ethics committee by quantitative criteria, for example by the number of inquiries. Rather, the success or failure of the committee rests on whether, through its various activities (ethics consultation, public discussion evenings, further vocational training for staff etc) it has contributed to a greater awareness and more open discussion of ethical problems in the hospital.

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1 Katholischer Krankenhausverband Deutschlands, Deutscher Evangelischer Krankenhausverband. *Ethik-Komitee im Krankenhaus*. Freiburg: KKD and DEK, 1997. The two top organisations represent about one third of all hospitals in Germany.
2 In a recent survey of the 795 members of the two Christian hospital associations, 29 hospitals said they had set up a health care ethics committee or a comparable institution for the consultation of people affected. At 16 further hospitals the establishment is imminent, at many others it is being discussed.
3 The Catholic hospital, Neu-Mariahilf, is a small hospital with five departments: gynaecology and obstetrics, internal medicine, surgery, orthopaedics, and anesthesia and 135 beds. Affiliated to the hospital is a nursing school with 42 training places. The fact that the hospital is supported by a Catholic order affects the medical care and the work of the ethics committee only insofar as the personal moral concepts of staff members and committee members are more influenced by Christian beliefs.
4 The Academy for Ethics in Medicine is a non-profit making organisation with offices in Goettingen. It aims to promote discourse on ethical issues in medicine, the health professions and the health care system by conducting suitable projects and events.
5 As a rule, the committee's meetings take place on the first Monday of each month. In urgent cases an ad hoc meeting may be called.
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The Freiburg approach to ethics consultation: process, outcome and competencies

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Abstract

The paper describes how ethics consultation can be valuable to health professionals, patients and their families in understanding and evaluating ethical values and their consequences in a particular situation. Ethics consultation as it is practised at the university hospital of Freiburg is a special professional service offered by members of an academic institution.
The practical approach and the goals are illustrated by a case study showing the difficulties of deciding about the limitation of intensive care medicine after heart surgery in the setting of maximum treatment. Here, the ethics consultation was initiated by the relatives of the patient who wanted a decision to withhold further life-sustaining treatment.

Following the experiences in Freiburg, it is concluded that clinical ethicists have to cover a variety of relevant fields of knowledge, need special analytical skills, and should have professional competence in counselling, including conflict mediation or crisis intervention.

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Keywords: Ethics consultation; case study; limitation of treatment; family involvement; qualification

Background and context of the Freiburg approach

Freiburg is one of the few places in Germany where a university hospital has made the considerable commitment of establishing its own Centre for Ethics and Law in Medicine (ZERM). The author, as medical ethicist and research coordinator of this centre, has been able to build a multidisciplinary team which is engaged in a clinical research programme across a number of clinical disciplines.[1] Members of the centre offer ethics case consultation as part of the research programme. The various settings for these consultations have been described in detail elsewhere.[1]

There has been a particular interest in ethical issues arising in the context of intensive care. The systematic documentation of such issues, together with the analysis of these cases, is carried out in much more detail as part of a research programme than is the case in the more routine case consultations in other clinical settings. This level of detail has been made possible because of national grants (principally from the German Research Council and the Robert Bosch Foundation). This connection between practical ethics support and clinically relevant research which is approved by major national funding bodies has contributed to the acceptability of clinical ethics both in the university and in the hospital.

Freiburg University Hospital has several years' experience of clinical ethics consultation as a result of ZERM and has never established a clinical (hospital) ethics committee. There are two possible reasons for this. First, the ethics support provided by the centre, which works closely with the research ethics committee of the medical faculty, may already be providing the ethics support needed. Second, establishing a formal committee may be seen as too bureaucratic a response to the problem of ethics support. By contrast, the support offered by the centre is accessible and responsive. It is also varied. In addition to case consultation members of the centre are involved in the ethics education, not only of students in the university, but also of hospital staff. Centre members have initiated ethics rounds—like "Grand Rounds" but focusing on the ethical rather than the purely medical aspects of management. Furthermore, in carrying out case consultation, members of the research programme take a central role in documenting the analysis and outcome of the consultation. Thus the centre seems to do much of the work that might be expected of a committee, and in a way that is closely connected with clinical practice.[2] Various models of ethics support have been discussed at meetings of the Network for Clinical Ethics Consultation. [AG Klinische Ethik-Konsultation, for information please contact the author.] One of the most interesting programmes in clinical ethics in Germany is at the Teaching Hospital Gilead, Bielefeld. This programme, like the one in Freiburg, offers clinical ethics support without a clinical ethics committee, but on the grounds of developing special competencies.

2. Ethics consultation in the clinical setting—a case study

I will describe the approach to ethics case consultation taken by ZERM by giving the example of a real, but somewhat changed case. The patient is a man in his late seventies who has diffuse cerebral damage following heart surgery. He has clouding of consciousness and is unable to communicate. It is unclear whether there is a chance left for his consciousness and communication to recover.

The legal position in Germany with regard to patients unable to take part in management decisions is complex. Family members of a previously competent adult patient can only make treatment decisions if they have been formally authorised to do so in advance by the patient, or by a court or by both. In the absence of such authorisation, or of an advance directive the presumed wishes of the patient are relevant if there is any way of knowing them. Here, the relatives may play an important role in reporting from the patient's life. If this is not possible, then the patient's best interests should be pursued in the light of medical criteria.

PROCESS

Two ethics consultations took place. The first was prior to surgery and had been initiated by the cardiac surgeon. An ethicist met with the cardiac surgeon. The surgeon wanted to discuss the question of whether the cardiac surgery should be undertaken in the first place in the light of the critical health status of the patient. The outcome of that consultation was that surgery was in the patient's best interests although it was recognised that it might not be successful. Although the ethicist suggested involving the relatives directly, this suggestion was not acted upon and the relatives were simply informed of the decision by the doctor, as was learned later.

The second consultation was initiated a few weeks after surgery by the patient's closest relatives, who contacted the author. A consultation was set up for a few days later, and in the meantime a colleague prepared a summary of the history to help with the consultation. The relatives had written to the cardiac surgeon's medical director complaining that they thought the patient was not being cared for in the correct manner.

The participants in the consultation were: the attending cardiac surgeon; a nurse; three relatives of the patient; a close friend of the patient who was not a relative, and two ethicists. The consultation was initially chaired by the surgeon. He explained the management plan that had been drawn up and implemented and responded defensively to the letter from the relatives. In his view everything ought be done to maximise the chance of as good a recovery as possible. His position, he thought, was in accord with the recent guidelines, *Guidelines for Medical Aid in Dying*, issued by the German Medical Association in 1998.[3] According to these guidelines the therapeutic goal need no longer be towards cure if such a cure is no longer attainable. He did not think the time had yet come to give up the goal of cure. The atmosphere in the consultation was tense. A conflict between the surgeon and the relatives over the appropriateness of continuing to strive for cure was felt rather than articulated. The relatives had little opportunity to express their views.

ETHICS FOCUS

At this stage one of the ethicists intervened. She suggested that since this was specifically an ethics consultation, and one which had been requested by the relatives, it might be more appropriate for one of the ethicists to chair the meeting and to focus it more on the ethical issues. A more traditional clinical discussion could take place after the ethicists left, if that was what was wanted. Accordingly one of the ethicists took over the chairing of the meeting. She structured the meeting so as to allow each person first to share his or her view on the present situation, then to outline the factors in the past that seemed relevant, and the important next steps.

The surgeon's view was as summarised above. The relatives felt the patient's current state was unbearable for him. They felt the most important thing at this stage was that the patient should be allowed to die with dignity. They said they thought the patient would not want to be kept alive under the present circumstances. The ethicists focused on helping to clarify the relatives' concerns and the points of conflict between their views and those of the surgeon. They also explicitly raised the issue of the letter the relatives had written to the surgeon's medical director. The focus then shifted to the difficulties each side had in understanding and accepting the ethical attitudes of the other party. This led to increased understanding and respect for each others' motivations. By this stage the atmosphere had become much more cooperative and there was sufficient sharing of fundamental goals to aim towards a consensus.

The outcome of the consultation

The ethical arguments of the people involved were explicitly formulated and elaborated until a mutual understanding was achieved. Some of the medical misunderstandings of the relatives were corrected. A consensus was reached that one of the relatives should formally be appointed, by a court, as legal guardian, able to act as substitute decision maker on behalf of the patient. This enabled more focused communication between the doctors and relatives, and allowed this relative to become involved fully in decision making. The formal appointment of a relative as legal guardian also allowed for this person to be fully involved as a partner in decision making.

It was also agreed that the therapeutic goal should be conceived in terms of palliative rather than curative care. It was explicitly elaborated that this change was accepted in the light of the German *Guidelines for Medical Aid in Dying*.[3] The importance to the relatives of dying with dignity was recognised and accepted by the cardiac surgeon.

3. Lessons for the future—competencies

Reaching consensus about limitations of treatment with patients unable to express their own views may be difficult in the German context. Our experience suggests that ethics consultation can be valuable to health professionals, patients and their families in a number of ways. First, ethicists can introduce ways

of analysing the ethical aspects of patient care that are helpful in coming to consensus. Second, ethicists can provide some information about relevant codes and the law. Third, the language of ethics can serve as a common language in which conflicting viewpoints can be discussed.

But, effective case consultation requires additional professional skills. Such consultation often takes place when there is conflict between different people or groups of people. Ethicists may need to be able to be effective in conflict mediation, psychological counselling and, occasionally, crisis intervention.[1 4 5]

Here are five conclusions from my experience with ethics case consultation:

1) Take sensitive fields such as end-of-life issues seriously even when colleagues try to avoid dealing with them.
2) Communicate with, and help, others to find ways to express their ethical values and goals.
3) Create a context for patients and relatives to prepare for ethical challenges such as end-of-life care planning.
4) Try to develop or benefit from ethics consultation; it may be helpful for conflict resolution.
5) Collaborate in specific clinical ethics research programmes if possible; they contribute to our knowledge and help to improve clinical ethics support services.

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What triggers requests for ethics consultations?

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Abstract

Objectives—*While clinical practice is complicated by many ethical dilemmas, clinicians do not often request ethics consultations. We therefore investigated what triggers clinicians' requests for ethics consultation.*
Design—*Cross-sectional telephone survey.*
Setting—*Internal medicine practices throughout the United States.*
Participants—*Randomly selected physicians practising in internal medicine, oncology and critical care.*
Main measurements—*Socio-demographic characteristics, training in medicine and ethics, and practice characteristics; types of ethical problems that prompt requests for consultation, and factors triggering consultation requests.*
Results—*One hundred and ninety of 344 responding physicians (55%) reported requesting ethics consultations. Physicians most commonly reported requesting ethics consultations for ethical dilemmas related to end-of-life decision making, patient autonomy issues, and conflict. The most common triggers that led to consultation requests were: 1) wanting help resolving a conflict; 2) wanting assistance interacting with a difficult family, patient, or surrogate; 3) wanting help making a decision or planning care, and 4) emotional triggers. Physicians who were ethnically in the minority, practised in communities under 500,000 population, or who were trained in the US were more likely to request consultations prompted by conflict.*
Conclusions—*Conflicts and other emotionally charged concerns trigger consultation requests more commonly than other cognitively based concerns. Ethicists need to be prepared to mediate conflicts and handle sometimes difficult emotional situations when consulting. The data suggest that ethics consultants might serve clinicians well by consulting on a more proactive basis to avoid conflicts and by educating clinicians to develop mediation skills.*

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Keywords: Ethics consultation; resolution of ethical problems; ethical conflicts

Introduction

Increasingly, health care facilities are establishing ethics consultation services composed of experts who apply ethical reasoning to dilemmas encountered in medical practice.[1] Yet, in spite of the breadth and complexity of ethical dilemmas in medicine, clinicians have been slow to use these specialised services.

One possible reason for this is that an ethical quandary as such does not prompt requests for a consultation. We hypothesise that consultation requests are usually triggered by concrete factors, such as the need to handle a difficult situation or resolve a conflict, rather than by a desire to use or apply ethical reasoning. An awareness of the factors that are associated with requests for consultations will enable consultants more effectively to address the ethical problems faced by clinicians, and will facilitate the integration of consultation services into the clinical setting.

We report a sub-analysis of a survey of internists in the United States in order to determine the factors that trigger requests for ethics consultations.

Methods

STUDY POPULATION

A national sample of 600 internists was randomly selected from the *American Medical Association Master List of Physicians and Medical Students for Mailing Purposes*. We randomly sampled 200 cases from each of: critical care and pulmonary critical care medicine (n=2,334); medical oncology and haematology/oncology (n=6,536); and internists, not otherwise specified (n=95,885). This selection strategy captured both physicians who serve patients with life-threatening illnesses and physicians serving more general patient populations. Following randomisation, physicians were deemed ineligible for this study only if they reported that they had not been in practice for a year or if they spent less than 20% of their time in direct patient care. Those physicians who acknowledged ever requesting an ethics consultation comprise the sample reported here. Results regarding those physicians who did not request a consultation will be reported elsewhere.

QUESTIONNAIRE

Telephone interviews were conducted between October 1999 and March 2000 by trained interviewers from the Center for Survey Research at the University of Massachusetts, Boston. The interviews took an average of 26 minutes to complete and included both closed and open-ended items.

The questionnaire used during the telephone interviews was composed of four sections: 1) questions regarding the types of ethical dilemmas faced at the physician's predominant practice site; 2) the strategies and resources used to address ethical dilemmas; 3) the need for, use of, and satisfaction with ethics consultation services, and 4) items regarding demographic data, education, practice characteristics and experience with medical ethics (the questionnaire is available upon request).

Participation was voluntary. The study was reviewed and exempted from institutional review board review by the Office of Human Subject Research at the National Institutes of Health.

ANALYSIS

From the broader survey, the following open-ended questions were analysed for the purposes of this report:

1. What was the situation that led to the most recent request [for an ethics consultation in which you participated]?
2. Was there something specific that triggered the request for an ethics consultation? If yes, please specify.

Verbatim responses were analysed using a coding scheme that was developed by a consensus process. Investigators reviewed a 20% random sample of responses to identify major themes and to establish coding schemes for each of the two questions. The coding scheme developed for question 1 included general categories of ethical dilemmas and issues (table 1). The coding scheme developed for question 2 identified triggers that lead physicians to request a consult (table 2). Two investigators (GD and LS) separately coded the responses. Because the description of the trigger sometimes involved multiple elements, two codes were assigned to some responses. Three investigators (GD, LS, and MD) discussed coding disagreements until consensus was achieved. The coded data was then reviewed for completeness and consistency within the final categories.

After assigning codes to the open-ended responses, we analysed the data using simple descriptive statistics, calculating the frequency with which each response code appeared for each question.

The triggers listed in table 2 were sorted into two categories. Category 1 responses included those in which conflict or distress on the part of some party motivated the consultation request. It includes the triggers that were labelled 1) wanting help resolving a conflict, 2) wanting help interacting with a difficult patient or family, and 3) an emotional trigger. Category 2 triggers included the remaining codes that were considered to involve process-oriented, more cognitively based, or introspective reasons for requesting a consultation. Univariate and multivariate logistic regression were performed to determine which factors predict whether an ethics consultation was triggered by conflict or distress (category 1) or by more introspective reasons (category 2). Only one responding physician gave a response that involved codes in both categories. This record was excluded from the analysis. Responses indicating that a consultation was prompted by someone other than the physician, responses indicating the physician could not recall the situation, and uninterpretable responses were excluded from analysis. A total of 177 physician responses were analysed, 93% of the total.

Table 1 Recent ethical dilemmas that have led to ethics consultation requests

Dilemma	*N*	*%*
End-of-life issues (futility, withdrawal of life-sustaining treatment, etc)	154	74.0
Patient autonomy (decisions made on behalf of patient)	119	57.2
Conflict (between or among involved persons)	82	39.4
Other (includes genetics, abortion, substance abuse)	13	6.3
Religious and cultural issues	11	5.3
Professional conduct (questions about possible misconduct)	9	4.3
Truth-telling and confidentiality	6	3.0
Justice issues (insurance, managed care and fair access to health care	2	1.0
Beneficence (the best way to promote the patient's welfare)	2	1.0

Note: Results add up to more than 100% because up to three category codes were applied to responses. Responses of "don't know," "no," (which comprised 5%) and uninterpretable responses (0.5%) were omitted from the table.

Table 2 Factors that trigger ethics consultation requests

Trigger	*N*	*%*
Category 1		
Wants help resolving a conflict	66	34.6
Wants help interacting with a difficult patient or family	19	10.0
Has emotional trigger	17	8.9
Category 2		
Wants help in making a decision or planning care	25	13.1
Has regulatory/legal/administrative reasons	15	7.9
Repeats previously described ethical problem	12	6.3
Wants help thinking through ethical issues	8	4.2
Someone else requested the ethics consultation	7	3.7
Wants assistance with communication	6	3.1
Has concern about the fairness of a decision process or procedural issue	4	2.1
Anticipates a bad situation	2	1.1

Note: Results add up to more than 100% because 2 category codes were applied to some responses. Responses of "don't remember," (which comprised 4.7%), uninterpretable responses (02.6%), and other explanations (2.6%) were omitted from the table.

Results

RESPONDENT CHARACTERISTICS

Of the 600 physicians selected from the AMA files, 537 met eligibility criteria. Of those, 344 (64%) completed an interview, while 76 (14%) actively refused. That left 117 (22%) who neither completed an interview nor actively refused by the end of the field period. Roughly half of the 117 in this latter group had been contacted on several occasions to provide opportunities for participation and the other half could not be located. The distribution among the physicians completing the survey

Table 3 Physician characteristics

	Sampled Physicians	
	N	%
Gender		
Male	150	78.9
Female	40	21.0
Religion		
Protestant	60	32.2
Catholic including Greek Orthodox	54	29.0
Jewish	27	14.5
Muslim	6	3.2
Hindu	10	5.3
Buddhist	2	1.0
No Religious affiliation, Atheist, Agnostic	25	13.4
Other	2	1.0
Race		
White	151	79.4
Non-white	39	20.5
Additional degrees held		
Yes	36	18.9
No	154	81.0
Country of birth		
USA	129	68.6
Other in North America, Aust, NZ	3	1.6
Central/South America, Carribean	12	6.3
Europe	9	4.7
China/Taiwan	4	2.1
India/Pakistan/Bangladesh	13	6.9
Other Asia/Pacific rim	6	3.1
Africa	4	2.1
Middle East	8	4.2
Medical training outside United States		
All	5	2.6
Part	43	22.7
None	141	74.6

Table 4 Practice characteristics

	Sampled Physicians	
	N	%
Number of People within 20 Mile Radius		
Fewer than 50 000	10	5.35
50 to 100 000	28	14.97
100 to 250 000	33	17.65
250 to 500 000	23	12.30
More than 500 000	93	49.73
Practice Type		
Solo	13	6.88
Single/multiple specialty group	117	61.90
Academic/military/general	47	24.87
Other	12	6.35
Medical School Faculty		
Yes	95	50.00
No	95	50.00
Percent Covered by Managed Care		
Up to 30%	94	56.63
More than 30%	72	43.37
Hospital Public or Private		
Public	88	47.06
Private	99	52.94
For or Not For Profit		
For profit	35	19.02
Not for profit	149	80.98
Teaching Center with University		
Yes	138	73.02
No	51	26.98
Number of Beds		
300 or less	75	39.68
More than 300	114	60.32

included 119 from the critical care/pulmonary stratum, 130 from the oncology/haematology stratum, and 95 from the stratum of internists without specified subspecialty.

One hundred and ninety of the 344 responding physicians in the study reported requesting consultations. This group of 190 physicians was predominantly male (79%) and white (79%) (table 3). The primary religious affiliations were Protestant (32%) and Catholic (29%). Nearly 39% of respondents had attended a bioethics conference, and one fourth had been a member of a clinical ethics committee (not shown).

Physicians were predominantly in single or multispecialty groups, and the majority were in private practices (table 4). Half of the respondents practised in densely populated communities (more than 500,000 people within a 20-mile radius), and half had an affiliation with a medical school.

DILEMMAS LEADING TO CONSULTATION REQUESTS

When asked about the most recent situation that had led to an ethics consultation (question 1), physicians most frequently reported dilemmas related to end-of-life care, patient autonomy, and conflicts between or among involved persons (table 1). Religious and cultural issues, issues of professional conduct, truth-telling and confidentiality, justice issues (primarily about access to health care) and questions of beneficence where physicians requested consultations to consider what was best for a patient, were less commonly reported. Some physicians cited other dilemmas such as questions regarding abortion, genetic testing, and substance abuse. Sixty-five per cent were assigned more than one code. For example when a physician described a situation involving a conflict about how to handle a patient's request for care at the end of life this response was assigned three codes (end-of-life issues, patient autonomy and conflict).

TRIGGERS OF CONSULTATION REQUESTS

We present samples of verbatim responses to illustrate the various types of triggers. Following are examples of category 1 responses—the more conflict-laden or emotionally charged triggers—reported in 57% of analysed responses.

Resolving conflicts

About one-third of responses were initiated to get help resolving a conflict. Many physicians described their frustration when conflicts led to ethics consultations: "[There was] an impasse between all of us . . . we couldn't agree, it came to a standoff". According to another respondent: "It had just gotten very difficult dealing with the family, and I naively thought that bringing in another party might help". Conflicts often arose when a patient was near the end of life, and emotions were charged: "[The problem was] saying she was brain-

dead with no hope, and having the husband say 'you're wrong'".

Interacting with a 'difficult' patient or family member
Similarly, 10% of responses described a request for help when interacting with a difficult patient, family, or surrogate. One respondent observed: "The surrogate was unreasonable and not consistent with what the patient said". Another felt "there was indecision and squabbling among the family", and a third was frustrated with the "[a]ntagonism between the family and the operating surgeon".

Emotional trigger
Almost 9% of responses referred to an emotional trigger such as intimidation, fear, frustration, feeling at a loss about what to do, feeling uncomfortable about a situation, or encountering patient pain or suffering. A typical response began: "A man was in arrest on the ventilator. I went into the ICU and saw him on the machine. I thought this was cruel; we should not do this to the patient. I wanted to ignore the wife's wishes to do futile care, that was why we requested the consult". As with conflicts, emotional triggers also typically occurred around the end of life: "[It was my] overwhelming frustration with the excessive use of medical resources and the pain caused to the patient, [it was] a painful death instead of a dignified death".

Following are examples of category 2 responses—the more process-oriented, cognitively based or introspective triggers—which comprised 43% of analysed responses.

Making a clinical decision or planning care
Of these, 13.1% of physicians requested a consultation when they needed to make a clinical decision or plan patient care: "Both the ethics consultation and legal consultation were used, and then the decision was whether you could legally and ethically take this patient's kidneys and use them in an operation". Another physician felt that: "The patient's illness required [the] direction of a decision". In some responses, there was no available decision maker for the patient. "It was the fact that there was no immediate family member there—someone acting as power of attorney–and we felt we wanted someone else with that decision", and: "The patient's HIV status was unknown to the family and the patient was unable to make decisions".

Legal or regulatory reasons
Physicians had legal or regulatory reasons for requesting the consultation in 7.9% of responses. "There was a new member of the ethics team and she knew a lot of the state laws and federal laws and we wanted to talk to her." Fear of liability sometimes triggered a request: "A family member . . . said they would sue the hospital if life support was discontinued." Administrative or regulatory reasons were often involved: "They wanted to use non-approved drugs."

Thinking through ethical issues
In 4.2% of responses, physicians needed help working through the ethical issues involved. One physician wanted "[t]o clarify what is appropriate and what is not appropriate with the dying. I wanted someone from outside to discuss this with the family". Another was struggling with the "...question as to whether it was ethical for a distant relative to make that decision".

Fostering communication
Less frequently cited reasons included a desire for assistance with communication (3.7%). One respondent related that, in requesting the consultation: "My goal was to increase the family members' understanding and acceptance of the patient's condition". Another expressed his "... concern that [he] didn't understand all the dynamics between all the family members".

Fairness and justice
A few (2.1%), were concerned about the fairness of some decision or decision making process, such as: "The patient was being prevented from getting the care needed" or, "Nursing staff were hearing things from the family—[they] didn't think the doctors were honouring what the patient wished".

Anticipation of a bad situation
Respondents called for consultations in 1.1% of responses because they expected a bad situation. One had: "[a] feeling that it was going to be long term with no curative treatment".

Other responses
Other factors were cited by physicians in 2.6% of responses. In 6.3% of responses, the physician referred back to the initial description of the ethical dilemma, without offering additional insight into the motivation for involving an ethicist. In a further 3.6% of responses, the physician indicated that someone else asked for the consultation.

ASSOCIATION BETWEEN RESPONDENT CHARACTERISTICS AND TRIGGERS

Univariate and multivariate analyses were utilised to determine what factors may be associated with a greater likelihood of requesting an ethics consultation triggered by conflict or other distressful situation. In the univariate analyses, no factors were significant at the .05 level (table 5). Moderately significant factors ($p<.15$) including ethnicity of the physician (white v non-white; $p=.08$), physicians who had all their training in the US ($p=.12$); community size (<500,000 vs >500,000; $p=.06$), and number of bioethics rounds attended (<5 vs >5; $p=.09$) were included in a multivariate logistic regression model.

The results of the multivariate model (table 6) were the following: physicians of white race were less likely to have requested an ethics consultation in response to a conflict, a difficult patient or family, or some other emotionally charged issue.

Table 5 Results of univariate logistic regressions on type of trigger response

Term	*A*	*B*	*OR**	*Prob >P²*
Gender	Male	Female	1.45	0.306
Years in practice†	20 or more	Less than 10	1	0.997
Race/ethnicity	**White**	**Other**	**0.49**	**0.08**
Community size (within 20 miles)	**>500 000**	**≤500 000**	**0.55**	**0.056**
Additional degrees	Yes	No	0.88	0.746
Country of birth	USA	Other	1.3	0.412
Training in USA	**All of it**	**Not all of it**	**1.74**	**0.119**
Practice type	Solo/group practice	University/military/Hospital/resident	0.98	0.953
Medical school faculty	Yes	No	1.23	0.501
% reimbursement from managed care	>30%	≤30%	1.3	0.428
Private or public hospital	Private	Public	0.93	0.815
Profit or non-for-profit	Profit	Not-for-profit	0.99	0.982
Teaching center affiliated	Yes	No	0.89	0.723
Patient beds	>300	<300	1.23	0.517
Bioethics rounds attended	**6 or more**	**5 or less**	**0.57**	**0.093**
Attended bioethics conference	Yes	No	0.91	0.77
Ever member of bioethics committee	Yes	No	0.97	0.931
Ties with current members of ethics committee	Yes	No	1	0.997
Recent situation included end-of-life issues	Yes	No	0.92	0.828

Moderately significant terms are in **bold**.
*Odds ratios >1 indicate that physicians in group A were more likely to request an ethics consultation for conflict or distress reasons.
†Physicians in the 10–19 year group were excluded from this analysis.

Table 6 Results of multivariate logistic regression on type of trigger response (using terms significant in the univariate analyses)

Term	*A*	*B*	*OR**	*Prob >P²*
Intercept				0.060
Race/ethnicity	**White**	**Other**	**0.32**	**0.016**
Community size (within 20 miles)	>500 000	<500 000	0.57	0.072
Training in USA	**All of it**	**Not all of it**	**2.30**	**0.038**

Significant terms are in **bold**.
*Odds ratios >1 indicate that physicians in group A were more likely to request an ethics consultation for conflict or distress reasons.

(OR=0.32, p=.016). Physicians whose training took place solely in the US were more likely to have requested an ethics consultation in response to a conflict, a difficult patient or family, or some other emotionally charged issue (OR=2.30, p=.038). To a somewhat lesser degree, physicians working in a community where less than 500,000 people lived within a 20-mile radius of their main practice were more likely to have requested an ethics consultation in response to a conflict, a difficult patient or family, or some other emotionally charged issue. (OR=0.57, p=.072).

Discussion

This analysis indicates that the triggers that prompt ethics consultations differ in most cases from a straightforward request for a description and analysis of the ethical issues at hand. The most common factors that triggered physicians' requests for ethics consultation were 1) wanting help resolving a conflict; 2) wanting assistance interacting with a difficult family, patient, or surrogate; 3) wanting help making a decision or planning care, and 4) emotional triggers. Logistical analysis indicates that physicians who are ethnically in the minority were more likely to ask for a consultation to deal with conflicts, while physicians who were trained in the United States and those from small communities were also moderately more inclined to call for consultations in response to emotionally charged situations.

Some limitations of the study must be recognised. The nature of the data collection, which involves self report, precludes our ability to examine the relationship between self reported and actual behaviour in requesting ethics consultations. In addition, all respondents were physicians, qualified in internal medicine, and predominantly specialising in oncology and critical care. Other physicians, and other health care practitioners, were not surveyed.

In this report, we describe factors that trigger clinicians to request ethics consultation and have not judged their reasonableness. However, we note that some triggers, such as the need for legal advice, are often inappropriate because ethicists are typically not legal experts.

Over half the consultation requests were triggered by a need for help in responding to conflicts, difficult patients or families, or other emotionally charged situations. This finding suggests a shift in emphasis for ethics consultation from the way it has sometimes been conceived. La Puma and Schiedermayer suggested a decade ago that the ethics consultant requires the skills of: identifying and analysing ethical problems; using and modelling reasonable clinical judgment; communicating with and educating the clinical team, patient and family; negotiating and facilitating negotiation, and teaching and assisting in problem resolution.[2] Similar descriptions of the skills required for ethics consultation have been offered by a number of writers

including Fletcher and Siegler,[3] Moreno,[4] Andre,[5] and the American Society of Bioethics and Humanities in their *Core Competencies for Health Care Ethics Consultation*.[6] The data presented here confirm that, in general, these skills are indeed the ones that clinicians are requesting. However, while identifying and analysing ethical dilemmas are important skills, these findings suggest there should also be a strong emphasis on the skills of conflict or even crisis resolution, and on handling emotionally charged situations.

The data suggest further that in offering their skills, ethicists must be adept at identifying the particular needs of the clinician. The ethicist must do more than grasp the clinical situation and analyse it from an ethical standpoint. The factors that trigger a consultation request must be clearly identified so they can be properly addressed. The data also suggest that the consultant should help the clinician move beyond the precipitating concern to an analysis that helps the clinician learn from the situation and develop skills to address the same sort of situation in the future. While education has long been seen as an important element of ethics consultation,[7] it appears that such teaching should ideally include proficiency in dealing with discord in clinical relationships.

Several authors have recently focused on the role of the ethicist as mediator. Walker has commended the shift toward this role as a positive philosophical shift "from thinking about morality as a theory applied to cases, to thinking about morality as a medium of progressive acknowledgment and adjustment among people in (or in search of) a common and habitable moral world".[8] This view is furthered by a growing contingent of ethicists who, drawing from the theories of Habermas, see consensus building not only as an intermediate service for physicians, but also as a means to the end of building defensible moral theory.[9]

The frequency with which physicians report calling upon ethics consultants to mediate conflict also points to the value of having ethicists involved at an early stage in particularly difficult medical situations. Early involvement might reduce conflicts and thus be helpful to patients, their families and clinicians.[10] Since conflicts are difficult to resolve once they have developed, early communication may reduce conflict.[11]

We note that conflicts were a more prevalent concern for minority physicians and physicians fully trained in the United States. We are cautious in asserting the validity of this finding because of the small number of minority physicians in the study. We can only speculate about possible reasons for the observation. Perhaps physicians in these groups either experience or perceive more conflicts. Physicians who represent minorities may experience more conflict-laden encounters with patients. Their patients may differ culturally from them and they may have disagreements as a result of this. They and their patients may face greater disadvantages that lead to greater conflicts.

As health care organisations review existing services, or look to establish ethics consultation services and hire or train ethics consultants, it is desirable for them to appreciate the motivations of clinicians who will seek these services.[12] As physicians are prompted to seek consultation to resolve conflicts and defuse emotionally charged situations, the ethicist will often have the intricate task of mediating a conflict-laden situation, while at the same time offering ethical analysis to shed light on the dilemmas at hand.

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Electronic communication in ethics committees: experience and challenges

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Abstract

Experience with electronic communication in ethics committees at two hospitals is reviewed and discussed. A listserver of ethics committee members transmitted a synopsis of the ethics consultation shortly after the consultation was initiated. Committee comments were sometimes incorporated into the recommendations. This input proved to be most useful in unusual cases where additional, diverse inputs were informative. Efforts to ensure confidentiality are vital to this approach. They include not naming the patient in the e-mail, requiring a password for access to the listserver, and possibly encryption. How this electronic communication process alters group interactions in ethics committees is a fruitful area for future investigation.

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Keywords: Clinical ethics committees; electronic communication; confidentiality

Introduction

The core process for a health care organisation's ethics committee is creating informed dialogue on the ethical implications of clinical care decisions and organisational policies. While the policy issues can be addressed at regularly scheduled meetings, ethical interpretations concerning specific patient care matters require prompt, often urgent, response. While this is commonly completed in a successful fashion by the ethics consultant or ethics consultation team, there arise a number of cases where the wider input of the ethics committee would provide additional insights and benefits. In the past some institutions' committees responded by calling urgent ad hoc meetings that were often difficult to convene at short notice. Moreover, when this occurs, it often diverts committee members from other responsibilities.

The advent of electronic communication processes such as electronic mail, listservers, and online discussion boards, creates the opportunity to conduct "virtual ethics committee meetings" whereby information can be exchanged and interpretations of specific ethical case dilemmas put forward. This article discusses how that process can occur, relates our experience with such processes at two hospitals in our medical centre and considers some of the ethical and operational issues raised by such an approach.

Ethics committees are oriented toward developing consensus on clinical bioethical dilemmas.[1] This reflects a pragmatic approach and is commonly associated with a consultation model that is instructional and communicative.[2] Even traditional medical consultations contain some value judgments.[3] However, since ethics consultation requires a prompt and individualised response, it is rare to get the full ethics committee's input prospectively on consultations.

We suggest it is generally preferable that such prospective input be made so that a diversity of views can be available to the ethics consultant or ethics consultation team when conducting the consultation. This is particularly valuable when there is a single ethics consultant responding to the request for a consultation. Moreover it lends greater institutional authority to the ethics consultation when others have been informed of and inform the consultation. Electronic computer-based communications make this possible now in a way not previously possible.

Electronic communication has a variety of health care applications today, and these are expanding rapidly. Electronic mail communications are occurring between patient and physician in individual medical practices, in internet-based websites, and between physicians in medical consultation.[4-5] It is natural then to enquire whether electronic communication can enhance the ethical consultation process since communication and consensus are so much at the core of ethics consultation.

Experience with electronic communications within ethics committees

VA HOSPITAL EXPERIENCE

Experience at the Westside Division of the VA Chicago Healthcare System's ethics advisory committee with electronic communication began in 1996 and was assessed until January 1998.[6] Requests for ethics consultations were answered on the hospital computer system in the same fasion as requests for clinical consultations. The consultations were formulated and forwarded by e-mail to twelve committee members, comprising seven physicians, one social worker, one patient representative, a chaplain and two nurses. The average time to respond to a consultation request was 8.9 hours with 63% of the requests responded to within 1.5 hours. There was an average of 9.1±11.5 electronic mail responses by committee members to each

consultation. This includes some multiple responses from the same member. The major issues addressed were questions or conflicts about withdrawal of therapy or do-not-resuscitate orders (36%); patient capacity to consent (26%); surrogate/patient-physician disagreement about treatment (20%); resource utilisation 12%, and confidentiality (4%).

The ethics consultant at this institution found this process lowered the barrier to timely input of other committee members, shifting the deliberative component of the ethics consultation in the direction of committee consensus and away from the individual consultant. This increased the likelihood that the consultant's recommendations were consonant with the communal values of that institution.

EXPERIENCE AT THE UNIVERSITY HOSPITAL

University of Illinois at Chicago Hospital instituted concurrent electronic review of the ethics case consultations by the ethics consultation service team. This review allowed all team members access to information about the consultation as provided by the primary consultant by a listserver through the medical centre electronic mail system. Principally one author (LAS) provided the consultation service during that time with input from other members of the consultation team. Summaries of the consultations were posted to the listserver, which included four physicians, one lawyer, one chaplain and one philosopher.

In a nine-month period, 39 consultations were performed. There were 68 responses averaging 1.7 response per consultation, ranging from zero to nine per case. Routine cases stimulated low response while controversial ones elicited the greatest response. Response time ranged from less than one hour to two days. The most perplexing cases generally received the most prompt responses. Electronic responses modified the consultant's activity and recommendations in several cases, especially those dealing with particularly uncommon problems.

ELECTRONIC ACCESSING PROCEDURES

In addition to using an e-mail listserver, a commercially available software program for discussion posting and commentary can be used. We are now converting to this methodology which will permit archiving, further limit access to parties with specific access codes, and permit access from any remote internet site—meaning parties can participate even if they are out of town at the time. The discussion board bars access to any directory or search mechanism and requires a password for access. All recorded attempts to access the site are recorded by user and time, even failed attempts. The management of such a site involves monitoring access and archiving completed cases. There has been no security breach in our experience with either system.

Discussion

DYNAMICS

Ethics committee meetings are usually small group meetings that are subject to the social dynamics of small group interaction as described by Jonathan Moreno.[7] Electronic communication can be expected to differ from the typical small group interaction by lacking communication via facial expression, intonation, body language, and other nonverbal content to such interaction. Although this difference has yet to be extensively studied, some observations have been made regarding internet group communication that may be relevant. Neil Postman observes that online groups do not develop a sense of reciprocal obligation.[8] This shortcoming can be overcome in our application by the continuation of regular actual ethics committee meetings, which preserve the sense of reciprocal obligation. The moral effects of online communication remain largely unstudied at this time.[9] However, Kiesler, Siegel and McGuire found that groups using e-mails were more likely to make shifts in decisions than in face-to-face encounters, possibly because the absence of face-to-face encounters minimised the influence of a group leader and other normative influences.[10]

Electronic communication among ethics committee members offers the opportunity for prospective review of consultation, a process made feasible by such a rapid communication device. Such an approach was inconceivable a few years ago.[11]

Ad hoc meetings usually take several days to arrange and vital time may pass without the needed inputs. While in the more routine cases this did not always change recommendations, being able to work through electronic communication was found to be particularly valuable in the unusual cases with atypical features. Trends in consultation can be monitored on the listserver and areas needing educational and quality initiatives may be more readily identified than during the scheduled meetings alone.

Electronic communication should be viewed as supplementary to regular committee meetings and by no means replaces them. Moreover there may still be occasions, albeit less frequently, where ad hoc meetings of the committee may still be needed.

CONFIDENTIALITY AND ENCRYPTION

Spielberg notes that electronic communication between physician and patients is increasing and altering the relationship, much as the advent of the telephone did in an earlier era.[12] She notes the need to obtain informed consent, encrypt e-mails to maintain confidentiality, and develop guidelines on the usage of e-mail.

The American Medical Informatics Association has a guideline for e-mail communication between patient and physician. It calls for informing patients of what type of information will be communicated by e-mail and notes that encryption for this purpose is limited by patients not having the encryption software.[13]

The situation regarding ethics committees differs from that of communication between patient and physician. No consent is needed for committee members and ethics consultants to communicate with one another. However, caution regarding confidentiality is a major concern in ethics case discussions. When committee e-mail communications are not encrypted, we encourage various practices that protect confidentiality. First the committee e-mails do not mention the patient by name. Second, committee members are urged not to leave e-mails describing ethics consultations on computer screens unattended. Third, they are asked to limit the access to their e-mails by other parties. Use of an on line discussion board, as noted earlier, permits access only to identified parties and records access history.

PRACTICAL ASPECTS

The potential for misunderstanding exists, given the one-dimensional nature of e-mail communication.[14] This can be minimised by simultaneous, interactive online connections but some limitation in communication via electronic media remains. Moreover the affective and normative aspects of the communication may be reduced by the lack of face-to-face encounters. Therefore we conclude that this type of communication should supplement not replace actual meetings of the ethics committee.

Reluctance to engage in e-communications may vary by group or individual. The duration of the group's existence and its interaction may influence willingness to engage in electronic communication. Members' level of trust in one another may be another factor because a record of comments may persist. Frequency of checking one's e-mail also could influence response rate and time.

Electronic communication permits access to the information at remote sites throughout the globe. It also keeps a record of the ideas exchanged, which means trends can be detected in consultations and problem areas identified: these can then become a focus of educational activity.

THEORETICAL CONSIDERATIONS

As electronic communication involves parties in new ways of communicating facts, values and judgments, it is important that we remain cognisant of McLuhan's adage that the "medium is the message".[15] The process of e-mail communication could potentially modify the nature of decision making itself. How e-mail committee meetings will influence consensus building and ethical judgments remains to be assessed and comprehensively analysed. It is easy to imagine that its effects will be substantial. Continuing to have regularly scheduled ethics committee meetings, however, dampens the effect.

As we use and analyse this new communication technology, we need to be aware of the effects of the technologies themselves as well as of the information they disseminate so rapidly. In addition to confidentiality concerns, the professional roles of ethics consultants and ethics committees can be affected by the technologies. Reasoned study and analysis of these technological developments will be important to assure that their implementation is beneficial as well as effective. This latest communication advance promises to enliven ethical debate, contributing both a new process that speeds communication and a new subject matter for deliberation.

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What is the role of clinical ethics support in the era of e-medicine?

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Abstract

The internet is becoming increasingly important in health care practice. The number of health-related web sites is rising exponentially as people seek health-related information and services to supplement traditional sources, such as their local doctor, friends, or family. The development of e-medicine poses important ethical challenges, both for health professionals and for those who provide clinical ethics support for them. This paper describes some of these challenges and explores some of the ways in which those who provide clinical ethics support might respond creatively to them. By offering ways of responding to such challenges, both electronically and face-to-face, the providers of clinical ethics support can show themselves to be an indispensable part of good quality health care provision

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Keywords: e-medicine; clinical ethics; internet; quality of information; bioethics

Introduction

Fujitsu-Siemens project that by 2002 there will be around 380 million users of the internet worldwide. There are currently 2.1 billion indexible web pages and the total number of pages is thought to be in the tens of billions.[1] The web is growing at a rate of seven million pages a day.[1]

Health care is one of the most popular reasons for accessing the internet. Increasingly, people are seeking health-related information and services to supplement (and perhaps to replace) traditional sources such as discussion with their local doctor, friends, or family. There are currently between 15,000 and 100,000 indexible health-related sites based in the United Kingdom. In 1999, health-related sites were visited by 30 million people from the United Kingdom, and it is estimated that this figure will have risen to 50 million in 2000 [personal communication, Tom Wilkie, 2000].

The changes being brought about by the development of the internet and other digital technologies are not, however, merely quantitative. Their impact inevitably has an important qualitative dimension, changing the way in which we understand ourselves and our health.[2] A wide range of interrelated technological developments is going to contribute further to this process of qualitative change: the impending merger of digital television and personal computers, and the growth in the power and integration of mobile points of access (WAP phones, palmtops and so on) will be important factors. In the field of health care, we will soon carry "smart cards" on which personal health care information will be recorded for easy access in emergencies (CD versions of something like this exist already). Perhaps too we will wear smart body-monitors which will record our health state and remind us of our nutritional intake requirements.[3] Perhaps these will be linked to the local hospital or to the local supermarket checkout, or to the gym.

What are the implications of the growth in e-medicine for clinical ethics? In this paper we describe some of the potential challenges and opportunities offered to clinical ethics support by such developments.

Challenges

(I) ACCESS TO INFORMATION

Traditionally, nominated health professionals have been the only, or at least the most powerful, "gateways" to health care information. This has already changed to some extent with the growth of consumer groups, patient support networks and popular publications focusing on health matters. Nevertheless, the continued growth of e-medicine is set to change this in ways unimaginable even five or ten years ago. With the emergence of a variety of both official and unofficial online sources of information available globally health-related information will no longer respect boundaries, other than those between people who have access to the internet and those who do not. The internet offers immediacy of communication, of information and of the internetworking of people, combined with the near impossibility of regulation or control of information flows.

Access to information is in itself clearly insufficient, however, for good judgment. More information does not equal better information. A key challenge for the future will be finding ways to enable consumers, and indeed health professionals, to tell the difference between good information and bad. A study by American gastroenterologists found that one in ten of the health-related sites in the field offered unproven treatments.[4]

The porosity of borders to information must inevitably lead to a weakening of policy-making power and the power to regulate and to maintain standards. Moreover, much of the information available to the public and to health professionals will be provided by pharmaceutical companies or by those, such as patient support groups, who are

attempting to exert pressure in order to bring a drug to the market. What will be the role of those who provide clinical ethics support in this context?

(II) ACCESS TO TREATMENTS

People will increasingly spend their discretionary income on health care in their own way. This may involve purchasing treatments or genetic tests over the internet or it may involve travelling for treatment they have learned about on the web. If a treatment is not available in their jurisdiction people will go elsewhere to find it.[5] This need not only involve expensive high-tech treatments—a more everyday example might be a woman from a country where termination or the "morning after" pill is banned on religious grounds who uses the internet to gain access to drugs through the post, or to information (including travel instructions) about a centre in another jurisdiction willing to carry out the procedure.

One possible consequence of the availability over the internet of drugs taken without supervision may be an increase in the number of people turning up in accident and emergency departments having used unlicensed drugs or having used drugs inappropriately. Who will be liable for the misuse or mis-selling of treatments if a drug is bought from a drug company, or if clinical advice is given over the internet by a clinician in a distant country? This raises important questions about the role of nationally funded health services and about the ability of finance ministries to manage health care spending. But it also raises important questions about confidentiality and clinical responsibility. One implication is likely to be that those who provide clinical ethics support in different national health trusts in the UK, or even in different countries, are going to have to find new ways of working together—perhaps using the internet.

A particularly interesting cluster of ethical questions may also begin to arise out of the ever closer relationship between clinical practice and research. The fact that, increasingly, the public will be likely to have electronic access to information about the progress of drug trials before they are completed, for example, may lead them to demand to be allowed to be research subjects in order to get access to new treatments. Or they may demand information about untested and unregulated and unregistered drugs. How will ethics committees (both clinical and research) respond to such demands? Clinical and research ethics committees will have to work out ways of working together.

(III) COMMERCIALISATION

Direct to consumer advertising (DTCA) is an inevitable consequence of the development of the web. Even though DTCA is banned in some jurisdictions, web sites from around the world containing it are accessible, as are the home pages of pharmaceutical companies. This means that the relationship between pharmaceutical companies and the public is set to become increasingly unmediated. One advantage of this may be that such companies will become more responsive to public demand. But such a relationship is more likely to pose important ethical challenges—the information available on such sites is very likely to be biased or limited in scope.

There is only a limited sense in which "independent" sources of information will be able to counter this. Commercial forces mean that the independence of health information sites other than those of pharmaceutical companies themselves cannot be guaranteed. The requirement for advertising revenue is one pressure. Moreover, the experience of DrKoop.com[4] shows that advertising itself is unlikely to bring in sufficient income to keep a site going and that a closer commercial relationship between such sites and commercial companies will be required if they are to remain viable. Who will take on responsibility for the provision of quality-evaluated health information and indeed information about the ethical implications of developments in medicine and medical science?[6]

Opportunities

Whilst the development of the internet and of the worldwide web poses important challenges for clinicians and for those who provide ethical support to them, such as clinical ethics committees and clinical ethicists, it also offers opportunities to meet such challenges, and ways of developing new and more responsive forms of ethics support. Some of these have been hinted at above, but below we sketch some possible ways in which the internet might be used to enhance the provision of clinical ethics support.

(I) MORE EFFICIENT AND FLEXIBLE CLINICAL ETHICS SUPPORT FOR CLINICIANS

Clinical ethics committees are well established in the United States but are a relatively recent phenomenon in the United Kingdom and elsewhere. Yet the committee meeting as such may already be in need of rethinking. Currently clinical ethics committees meet relatively infrequently, perhaps once a month or so. The ethical issues presented by clinical practice are not limited in this way. Health professionals face ethical challenges on a daily basis. The web offers the opportunity to develop forms of clinical ethics support of a much more flexible and ongoing kind, less determined by geography and the availability of members for physical meetings. The internet and e-mail mean that ethics support might be provided through the use of moderated discussion lists, case consultation services and so on. This also means that support would be available to those who work in remote communities.

In addition to case consultation, committees will continue to be involved in the development of policy. The web will make it possible for this to be a much more inclusive and responsive process where policies are perhaps posted on controlled access sites as "requests for comment" from staff members and/or the local community. These policies could

be updated on a regular basis. The web also makes it much easier for the committee to co-opt non-members to assist with a particular decision or policy development. For committees who do not have access to an ethicist, for example, this offers one way in which such support might be accessed, perhaps from another committee or geographical location. The internet offers the possibility for committees to pool their resources.

(II) COMMUNICATION BETWEEN COMMITTEES

A national network of clinical ethics committees has recently been established in the United Kingdom[7] as a result of demand from the members of clinical ethics committees themselves for just this kind of mutual support. The aim of this network, which meets annually, produces a newsletter and provides training for committee members, is to facilitate the contacts between committees and the sharing of experiences. This process could be made much easier and more efficient through the use of the internet: through the creation of electronic newsletters, thematic discussion lists, databases of policies, training materials and skill resources etc.

(III) EDUCATION AND TRAINING

The internet also offers the possibility of developing innovative forms of ethics education and training at a distance for members of clinical ethics committees and also for health professionals. The education of health professionals about ethical issues and about policies of national health trusts is a key function of clinical ethics committees and members of committees often express their wish for more training on ethical issues. The web offers the possibility of developing online education (textbooks, interactive courses and training). One particular advantage of this approach to training is the possibility it offers of continuously updating such education and textbooks in the light of policy changes, new cases, discussion and feedback from users. There is in effect the possibility of committee members creating an open-ended textbook for themselves.

Some concluding remarks

The development of e-medicine poses important ethical challenges for health professionals and for those who provide clinical ethics support. In this paper we have sketched out some of the ways in which committees and clinical ethicists might respond creatively to such challenges. The next few years have the potential to be an exciting time in the development of ethics support in the clinical setting. Clinical ethics committees and other forms of clinical ethics support will only prosper however, if they are able to show themselves to be of real use to health professionals and patients. True, the internet offers many ethical challenges but by offering health professionals ways of responding to such challenges both electronically and face-to-face, the providers of clinical ethics support can show themselves to be an indispensable part of good quality health care provision.

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Developing standards for institutional ethics committees: lessons from the Netherlands

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Abstract

This article presents standards for setting up and educating institutional ethics committees (IECs). These standards are based on experiences in the Netherlands, where IECs have been established in a large number of health care institutions. Though the IEC has become a generally accepted institution within Dutch health care, there are concerns over its effectiveness regarding the improving of the moral quality of clinical decision making. Health care practitioners and members of IECs too, experience a gap between the IEC and the reality of the clinical environment. At this moment, there is interest in developing programmes which educate practitioners in moral issues and how to deal with them, using the method of a structured debate on the ward. The IEC will not be made obsolete by this development, but can play a guiding role in the implementation of such programmes. Current concerns are the lack of patient representation in the Dutch IEC, and the loss of contact with the local community of health care practitioners because of the merger of hospitals into bodies similar to UK National Health Service (NHS) trusts.

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Keywords: Institutional ethics committee; ethics education; moral debate

Authors' note

In this article we will use the term "hospitals" to refer to the different type of health care institutions mentioned here.

Introduction

Over the past decade institutional ethics committees (IECs) have become generally accepted in the Netherlands.[1] Since the eighties, an increasing number of IECs have been established by various health care institutions. These committees serve multiple purposes, whether they be active in general hospitals for acute care, nursing homes, institutions for the physically and mentally handicapped or psychiatric hospitals. Their assignment may be limited to one particular task or to a specific theme, for instance consulting with staff about complicated cases, or providing the hospital management with ethical advice on institutional policy such as palliative care. Alternatively, the ethics committee may have as its sole task the raising of moral awareness among employees in general, thereby enhancing the moral quality of the service. However, most IECs in the Netherlands have multiple responsibilities, combining a number of the tasks mentioned above.

As well as IECs, there are a considerable number of research ethics committees. It is a legal requirement that the ethical aspects of clinical trials are discussed and commented upon by institutional review committees.[2] In order to be legally recognised, these committees must comply with strict legal standards regarding the disciplinary background of the members, the operating procedures and the number of protocols to be reviewed on an annual basis. At this moment, 78 review committees have been officially acknowledged by the central committee.[3] Many of these committees combine the review of research protocols with the tasks of an IEC, as mentioned above. However, the review of protocols is usually very time-consuming so many of these so called "mixed" committees have little or no time to fulfil the tasks of an IEC. The guidelines laid down by the the recent law on medical research compelled many "mixed" committees, particularly those in smaller hospitals, to give up their task of a review committee for medical-scientific research protocols because they were no longer able to comply with the new requirements. For example, many of them were not able to appoint a methodologist, which is one of the requirements of the new law. Thus, currently, the large hospitals (including the academic hospitals) have a separate IEC as well as a research review committee, middle-sized hospitals have a "mixed" committee, combining research review and clinical ethics, and smaller hospitals (if they decide to have an ethics committee at all) tend to have only an IEC.

Except for the research review committees, there are no recent figures of the numbers of ethics committees. In 1992, in a survey of the federal health care organisations 234 hospitals were reported to have an IEC.[2] This was 33.7% of all the health care institutions in the Netherlands (n = 434). There are no hard figures on the number of IECs at this moment. However, it is estimated there are a few hundred ethics committees, most of them being IECs. One reason for the rapid increase in the number of ethics committees might be the increasing influence of disciplines other than medicine in

clinical decision making. The ethical quandaries, which in part could be attributed to conflicting disciplinary perspectives, needed a platform where they could be debated and resolved. As well as this internal process, there are external processes contributing to the rapid increase of IECs in the Netherlands. One important societal development is the increased number of government regulations, legal standards (for example regulations in regard to compulsory treatment), and professional guidelines. The ethical aspects of these measures needed a forum where they could be translated into guidelines for an institution, and where practitioners could ask for advice in individual cases related to these measures. Another external influence is the Dutch culture of consensus, also called the "polder model", implying that once confronted with a complicated issue an ethical committee may indeed be the appropriate framework in which to consider the dilemma at hand. Ethics committees provide society at large and the health care sector in particular, with a forum where professionals, in search of some form of consensus, are able to debate the ethical aspects of issues that arise in the arena of health care

In this contribution we will provide the reader with information concerning standards for education and the process of the setting up of an IEC. At the end we will draw some conclusions regarding the developments in the Netherlands.

Setting up the IEC

Here we will focus mainly on the preparatory phase of setting up an ethics committee.[4]

Before one can make the decision to embark upon the establishment of such a facility *a strategic plan* is needed. The plan should contain a road map of how to proceed, and include matters such as an assessment of local circumstances and current conditions. Ethics committees should not come into being simply because someone, one day, decided that it was a "good thing" to have one, or because there happened to be some ethical emergency that needed acute attention. This approach is analogous to running before one has learned to walk. One can almost guarantee that this type of initiative will be short lived. Setting up an institutional ethics committee takes time and an amount of effort, as we will illustrate below.

One of the questions that requires an answer in the early stage is: "What kind of facility do people within our organisation envisage?" Roughly there are two models from which to choose.

The first model is a hierarchical model. One can opt for an ethics committee which functions as an ethical expertise centre. Complicated and difficult matters are turned over to the committee for advice. The committee is well equipped for the task, because all the available expertise is drawn into it. Under these circumstances the most likely consequence is that the committee will share its wisdom with the organisation. It will issue either its own, or on request, statements about particular situations that arise within the hospital community. In this situation it is the norm for the committee to work "top down" and its activities are policy orientated. In general people will not be tempted to challenge the insights of this committee because of its expertise and professionalism. Given local circumstances this may be a realistic option.

The other option is to organise an ethics committee "bottom up". Committee members team up with employees and make themselves available wherever and whenever there is a need for ethical consultation. The focus is to help caregivers understand their own motives for the decisions they make. By discussing the issues, those involved add another dimension to the deliberations, the ethical dimension. During the process of discussing this ethical dimension, one can often be helped to understand either one's own, or others' reluctance to a presented solution. The outcome often provides the caregiver with alternatives not previously thought of. A side effect of this model is that caregivers often find that the heightening of their moral awareness becomes a valuable personal experience. In this scenario the endeavours of the committee members enhance ethical awareness throughout the organisation. One may not be able to pinpoint the spin-off, no documents or guidelines are produced, but it is all happening in the minds of the people who work in the institution. In contrast with the first option this choice can be very time-consuming, but it is well worth the effort.

The choice made determines the tasks and the composition of the ethics committee. The most common tasks are in the area of case consultation; raising the moral sensitivity of personnel (education); commenting on the ethical aspects of (existing) protocols and guidelines; advising the organisation on ethically sensitive policy issues, and organising the institutional debate on specific topics or themes (the "platform" function). Reading this list one is able to understand why some hospitals prefer a "top down" approach, while others think that a "bottom up" approach will suit their purposes best. The choice will also determine the committee membership. If the organisation thinks expertise is most needed the membership will differ from a situation where close contact and communication with the work-floor is prominent.

Membership

There are no legal or even general rules as to membership of the IECs. Generally membership consists of one or two physicians, a psychologist or psychiatrist, one or two nurses, a pastor, an ethicist, a lawyer and one or two paramedics. There is one person not mentioned here—the patient. Though the IEC is expected to protect the interests of the patient, IECs in the Netherlands never involve the patient or client directly. Statistics in the Netherlands are very consistent in showing that patient participation is practically non-existent in ethics committees.[2] The reality is that committees serve the members of the hospital community first. However, one may argue that patients benefit indirectly, because the quality of the decision making process

is enhanced by looking at the ethical implications of different treatment options.

General acceptance of such a facility by employees is essential for an ethics committee to survive. This raises the issue of professional responsibility versus the work of the IEC. Practitioners argue that professional standards require each individual health care provider to account for the ethical aspects of the decision he or she has to make and that these decisions could never be altered by additional insights or advice from ethics committees. This misrepresents the aim of ethics committees, which is not to replace the professional responsibilities of the individual caregiver but to enhance the quality of the decision making process, leaving the responsibility for the final decision to the professional.

More complicated, however, is the issue of conflicting interests among various groups of professionals, leading to resistance to a facility for ethical consultation. This is often related to traditions within the organisation and with the balance of power between different groups. Methods of communication are important: whether communication between different groups is strictly hierarchical and formal, or whether people are open to more casual forms of communication. Some may claim specific knowledge and impose their opinions on others on the basis of that knowledge, causing others eventually to lose heart. These circumstances may easily jeopardise the moral debate before it even has a chance to get under way. In this respect starting an ethics committee could constitute a significant challenge to the prevailing culture within the hospital environment. Starting such a committee needs a considerable amount of thought, effort and above all commitment.

Management

From the beginning those seeking to establish a committee should seek support for their initiative from the senior management of the organisation. The authoritative head (the president of the board or the chief executive officer) should be aware that the initiative to establish an ethics committee is his/her responsibility. The management may commission a staff member to look into the matter more thoroughly. If the management fails to take this initiative then a member of staff could take the lead on behalf of the organisation, turning responsibility over to the management as soon as possible. In any case it is very important that the management endorses the need for ethical consultation and provides for it. An ethics committee should be part of the institution's policy regarding the way the organisation intends to cope with the ethical quandaries that may arise. Activities that issue from this policy should be made public and should also be an integral part of the annual report of the organisation.

The hospital administration is also responsible for creating the conditions under which the ethics committee can thrive. They do that by making the work of the committee a legitimate and integral part of the hospital services. In an organisation like a hospital acknowledgement of a committee's existence by the management is vital. This can be made explicit by facilitating the ethics committee activities, for example by providing the committee members with time to do their work. The management should also budget for a secretary to take notes, to convene the meetings and to provide clerical support in general. If necessary it should provide the committee with expertise in the field of health law and health care ethics, and with an adequate education and training programme. A hospital cannot maintain an ethics committee in its "spare" time. This kind of investment requires a real policy decision. The institution may have to prioritise ethical consultation over and above other items. Consequently, if an organisation decides to establish an ethics committee it must do so on a long term basis, otherwise it will be a waste of resources and a disappointment for all those who participate.

Setting standards for educating the IEC

Once started, the members of the IEC often realise they lack the necessary skills to analyse ethical issues and to set up a structured debate. Training courses have helped committee members to get a better grip on the issues at hand. The priority is to make employees aware that "doing ethics" is not something new. On the contrary, as individuals, we have already developed our own ways of dealing with ethical quandaries. Some practise ethics by applying professional standards, others do it on the basis of their experiences and their moral intuitions. Some do ethics on the basis of what their organisation has stood for over time, others will rely on the values and norms that have been handed down to them from when the organisation was still in its infancy. Consequently, one of the main aims of any educational programme is to explain to the committee members that practising ethics together is less difficult than is often thought. Secondly, during the process of moral deliberation, committee members benefit each other and the organisation by clarifying those (professional or personal) norms and values which lie at the heart of their moral positions.

However, to organise a structured ethical debate takes more than a clarification of the personal and professional values of committee members. What is required then, is a theoretical framework to guide the moral debate among the members, enabling them to weigh the different moral values at stake in a specific case or protocol. In the training courses organised by the Institute for Bioethics for instance, we begin with a presentation of some of the main theoretical concepts in health care ethics, illustrated by practical examples and cases. It is important that such a theoretical introduction does not go too far above the practical level of the clinic. On the whole health care practitioners are not interested in a thorough introduction to the philosophy of Immanuel Kant or John Stuart Mill. What they do need are practical tools for ethical analysis, for example, the distinction between "positive" and

"negative" autonomy or criteria for incapacity. The "principles" approach, often despised for its abstract and rational nature, is often very helpful in structuring discussions on ethical dilemmas and in interpreting and weighing the values involved.

After this theoretical introduction, trainees are offered a step-by-step approach to analysing cases.[5] This approach teaches them how to make the moral aspects of a case explicit (as distinct from communication problems or other non-moral problems), to analyse the main moral values that are involved, to weigh conflicting values in the case of a dilemma, and to formulate options for resolving the conflict. A similar analytical approach can be applied to drafting guidelines and protocols, such as "do-not-resuscitate" protocols or protocols on organ donation. Committee members find such a step-by step approach very helpful in structuring their own individual thought processes. It also provides them with a mutually shared framework for debating various topics.

Another area of focus is teaching committee members about the advantages of a multiprofessional approach to ethical quandaries. Today IECs thrive because the whole approach to health care delivery has changed. The days have gone when the daily practice of health care meant one decided for all. Nowadays the team approach is paramount throughout the organisation. It has amounted to a profound change of culture. Teamwork implies the contribution of various disciplines important in preparing for, or evaluating, the course of action. A truly multiprofessional approach is based on professional respect for each individual contribution. There are cure-oriented solutions to a problem, but there may also be care-oriented solutions to the same problem. To minimise the effects of pain one may advocate a step up in the administration of pain treatment, while others may suggest music therapy. Likewise, ethical insights and solutions offered may come from different professional perspectives.

Finally, committee members need to learn about the way modern organisations like a hospital operate. There seems to be a gap between the ethical way of thinking and speaking and that of the health care institutions at large. Attention has to be given to the kind of language and methodology organisations use when announcing their intentions and outlining their goals. Ethics committees are sometimes perceived by management to be occupying themselves merely "talking", implying that these committees are not adding much benefit to the hospital. An ethics committee which wishes to be effective will aim at conforming to the present institutional "way of life".

Looking back and concerns for the future

The IEC has become a generally accepted phenomenon in the Dutch health care setting. The majority of Dutch health care institutions have a committee for ethical advice on individual cases, for the development of policies and for educational activities on ethical issues. Now that the IEC has become a well established institution within the health care arena, it is time to look back and assess some of the outcomes for the future.

First of all the whole process has taken a considerable amount of time. The first ethics committee was established as far back as 1975! Apparently it is a facility that professionals have to get used to in order to incorporate it into their daily routine. Secondly, in the Netherlands we have had to learn not to underestimate the role of hospital management. Institutional ethics committees have no legal or federal footing, consequently, if management does not endorse the initiative it becomes extremely difficult for the committee to become firmly grounded within the organisation. The management helps to make ethical consultation within the hospital respectable by legitimising it, by providing for it and integrating it with hospital policy and services. This is a mutual responsibility, because in turn committee members should make the management aware of why the committee needs their support. Thirdly, an IEC can only thrive if it takes care of itself. Support from the management should be made visible in its providing the committee with training programmes and promoting the continual education of its members.

Patient representation

With regard to the future there are some concerns. Some have voiced their concern over the effectiveness of the IEC.[6] Does the committee really improve the moral quality of clinical decision making? Do doctors, nurses and other practitioners profit from the activities of the IEC in dealing with moral issues in their work? Practitioners, managers and even members of the IEC themselves, often experience a gap between the IEC and the reality of the clinical environment, where people are continuously exposed to moral dilemmas and often do not know how to cope. For this reason, there is an increasing interest in other methods and instruments to achieve the goals of the IEC. Moral awareness is needed on the wards, thus the ethical debate should take place among the practitioners themselves. Some managers prefer the methods associated with quality assurance programmes and doubt the necessity of a separate facility for ethical issues: they believe that such an integrated instrument is of more help to them when trying to analyse a case than advice from a "distant" committee. However, this development will not render the IEC superfluous. The committee itself can become instrumental in initiating and guiding the implementation of such instruments and programmes. Another concern is the issue of patient representation. Enhancing the quality of care by looking at ethical aspects is in the direct interest of the patient, so why is the patient not represented on the committee so that the patient can express an opinion? Is it acceptable that practitioners speak on behalf of their patients? Do caregivers always have the best interests of the patient in mind? One has to acknowledge that there is an imbalance and this may be a difficult problem to

solve. We believe that both concerns need further exploration.

We have recently observed many health care organisations merging into big conglomerates, a development akin to the setting up of health care trusts in the United Kingdom. In the wake of these mergers local IECs have also merged, thus becoming estranged from their local surroundings. It has turned them into truly "distant" entities for ethical consultation. As communication lines grow longer IECs are faced with the problem of how to maintain contact with the practice of daily care. Some committees have developed sites on their organisation's web pages and can be consulted directly via the internet.

Change is an ongoing process. Institutional ethics committees came into existence because employees developed a multiprofessional approach to ethical quandaries in health care. Perhaps IECs will become superfluous and disappear as professionals discover new forms of communication regarding the moral dilemmas they encounter. In retrospect the acknowledgement that these dilemmas exist and that something can be done about them, would imply that, over time, IECs have made a significant contribution to the raising of moral awareness within the health care profession.

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Teaching old dogs new tricks—a personal perspective on a decade of efforts by a clinical ethics committee to promote awareness of medical ethics

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Abstract

To incorporate medical ethics into clinical practice, it must first be understood and valued by health care professionals. The recognition of this principle led to an expanding and continuing educational effort by the ethics committee of the Vancouver General Hospital. This paper reviews this venture, including some pitfalls and failures, as well as successes. Although we began with consultants, it quickly became apparent that education in medical ethics must reach all health care professionals—and medical students as well. Our greatest successes came in the formative years of a medical career (ie, in medical school and residency training programmes), but other efforts were not wasted, particularly among nurses and other health care professionals.

Although this is a personal review of the experience in one institution, the lessons learnt in Vancouver are applicable to the further development of medical ethics in the UK.

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Keywords: Medical ethics; ethics committees; continuing education

Some 12 years ago, a small group of people sat contentedly in a meeting room at the Vancouver General Hospital. They had originally been called together from various disciplines to develop a policy for the hospital on cardiopulmonary resuscitation (CPR), specifically on "do not resuscitate" orders. The work was complete, and the final document was now ready to go to the hospital board for ratification and implementation. For its time, the document we had prepared was quite radical. It was developed through our own discussion of the issues, through review of the literature and with outside help in dealing with ethical issues and concepts. At that time there was no medical ethics committee in our hospital, but we received valuable instruction and guidance from the ethics committee of the local children's hospital (which even then was well established). This aspect of the process was a revelation to me, and I think to others of our group. Although I had been practising critical care medicine for more than a decade, this was the first time I had been exposed to the systematic analysis of clinical problems based on a thorough review of the relevant ethical principles. Not only had the process proved to be very rewarding, but it had resulted in an excellent final document—clear, practical, based on the current literature and solidly defensible on ethical grounds.

Our confidence was well founded, for the policy served the hospital well for a number of years before needing revision. On the other hand, our attendant euphoria was short-lived, for we soon came face to face with an important practical issue: how could we, or should we, get acceptance of our document? Excellent though it was, it was based on ethical principles with which most members of our medical staff were unfamiliar. How, then, could it be understood, let alone acted upon, when its premises and foundations were unfamiliar to those to whom it was directed? Put another way how does one educate an ethically naïve clinical staff? Or, rather, how does one change the ethical climate of a health care facility from one of ignorance and suspicion (or even hostility) to one in which ethical principles are not simply understood, but are actually used to underpin hospital policies and to guide clinical decision making?

At this point I must acknowledge that things did not happen exactly as I have described. Nevertheless, the above scenario brings into sharp focus the educational task our nascent ethics committee (for that is what we became) had to face. The problem is a universal one, and arises whenever a new discipline or process is introduced into an environment of established practice. It will therefore come to light repeatedly around the UK as (hopefully) medical ethics becomes a more prominent part of life in the new National Health Service (NHS). It is arguable that any new clinical ethics committee will inevitably face the same problem as we did, and will, like us, need to educate its clientele on ethical issues. And this is no small problem.

Our original document on CPR was primarily directed at consultant physicians and surgeons. However, by its very nature, a cardiac arrest immediately involves other personnel (for example, nurses and junior doctors). Furthermore, our document advocated involving the whole clinical team in any decision to withhold CPR. For this to occur, all members of the team would need an equal understanding of the ethical principles underlying our document. Therefore, for ethical guidelines to be successful, it is apparent that the entire clinical

workforce must be taught medical ethics. At the Vancouver General Hospital this involved about five thousand people. Finally, it is also obvious that this educational effort will be never-ending unless medical schools and other training institutions change their curricula to produce ethically literate graduates. So, in response to an immediate practical need, we began a process that continues to this day in Vancouver. And now that I have relocated to the UK, it has started all over again in my local trust.

In what follows I have tried to outline some of the approaches taken in Vancouver to improve ethical awareness among clinical staff. The assessments and opinions are my own, and no doubt some of my colleagues would have a different perspective. No attempt has been made to review or analyse the literature, or to draw evidence-based conclusions, so this paper remains a descriptive account of attempts made in one institution to solve the practical problem outlined above. Certain lessons were learnt which, should prove to be applicable even across the Atlantic. (In this context it should be pointed out that Canada is not to be confused with the USA. Despite differences in detail, the Canadian health care system is based on the same general principles as the NHS.)

Consultants

Sadly, little progress was made with this group. It is hard to find a forum for consultants at which ethical issues can be presented and discussed. Medical staff meetings tend to be poorly attended and to be preoccupied with practical and political issues. Attendance at "grand rounds" is generally poor. We did arrange regular ethical sessions at medical grand rounds, but the results were predictable—medical staff were generally outnumbered by others (for example, nurses, physiotherapists and pharmacists), and among the medical staff junior doctors generally outnumbered consultants. In fact, many consultants rarely, if ever, attended such rounds. My brief exposure to grand rounds in the UK suggests that the situation is no different here. Therefore, trying to raise awareness of medical ethics among UK consultants by this route is no more likely to be successful than it was in Canada.

Specialty-specific rounds are potentially more fruitful. Generally there is better consultant representation at such rounds, but this is offset by the fact that each specialty-specific round is of interest only to its own consultants who make up a small fraction of the total number employed by the hospital. Hospital-wide ethical input can therefore be provided only if members of the ethics committee are able and willing to attend many such rounds in different departments on a continuing basis. Such a process is very time-consuming and inefficient as a means of general ethical education, but it does have the advantage of specificity. If a clinical case can be found which is relevant to the practice of that particular specialty group, it is possible to raise, review and discuss general ethical issues in the context of that case. This avoids two common problems. First, it is human nature (especially among highly trained professionals) to believe that one knows more about a subject which is peripheral to one's own discipline than is actually the case. Thus, consultants may not attend a session devoted to ethics because they believe the material is already familiar to them. In this context, specialty rounds provide an opportunity to review and expand consultant knowledge of medical ethics indirectly, as a byproduct of discussing a relevant clinical case. Secondly, some consultants tend to believe that medical ethics is all right for others, but is not relevant to their domain. Once again, reviewing cases from their own practice can often highlight the relevance of ethical principles to that discipline.

Another relatively unsuccessful approach taken in Vancouver was to have the provincial medical licensing body sponsor an annual lecture series in medical ethics. Various prestigious ethicists came to Vancouver through this programme, and provided excellent and thought-provoking presentations in small group sessions as well as in formal lectures. The major benefit, however, was to the already converted, and there was not large attendance from outside this clientele.

Finally, national and regional meetings were considered as a forum for providing ethical education to consultants. At first sight, this approach appeared successful (ie there was a room full of people and the feedback was positive). However, closer examination was less encouraging. Attendees were generally few in relation to the total registration at the meeting, and the audience was primarily drawn from those who were already interested in medical ethics. Medical ethics is not a glamorous discipline. Unfortunately, since many meetings have multiple parallel sessions, the latest medical advances generally take precedence over ethical sessions.

Although I am definitely jaundiced about the overall success of our attempts to provide our peers with ethical tools to use in practice, not all our effort was wasted. While certain individuals and groups were uninfluenced by our activities, there were others who became conversant with ethical principles, and used them in clinical decision making at the bedside. Over time, such individuals exerted a profound influence on the culture of their own clinical area. Because they acted as role models, promoted better team interactions in their discipline and brought ethical principles into the clinical arena, slowly but steadily their colleagues came to accept and use ethical principles, even though this process happened unconsciously and by osmosis.

Junior doctors

Since junior doctors will become tomorrow's consultants, it is logical that educational efforts in medical ethics should be focused on this group. In our experience this tactic proved to be not only logically sound but also rewarding.

On the whole, Canadian junior doctors are keen to learn during their residency training programme. The Royal College of Physicians and Surgeons of Canada has encouraged a positive attitude to instruction in medical ethics by ensuring that this subject is included in the objectives for training of all major disciplines. Further reinforcement comes from the college through its requirement for regular

in-training assessments which, in turn, contribute heavily to the final assessment of eligibility to sit the (exit) examination for recognition as a consultant. In this system, one has the triple benefit of a "captive" audience which has an incentive to learn and also has protected time for formal teaching within a defined curriculum. If, in this context, trainees are encouraged to select a problem case from their own experience, and to analyse the ethical issues involved, one has all the makings of an excellent educational experience in medical ethics. A number of clinical areas, including our intensive care unit, incorporated such sessions in their regular teaching programmes for junior doctors on rotation through their area. This not only allowed such trainees to understand and participate in the discussions of ethical issues which regularly took place at the bedside in such clinical areas, but it provided them with a solid grounding in biomedical ethics to take back to their own discipline. This process was time-consuming, repetitive and sometimes very dull, but it did, eventually, produce a cadre of ethically informed residents who, with the passage of time, formed a cadre of ethically informed consultants.

Medical students

Clearly, the education of junior doctors in medical ethics would be greatly simplified if they were already familiar with this subject when they graduated. As the major teaching hospital for the Faculty of Medicine of the University of British Columbia, the Vancouver General Hospital was in an excellent position to further the teaching of ethics to medical students. We were also fortunate in having on our committee a number of faculty members who were not only well versed in this subject, but who also had the position, energy and drive to promote the incorporation of medical ethics into the medical curriculum. Arguably, this was our most successful venture in promoting medical ethics within the medical community.

Our ethics course was in two parts. In the first year, before any exposure to clinical medicine, students were given a brief introduction to the principles underpinning ethical decision making. This was reinforced by a series of small group tutorials in which students were asked to apply those principles to stylised clinical situations. Obviously, their conclusions were often "black and white" and untempered by clinical experience, but at least they were working through issues such as consent, autonomy, withholding/withdrawing active treatment etc. Furthermore, this ethical background was available to them from their first clinical encounter onwards. This ethical teaching was reinforced in the final (4th) year, just before the students began their "clinical clerkship" (a kind of junior house officer role). This time the course had a more clinical emphasis. For example, one session was devoted to death and dying, while others dealt with various aspects of ethical decision making in clinical practice. Once again, the formal teaching was backed up by a series of structured small group sessions in which real (and often difficult) clinical situations were discussed in depth with a tutor.

This approach to undergraduate education in medical ethics was very costly in terms of the number of instructors needed and the time involvement required of them. On the other hand, this was also one of its great strengths—students learned that ethical decisions do not come by rote, but are honed through group interactions. By discussing with their peers and tutors, they not only processed ethical principles, but they also learned the value of multiple inputs and perspectives. They also discovered that, in the end, there is often no single right answer.

Obviously, other places in Canada took a different approach to teaching medical ethics to medical students, junior doctors and consultants. Our approach is certainly not the only one possible, nor is it necessarily the best—but it does show what can be achieved, in a fairly short time, in one institution, by a committed and enthusiastic team.

Other health professionals

We soon discovered that nurses, physiotherapists, social workers and other health care professionals were keen to learn about medical ethics and to participate in clinical decision making with this knowledge. Our document on CPR advocated a team approach to this issue, and was therefore welcomed in areas where teamwork was already well developed. Furthermore, nurses in particular had structured programmes in place for career development and the maintenance of skills and knowledge. Thus a suitable infrastructure already existed for the promotion of medical ethics. Added to this, our ethics committee was fortunate to have as a member a clinical nurse specialist who had completed a master's degree in medical ethics. The rest, as they say, is history.

However, it would not be fair to suggest that this tide of enthusiasm for medical ethics among other health care professionals was attributable only to the medical ethics committee. Perhaps more than the physicians, these groups recognised both the utility of ethical principles in clinical practice, and the need for a common currency with which to conduct team discussions on ethical issues. They were keen to participate in the latter and therefore recognised the need to become conversant with the former. Ethics therefore became a regular part of their continuing education efforts, both in the hospital and outside it (for example, in regional and national conferences). It appears that if the climate is right, and the benefits are apparent, all it takes is a kick-start to initiate a self-perpetuating process.

Hopefully medical ethics will quickly develop in the UK over the next few years. All it takes is local ethics committees to seize the available opportunities, and to provide the support and drive necessary to bring medical ethics into the centre of the clinical arena.

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Clinical ethics committees and the formulation of health care policy

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Abstract

For some time, clinical ethics committees (CECs) have been a prominent feature of hospitals in North America. Such committees are less common in the United Kingdom and Europe. Focusing on the UK, this paper evaluates why CECs have taken so long to evolve and assesses the roles that they should play in health care policy and clinical decision making. Substantive and procedural moral issues in medicine are differentiated, the former concerning ethicolegal principles and their paradigmatic application to clinical practice and the latter dealing with how such application should be negotiated in the face of disagreement and/or uncertainty. It will be argued that the role of CECs is both substantive and procedural. Provided that they do not overstep their appropriate moral and professional boundaries, CECs will be shown to have an important and positive function in improving hospital care within the UK and elsewhere.

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Keywords: Clinical ethics committees; policy; ethics decision making

Introduction

Over the past twenty-five years, a new player has emerged in North American health care. Clinical ethics committees (CECs) are now found in many hospitals and influence patterns of care.[1] The functions of these committees include the formulation of hospital policy on ethicolegal matters, the provision of individual consultation about specific clinical cases and the organisation of education and training.[2] Clinical ethics committees may also engage in the resolution of conflict between clinicians or patients, relatives and clinicians.[3] More recently, some CECs have extended their policy brief to the review of institutional barriers to the conduct of good ethicolegal medicine within the hospitals they serve.[4] Professional organisations and journals have been established to support those who work on CECs and to receive professional accreditation, hospitals must demonstrate their ability to deliver health care that reaches an acceptable ethicolegal standard. Many do so by reference to the work of their CECs.[5] In North America, CECs have, therefore, become an integral part of the organisational infrastructure of hospitals.

Things could hardly be more different in hospitals within the United Kingdom.[6] Here there are very few CECs. Even when such committees do exist, few problems may be referred to them and clinical staff may not even know of their existence.[7] The reasons for this much slower development are complex but the following factors appear to have played a part.[8 9] In North America there has been:

- a longer tradition of federal and state regulation of ethicolegal aspects of clinical activity (for example especially those concerning research);
- less tolerance of overt paternalism in medicine, along with a greater desire for transparency and accountability in decision making;
- a system of statute and common law which more actively supports patients' rights and a more accessible legal system;
- more willingness of patients and relatives to litigate or to make formal complaints over perceived breaches of professional duty;
- more authority vested in adults as legal proxies for treatment decisions concerning other adults, with resulting potential tensions with clinical staff, and
- more bioethics training programmes and thus more trained personnel to organise, advise and serve on CECs.

Factors such as these helped to convince many clinicians and clinical managers in North America that CECs can help to maximise the moral and legal standards of hospital care and may minimise the risks of litigation, complaint or running foul of state or federal authority.[10] What lessons can we learn from the work of CECs in North America as they begin to expand in the UK?

This paper will explore the philosophical foundation of CECs, arguing that their presence is necessary for any coherent approach to the formulation and implementation of good ethicolegal policy in a modern hospital setting. A theoretical distinction will be developed between substantive and procedural ethics. It will be argued that the adequate resolution of difficult and complex "hard" ethicolegal cases in medicine requires collective discussion and debate similar to that already accepted as important in other aspects of clinical decision making (for example, case conferences). After outlining the types of work most important for properly structured and functioning CECs, the paper concludes by evaluating some of the constraints that may keep this work from being successfully implemented.

1. Substantive ethics and CECs

Despite the large numbers of CECs in North America, evidence suggests continued scepticism

about them on the part of some clinicians. The fact that so few committees have been created in the UK indicates the existence of similar reservations.[11 12] One often stated concern is that the collective character of CECs will contaminate the doctor-patient relationship because of its dependence on the trust patients place in their individual clinicians.[13] Equally, there are fears that individual clinicians might abnegate personal responsibility for difficult ethicolegal decisions through becoming overly reliant on CECs. This blurring of clinical responsibility could also damage the clinical relationship.[14] Some criticisms have also highlighted the potential ineffectiveness of "decision making by committee" and expressed frustration at arguments that trained senior clinicians might need ethicolegal support and advice from colleagues who are in different specialisations or have no medical training at all.[15]

On the face of it, such scepticism is understandable. Regulatory and professional bodies of all kinds within medicine are continuously disseminating information about the principles that should govern the conduct of good clinical practice. Undergraduate and postgraduate courses in ethics and law applied to medicine also play the same role. Thus if there is agreement within medicine about what should be done from an ethicolegal perspective then why shouldn't experienced clinicians be able to conduct their clinical life accordingly, without the help of a CEC?

In the UK, there certainly appears to be a professional consensus on such matters. Most published guidance about good ethicolegal practice in medicine embraces the same substantive moral principles and these are reflected in statute and case law.[16-19] To an appropriate or reasonable standard, clinicians should: protect the life and health or their patients; respect their autonomy—their right to make competent and informed clinical choices on the basis of adequate information, and protect and respect patients justly and without prejudice.

The precise formulation of these principles is somewhat arbitrary. For example, Beauchamp and Childress famously characterise them as beneficence, non-maleficence, autonomy and justice.[20] But however the details are spelled out in the many documents concerned, the substantive ethicolegal message is much the same. Similar agreement is to be found in various professional bodies in North America.[21 22] In both the UK and North America, a variety of legal judgments concerning the duties of care also reflect this common moral vision.[23]

A further reason for the commonality of such regulatory principles is their capacity to be derived from otherwise competing moral theories. For example, the duty to respect the autonomy of patients follows from arguments supporting the existence of the human right to bodily integrity, itself derivable from (among others) principles of rational self interest and human need. Yet the same duty also follows from utilitarian reasoning about the negative consequences for the doctor-patient relationship of not respecting autonomy—disrespect leading to an increase in aggregate unhappiness. Finally, casuistic moral reasoning argues that the general consensus about the importance of respect for autonomy derives not from general philosophical arguments of whatever kind but from a host of individual cases to which diverse clinicians have the same moral reaction. Thus philosophers may and do disagree about the moral foundations of medicine but still agree about what constitutes good and bad clinical conduct.[24] Therefore, it is hardly surprising that so much law in the UK, North America and elsewhere shares the same moral vision. It has evolved against the background of what is in effect a moral consensus.

Many clinicians question the need for CECs because they resent the suggestion that they are not perfectly capable of understanding their professional duties and conducting their practice in a way that is consistent with them.[13 15] While there may be an educational need for CECs to ensure that local clinical staff are up to date on the content and practical implications of national ethicolegal policies, any further intrusion into the conduct of clinical practice should be regarded as presumptuous, potentially harmful and unnecessary. To the degree that some clinicians do conduct themselves professionally and are blind to the moral and legal importance of certain basic standards of clinical performance, regulatory mechanisms already exist for their further education, discipline or possible exclusion from the medical profession. Education aside, therefore, CECs are argued to be both irrelevant and redundant.

2. Procedural ethics and moral indeterminacy

The fact that there is a general consensus about the moral and legal principles associated with the duties of care does not mean there is also agreement about how to interpret these principles in practice. The same point holds for agreement about the moral and legal status of particular examples of clinical conduct. Clinicians who concur about some examples may disagree about others—and they may do so citing the same moral or legal justification.[24] This is the case for two reasons.

On the one hand, the formulation of each duty of care contains variables that are essentially open ended and subject to different interpretation. For example, what does it mean to protect life and health and respect autonomy to an "appropriate" or "professional standard" and do both "fairly"? While on one level of abstraction, there may be agreement about substantive principles, on a lower level this may be impossible because of other conflicting beliefs and values. Thus two clinicians may accept the duty to protect life and health but because of other disagreements about the moral status of the fetus or severely brain damaged patients may still disagree over issues pertaining to termination of pregnancy or the non-provision or withdrawal of life-sustaining treatment. Disagreements may occur for the same reason when trying

to anticipate future legal judgments where common law is unclear.

On the other hand, substantive moral and legal principles may themselves conflict with each other and clinicians can disagree about how to resolve the conflict. For example, respect for confidentiality may be incompatible with the duty to protect the public. Similarly, when managing scarce resources, the duty to provide treatment to patients in need may conflict with the responsibility to do so justly. Justice may appear to dictate not treating some patients in order to protect the lives and health of others. There may be disagreement, however, about which patients fall into which categories.

When clinicians interpret the same duties of care in different ways or cannot agree about the resolution of conflict between such duties, they are thrown into a state of moral and legal indeterminacy.[25] In such circumstances, there is no point in looking for help from the substantive moral or legal principles that are in question: for it is their susceptibility to conflicting interpretation that poses the problem. The moral indeterminacy may not be resolvable by the individuals who disagree. This may be because of poor communication between them or their unwillingness to depart from favoured interpretations of the substantive principles in dispute. For example, many moral arguments in medicine continue to question the boundaries of acceptable paternalism toward patients. The protagonists in this debate can be so entrenched that they often seem to be talking past each other, with little prospect of an agreed practical outcome. Yet the disputants may all still accept that clinicians should respect the autonomy of patients to an appropriate standard!

Unfortunately, appeals to "the law" can also be unhelpful in resolving such disagreements.[26 27] This is because there may also be dispute about what the law entails in clinical practice or because it is not regarded as a good guide to morally acceptable practice. As an example of the former, there has been much debate about the circumstances under which feeding and hydration can be withdrawn without the agreement of the court from patients who are severely brain damaged but not suffering from persistent vegetative state (PVS). Case law is not totally clear on the matter and published professional guidelines have had to proceed despite this.[28] The degree to which the law may not be a guide to good practice is best illustrated by debates about informed consent. English law demands a low "professional" standard of disclosure of information about risks—still governed by the Bolam test—while the General Medical Council and the British Medical Association have now backed a higher standard. Thus clinicians can have a very good understanding of the law and still not be sure how to proceed in specific cases. They can also disagree about how to set professional standards higher than the current legal denominator.[27]

Yet clinical life must go on and moral and legal indeterminacy within medicine cries out for practical resolution. When negotiation about acceptable professional conduct breaks down between individuals, clinical policy should be formulated through a respected forum of wider debate, discussion and conflict resolution.[29] If a particular "hard case" poses dilemmas for clinicians and health care teams, good clinical practice requires a procedural means to generate the most rational course of action in the circumstances.

It has long been accepted that due process in law requires that contesting parties have an equal opportunity fairly to put their case before a judgment is given. The collective proceedings of court hearings are designed to achieve this goal. Similarly, at their best, research ethics committees try to ensure that their members represent the different types of expertise and experience required for optimally informed decision making—say, about the appraisal of risk-benefit ratio for a proposed clinical trial. They should also ensure that however much the views of members may differ, everyone has the same right to be heard and the vested interests of individuals are not allowed to determine conclusions. By this means final judgments can be made to embody the most rational compromise possible.

The practical resolution of moral and legal indeterminacy within clinical practice requires the same approach to optimising rational deliberation.[30] At their best, CECs should take on this role through appropriate terms of reference, rules of debate and membership. Beginning with their terms of reference, these committees should serve two functions aside from education: pro-active policy formation and reactive consultation about particular ethicolegal dilemmas.

Clinical ethics committees should be pro-active in that they should formulate policies concerning good clinical care. These should create a feeling of institutional ownership of moral and legal principles that have been agreed nationally. This can be achieved through the translation of such principles into locally agreed language, along with paradigm examples of their appropriate application. Where there are disagreements about the implications of local policies for clinical practice, compromises must be reached which are deemed to be consistent with the law and other regulatory commitments (for example, GMC guidance). Second, CECs should also be reactive through providing a respected forum where clinicians can bring ethicolegal queries about particular cases, including disagreements about the duties of care between themselves, colleagues, patients or relatives. Here, the problem may just be educational—a clinician, for example, may be confused on a point of law or unaware of published and professionally agreed policies. However, the problem may also require some form of conflict resolution, as a result of helping those concerned to see the weaknesses or unforeseen and unacceptable consequences in their arguments, values and beliefs.

Pro-active decisions should always be taken by the CEC as a whole. Because these may affect all personnel in the hospital—the only health care

environment that is the focus of this paper—a high level of accuracy about moral and legal matters will be of the utmost importance. The degree to which policies drafted by the committee are taken seriously will partly be a function of the respect which staff have for committee members and the past relevance and usefulness of their work. For this reason, it is essential that membership is seen to reflect a broad range of expertise—including that of informed lay members—and that attention is paid to the way in which new policies are presented and publicised. If they are not seen to be practically feasible, as well as academically informed, they will not be taken seriously, with potentially damaging consequences for both patients and their carers.

Because ethicolegal problems requiring a reactive and quick response are often brought by individual clinicians, they may require consultation with an individual member of the CEC who has relevant experience and training.[31] Membership should include a professional bioethicist with a good understanding of medical law and a track record of engaging in such consultation.[32] The commitment to confidentiality in the imparting of such individual advice will be of paramount importance. Any breakdown in trust between CEC representatives and clinical staff will be just as disastrous for successful ethicolegal consultation as it is for successful clinical consultation. Unless staff request otherwise, an outline of the details of consultations about individual cases should be brought back to the CEC to inform its future pro-active deliberations. There may be circumstances where reactive issues should be heard by either the whole CEC or a standing sub-committee that can meet in emergency session. Here, dilemmas will almost invariably be about the medical or surgical care of inpatients and may require conflict resolution. If the latter is the case, provision must be made for all contesting parties to have relevant access to the committee.[33]

Policy profiles: what should be done?

The importance of procedures being in place for optimally rational decision making applies to the formulation of ethicolegal policy at all levels. Without appropriate expertise, discussion and debate, such policies are more likely to be ineffective and to reflect arbitrary rather than public interests. Therefore, it is hardly surprising that nationally agreed ethicolegal principles concerning the duties of clinical care have all been formulated by committees procedurally constituted in much the ways outlined. It should be equally unsurprising that a diverse range of such committees (for example in the UK, those of the GMC, the BMA or the royal colleges) have all reached much the same general conclusions about these duties. The work of CECs, therefore, should be seen as carrying on these same traditions of collective deliberation, further articulating, applying and teaching the principles thus generated.

Because local CECs will always work against the background of more generally agreed policies, their own pro-active policies should take two forms. On the one hand, national guidance and legal judgments are often stated in long documents, the details of which busy clinicians cannot be expected to remember. It is therefore of particular importance that concise summaries be developed and disseminated in a manner believed by CEC members to be practically useful. On the other hand, it has already been noted that despite their detail, many national policies and guidelines can still be open-ended in their potential for different interpretation. Once CECs have reached agreement on a specific interpretation which is believed to be both consistent and practically feasible, this too must be communicated in a way which gives constructive and specific advice, with copies available to staff on all appropriate hospital wards. More detailed documentation about the reasons for the adoption of this interpretation should also be agreed, distributed to clinical managers and made available for inspection by all staff.

In illustration, two types of ethicolegal issues in medicine have traditionally dominated policy formation on CECs at both national and local levels. By far the most important has been, and will continue to be, problems concerning the non-provision or withdrawal of life-sustaining treatment. Within the UK and elsewhere, policy documents abound from respected organisations and their own clinical ethics committees. For example, the BMA has recently published a long and impressive policy statement about the circumstances in which clinical duty to protect life and health can be overridden.[28] Yet the monograph is quite long and begs for a concise summary, including practical examples of how various open-ended waivers of this duty should be interpreted in clinical practice. It is one thing for the BMA to argue for the importance of a clinical consensus about decisions to withdraw life-sustaining treatment for children or adults. It is quite another for such a consensus to be regularly achieved. This will require policies designed and presented in ways that are calculated to facilitate team building and good communication.

The second most likely issue to demand pro-active CEC attention concerns the boundaries of obtaining informed consent to clinical treatment. Within the United Kingdom, the law offers scant guidance for good clinical practice in obtaining consent. It is still common for medical lawyers to state that there is no such thing in law as the doctrine of informed consent and that the standard of disclosure of information commanded by common law is very weak indeed. The Department of Health has hardly helped matters through failing to grasp the importance of raising professional standards in their own published guidance.[34] As has been indicated, the BMA and GMC have taken a lead in their policy documents, advocating a higher standard of disclosure rather than the professional or "Bolam" standard incorporated in law. Yet these documents are written at such a general level that clinicians require more specific local policies that encourage them to improve their traditional

patterns of obtaining consent and provide practical advice about how to do so. For example, CECs should review hospital consent forms, making it impossible to complete them without the inclusion of minimally acceptable information about diagnosis, treatment and risks. Concise advice should also be provided about how a higher standard of disclosure of information should be applied in practice.

Clinical ethics committees should also formulate local guidance about other areas of clinical life. These cover the spectrum of issues discussed in current texts on bioethics. Included should be local policies on (among others):

- confidentiality—improving the security of clinical records (especially in light of the 1998 Data Protection Act) and regulating the use of such records (for example for educational purposes) and their transmission between health care staff;
- relatives—clarifying the fact that in the UK, relatives cannot act as legal proxies for adult patients, along with the practical implications of this for good professional practice in consultations with carers;
- reproduction—advising on how best to implement professional and legal guidance on in vitro fertilisation (IVF) and other forms of assisted reproduction, on genetic screening and on good obstetric care (for example dealing with refusals of caesarean section);
- psychiatry—articulating the role of the duty psychiatrist throughout the hospital and the circumstances when incompetent patients or patients strongly thought to be incompetent, can be given emergency care without consent (for example in accident and emergency medicine), and
- resource allocation–formulating policies for the fair distribution of scarce resources for all clinical specialisations within the hospital, including the organisation of fair waiting lists, of transparent and effective triage and of the prioritisation of expensive drugs and equipment.

Clinical ethics committees should formulate such local policies and practical guidance for the hospital as a whole. Sometimes, however, the development of both will best occur in relation to the needs of particular clinical specialisations.[35] When this is so, initial contact between the specialisation and the CEC should occur through the most appropriate committee member and, again with appropriate consent, details of the consultation should be reported back to the committee.

Constraints on the success of CEC policies

There are three key constraints on the potential success of CECs in formulating local policy and providing a reserve of individual consultants who can work with colleagues to put it into practice.

First, it is essential that CECs do not exceed their terms of reference as bodies that advise on, but do not formulate, clinical policy about specific patients.[13] This should remain the responsibility of their clinicians. Those who have been hostile to the creation and operation of CECs have been most concerned about their potential for clinical interference and for good reason. Clinical relationships with patients are highly individual in character and depend for their success on a strong bond of trust. If patients come to believe that "strangers at the bedside" are making key decisions then this bond may be undermined.[8] If patients or relatives believe that a committee rather than their doctor is making important decisions about their specific care then accountability will become blurred, with potentially disastrous consequences for effective counselling and communication. If CECs overreach their advisory role, clinicians may react by not taking seriously policies which have been properly formulated and will improve patient care.[36] Therefore, the terms of reference of CECs should be publicised, making clear their advisory status as regards individual or collective consultation.

Second, the long term success of CECs depends on much more than the theoretical coherence and practical feasibility of the policies they create. The real test of success will be the extent to which clinical staff actually implement these policies. Without appropriate training, however, implementation will at best be patchy. For example, it is now BMA and United Kingdom Central Committee for Nursing and Health Visiting (UKCC) policy that most competent adults should consent to a do not resuscitate (DNR) code in their notes. Many hospitals have also formulated policies that say the same. Yet clinicians sometimes ignore this advice and still administer DNR codes without consent. They may do so because they are uncomfortable with discussing the non-provision of resuscitation with very sick patients and they have not received any training or practical advice about how to have such a discussion.[37] Similarly, there is extensive evidence that clinicians can be poor communicators. Even if they accept the local policies about the moral and legal importance of informed consent, they may hardly be in a position to act accordingly.[38] Therefore, CECs should never rest content with the role of policy formation. They should press hospital administrations to resource appropriate training programmes.

Finally, CECs must address the fact that the effective implementation of ethicolegal policy requires supportive institutional structures.[4] For example, if no mechanisms exist for monitoring the degree to which staff conform to the committee's published policies, the success of its work will be impossible to judge. Similarly, the CEC may formulate local ethicolegal policies but it will not have the capacity or authority to disseminate them. The extent to which the institution does so will signal to staff its commitment to the work of the committee. Furthermore, unless institutional structures are in place to ensure that recommendations of CECs can be practically implemented, they will remain little more than devalued or ignored moral abstractions. For example, it is one thing for local policies to stress the professional importance of the confidentiality of clinical records. It is quite another

for the actual management of these records and the maintenance of their security to be done in ways that make the strict preservation of privacy a practical proposition. CECs should keep such institutional issues under review and, when appropriate, press them home to hospital management.

Conclusion

This paper has explored the background to and need for CECs in hospital medicine. To be optimally rational, the creation and effective use of substantive moral and legal principles must be grounded in collective discussion. In the face of moral and legal indeterminacy, such discussion should conform to procedural principles that ensure the participation of those with relevant expertise and effective, fair debate between them. Provided that CECs work to such principles and their members are trained to do so then there is every reason to believe they can make an extremely positive contribution to improving clinical practice and the general quality of health care.[39] At their best, research ethics committees have made just such a contribution to good research practice in clinical medicine. Resistance to the creation of CECs risks, therefore, the appearance of self serving. Such resistance is particularly ironic in a country where the professional reputation of doctors has recently come under attack for poor ethicolegal practice. There is no reason any longer to tolerate a double standard where rigorous regulation of clinical activity is confined only to research.[40]A high standard of clinical care is essential, whatever the context of its delivery. Properly organised and functioning CECs can help to ensure such a standard through the active involvement of clinicians themselves.[41 42]

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Legal aspects of clinical ethics committees

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Abstract

In an increasingly litigious society where ritual demands for accountability and "taking responsibility" are now commonplace, it is not surprising that members of clinical ethics committees (CECs) are becoming more aware of their potential legal liability. Yet the vulnerability of committee members to legal action is difficult to assess with any certainty. This is because the CECs which have been set up in the UK are—if the American experience is followed—likely to vary significantly in terms of their functions, procedures, composition, structures and authority. As a consequence it is difficult to generalise about the legal implications. Nevertheless, despite these difficulties this article will outline the broad legal principles governing the potential liability of committee members. It will also consider the relationship between CECs and the courts. It begins, however, with a brief analysis of the relationship between ethics and law in committee deliberations, and in particular of the role of law and legal expertise on CECs.

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The relationship between law and ethics

To assert that law and ethics are interconnected is to state what is self evident and uncontroversial. Not only have they sprung from the same philosophical roots and Judaeo-Christian traditions,[1] but they share the same vocabulary, in which terms such as rights, duties, responsibilities and obligations dominate, alongside concepts such as justice, fairness and equity.[2] As Lord Chief Justice Coleridge stated over a century ago: "It would not be correct to say that every moral obligation involves a legal duty; but every legal duty is founded on a moral obligation".[3] Both law and ethics are also normative and so aim to distinguish between acceptable and unacceptable behaviour by reflecting public opinion and current mores.[4] Yet although law and ethics are related activities they are distinct. Thus the law is mandatory, setting minimum standards that can only be breached at the risk of civil or criminal liability. Accordingly, the questions asked when legal decisions have to be made are likely to be instrumental, such as: "What can we get away with?; Will we get sued if we do this?" Ethics, however, is aspirational, setting universal goals that we should try to meet but without there being penalties when we fall short.[5] And whilst what is ethical is usually legal and vice versa, this is not always so since certain ethical principles are too vague to be translated into law or the law may be too blunt an instrument to enforce a moral idea. Telling lies, for example, is widely condemned as immoral yet there are very few laws against it. Note too that whilst the law has spoken clearly in many areas of bioethical concern—about death and dying, reproductive technologies, organ transplantation and so forth—in many areas there is no legal consensus and questions remain unresolved. That society should turn to the "magic" of the law and the legal system at a time of rapid technological advances in the belief that they can provide speedy, certain answers is, perhaps, not surprising. As Dworkin has observed, concern for medical ethics has often become a plea for medical law.[6]

What should be apparent, even from the above brief analysis, is that the relationship between law and ethics is a complex one. It is also controversial—or so it would seem from the very divergent views held as to the role of law in ethics discussions.[7] Thus for some commentators law and legal expertise is very welcome, enriching and enhancing ethical analysis, particularly when applied to such legal concepts as informed consent, best interests and advance directives. The explicitly analogical nature of law and its clear articulation of distinctions among cases can likewise improve ethical analysis and study.[8] Information about the law is useful too, in debunking legal myths and correcting misperceptions of the law.[9] If these are not addressed, the most ethically desirable course of action may be ruled out on false legal grounds. Similarly, knowledge of the law can help physicians and others to understand what the real risks of civil or criminal liability are, and thus alleviate excessive fears.[10] Identifying legal issues and in particular invoking the law to show whether an option recommended by a clinical ethics committee (CEC) is realistic, ie whether it can be implemented under current law, is another advantage which has been cited. Attention to legal criteria in decision making and legalised approaches are similarly said to foster deliberation and careful weighing of evidence as well as playing a fundamental role in tempering subjective discretion and minimising arbitrariness.[11]

For many legal scholars and ethicists, however, the law is more a menace than a friend and certainly a poor substitute for moral consensus.[12] This is because legal intervention almost inevitably leads to "legalism"—a process Callahan[13] describes as the translation of moral problems into legal problems; the inhibition of moral debate for fear that it will be so translated, and the elevation of the moral judgments of the courts as the moral standards of the land. Overemphasis on formal legal procedures

and too narrow a focus on the law also inevitably, it is argued, reduce moral reasoning to mere rule-following. If this happens there is a danger of the focus shifting from what should be done morally to what needs to be done legally, with the consequence that CECs become little more than legal watchdogs whose only function is to promote adherence to law.[14] Another of the law's sternest critics, Annas,[15] claims that "good ethics committees begin where the law ends" and argues that setting up additional bureaucratic entities—or rather "risk management" or "liability control" committees as he prefers to call CECs—to make legal pronouncements can only make medicine more legalistic and impersonal. Using the law in ethics discussions also encourages committees to attempt to anticipate litigation behaviour and predict what a court might do—a practice which may directly conflict with what those consulting them believe to be the best outcome ethically.[16] Finally there is the argument that an inappropriately placed legal comment can all too easily stifle ethical discussion. It has been suggested, for example, that "where there has been a lawyer on the ethics committee everybody looks to one end of the table where the lawyer sits and asks: 'What is the answer?' or 'Is that legal?' and the lawyer says: 'Yes, it's legal, it's fine,' or 'No, it isn't.' That, in some cases, will end the discussion."[17] Whether this deference to the law is due to the tendency of lawyers to want to control proceedings and dominate discussion or is prompted by anxiety about potential legal responsibility is, of course, difficult to ascertain. But it is an important issue and a central concern for Bateman,[18] who provides the most detailed analysis to date of the various roles lawyers have, if any, as members of CECs.

The functions of CECs and the lawyer's role

Although CECs have no standard mission, three main functions have been consistently identified in the literature, notably education, policy development and case review.[19] Other functions less frequently cited include reducing litigation,[20] helping to protect health care professionals legally by making them aware of any applicable law,[21] and providing a forum for discussion of legal issues. Indeed it seems there is a common belief that CECs exist simply to provide legal assistance.[22] But whatever the function there is widespread insistence that CECs are and should remain primarily advisory. Whilst this might be the intention, with little guidance about whom they are advising and in respect of what, there is likely to be confusion and this is where lawyers, trained to clarify issues, may be able to help.

Arguably the least controversial role for lawyers is in relation to a CEC's educative function. Here they can not only educate committee members about the law, dispelling common legal myths and explaining what the law allows but also contribute to seminars, lectures and other forums designed to educate hospital employees about legal and ethical aspects of treatment and so forth.

The second function, policy formulation, can take several different forms. Many committees actually make policies or draft policies for review by the hospital administration. Others may modify national guidelines, for example, on "do not resuscitate orders".[23] But whatever the precise form policy development takes, lawyers, whose training teaches them to scrutinise words carefully, can be especially useful in playing "devil's advocate", alerting members to subtle ambiguities and uncertainties in the wording used and ensuring that a particular policy or set of guidelines is clear.[24]

Wide variations

The third function, case review, is the most problematic in terms of the lawyer's role not least because whilst much of the literature refers to some type of case analysis there are wide variations in the procedures adopted by committees, likewise what actually happens when they discuss cases. According to Bateman there are in practice four different approaches to resolving ethical issues through case analysis. As he notes, however, committees do not always consistently follow one specific approach and may even switch from one to another within the same case analysis. The most formal type of approach is the "case review". Issues which typically concern committees using this model are procedural, such as who can bring a case before the committee, who attends the review, who acts as the patient's advocate and who can vote.[25] Given the legalistic nature of this approach—which is most pronounced if the review process is viewed as a potential substitute for the courts—it is not surprising that lawyers, who are familiar with quasi-judicial methodology, are best placed to ensure that proper procedures are followed and that the rights of patients and others are fully protected. "Case consultation" on the other hand is, as the name suggests, a much more consultative process. Like the "case review" scenario committees adopting this approach may reach decisions or make recommendations but will do so as specialists asked to consult on a difficult case. Their focus is thus on issues such as whether there is a need to see a patient or interview family members. In their deliberations they usually clarify what options exist (and the likely consequences of each).The lawyer's role here may be as an expert in the relationship between law and ethics and as an advisor on the legal ramifications of the various options discussed. The other two approaches, namely "case counselling" and "case discussion" will not be so dependent on a lawyer's special skills. In the former the concern is to "reshape the problem so that those facing the ethical dilemma can see appropriate solutions".[26] Lawyers involved in this type of approach do not give legal advice or discuss legal implications of particular courses of action. Instead they can help clarify the issues—crucial if a consensus has to be reached but there are several issues, some of which may be obscure. In "case

discussion", the intention is not to reach a decision or make a recommendation at all but to increase members' understanding. Lawyers contributing to this scenario are primarily likely to provide a legal perspective, for example, explaining how and perhaps why the law has developed as it has.

If Bateman's analysis of the lawyer's potential role is accepted it is clear that lawyers have much to contribute to a CEC. Nevertheless their participation has, as was noted above, been seriously challenged. Given too the ambivalence about the role of law in ethics discussions, it is almost inevitable that there is little consensus about the "proper" relationship between CECs and the courts.

Clinical ethics committees and the courts

The American experience reveals how almost every possible arrangement of courts and committees has been suggested.[27] Thus some commentators have advocated case consultation as a way of trying to keep cases out of court. Others have argued that consultation should actually substitute for judicial review—an approach which is rejected unequivocally by Wolf not least because committees vary enormously, in ethical expertise, commitment to patient protection, and involvement of patients in the committee's processes. She also doubts that committees have the legal expertise, impartiality, commitment to precedent, or the public accountability to adjudicate legal rights.[28] Given these divergent views it is not surprising that American judges have also failed to be consistent in their approach. Thus in one case[29] the courts treated a committee's determinations as highly persuasive "evidence" in so far as they used its documentation both to illuminate the process followed in arriving at the decision and to validate the decision. In other words the court seemed to use the committee's documentation for assurance that the doctor and experts had come up with the right answer, and that the appropriate procedure would yield that answer.[30] But in other cases the courts have virtually ignored a committee's recommendations[31] or have ordered some kind of future committee process.[32] Nor is the position in the UK any clearer. This is because no court has yet considered an ethics committee's recommendation. What legal authority it would ascribe to such a recommendation in the future is therefore uncertain. Nevertheless in view of the UK courts' traditional deference to the medical profession, it is unlikely that they would seriously challenge a CEC's decision—unless of course, it failed to comply with a responsible body of medical opinion.[33] It is also probable that the courts would endorse a CEC's interpretation (and modification) of national guidelines, for example, those issued by the BMA concerning "do not resuscitate orders".[34] Again, however, this would be subject to any modification conforming to accepted practice.[35] However, the issue of adherence to guidelines raises another important aspect, notably the risk of CEC members being sued for the ethics advice they give.

Legal liability of CEC members

A decade ago it was commonly, if not universally, believed that ethicists and other members of CECs, were unlikely to be legally liable when conducting clinical ethics consultations.[36] However, concerns about liability are now being taken far more seriously, with one commentator suggesting it is only a matter of time until a CEC is held liable for a bad outcome; in short an "ethics disaster" is waiting to happen.[37] It is, of course, difficult to draw generalities about the potential legal liability of CECs, given the wide variety of functions they perform (ie education, formulating policy and guidelines, and review of cases). Nevertheless it is widely agreed that the clearest potential for legal responsibility—for ethicists and other CEC members performing consultative services—lies in giving prospective advice concerning the treatment of a particular patient. In other words, committees acting as advisory bodies offering recommendations may be liable for the advice they give.[38] Should any action be taken, however, it would almost certainly be a negligence claim, in which it would be alleged that there was a failure to exercise due care in giving advice or making a recommendation, and the patient suffered injury as a result.[39]

To succeed in such a claim, four conditions would need to be present. Briefly these are: first a duty of care must be established. For some writers there is no doubt that such a duty is owed to any patient who is the subject of consultation.[40] Others are less convinced. Merritt, for example,[41] notes that in some circumstances it is arguable that the duty of care is owed to the doctor asking the committee's advice rather than the patient in question. Accordingly the courts are only likely to recognise that committees owe a duty of care to patients when they consult the committee directly or when the committee otherwise purports to act in their best interests. Similarly debated in the literature is the second condition in a negligence claim, namely breach of the required standard of care. In the absence of a *Bolam* test in this context (likewise any standards of accreditation, licensing or formal guidelines governing CECs) there has been much speculation as to the skills a court might expect of an ethicist and other committee members. Nevertheless the most "fundamental" which have been suggested include an ability: to identify and analyse clinical ethical problems; to use and model reasonable clinical judgment; to communicate with and educate team, patient and family; to negotiate and facilitate negotiations, and to teach and assist in problem resolution.[42] The third condition, ie that the claimant has suffered injury, may not present too much of a hurdle for the victim of the alleged negligence but it still has to be established and would require medical evidence. But the fourth condition, that the negligence of committee members is both the legal and proximate cause is certainly problematic. The widely accepted test for cause which works in most but not all cases is known as the "but for" test. That is that the defendant's breach of duty is the cause of the

damage if that damage would not have occurred "but for" the defendant's behaviour. Hence, if the victim can show that the doctor would more likely not have acted as he or she did if the committee's advice had been otherwise, then its advice could be said to be the cause of the injuries. The difficulty here, however, would be proving this causal link when the precise authority of the CEC and how its consultation service was categorised may be very flexible or uncertain. As DuVal notes, a CEC can be mandatory or optional, both as to whether cases are brought before it and as to whether its determinations are binding on the clinical team. Only in cases where a CEC had the power to dictate the appropriate course of action would the causal link be clearly established.[43] In others, such as those in which the doctor could ignore the committee's advice, the legal position is much less clear.

Conclusion

This article has outlined the legal aspects of CECs which have most often been discussed in the literature and are typically regarded as the most controversial. But it is by no means comprehensive. It does not address issues such as indemnity for committee members; how they can ensure that any guidelines or policy they formulate are lawful, and that procedures and processes comply with the principles of natural justice. Its failure to do so, however, will hopefully not deter those considering becoming committee members in the future nor hasten the resignation of those already in place. As Weir has remarked: "We would all be gutless wonders if we didn't realise that there are worse things than being sued".[44]

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Clinical governance—watchword or buzzword?

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Abstract

In the latest reform of the National Health Service great emphasis has been placed on the achievement and maintenance of quality. Mechanisms for ensuring this are being set up under the general title of "clinical governance". What is the meaning of this term? The metaphor behind the phrase is of navigation through stormy seas, but who guides the helmsman? Clinical ethics committees could have a part to play in these changes, provided their role is properly understood. Clinical governance is concerned with management according to an agreed set of aims. The task of ethics committees is Socratic rather than managerial. They should ask fundamental questions about the ethical norms of the services provided and give critical appraisal of the moral character of institutional policies. If these tasks are carried out then governance may become a watchword rather than just another buzzword.

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Introduction

How might clinical ethics committees (CECs), if established, relate to the new obligations imposed on National Health Service (NHS) organisations to set up and implement systems of "clinical governance"? One of the difficulties in answering this question is that it can be hard to distinguish rhetoric from substantive change in political proposals to reform the NHS. Under New Labour all things have become "new". The NHS is no exception. We now have the "new NHS",[1] though this phrase is in fact a deliberate echo of the historic proposals to establish the service in the postwar era. Proposals for the renewed new health service come with a whole collection of buzzwords: "partnership", "joined up working", "modernisation", and—most prominent in all recent communications—"governance".[2] Governance itself subdivides into three sectors: financial governance, research governance, and clinical governance. In this article I shall focus on the last of these, since the first is fairly self evident, dealing as it does with financial accountability and probity, and the second (research governance) is yet to be explained in any detail. .

The question at issue in this paper is whether the concept of clinical governance has anything of substance to offer to effective ethical monitoring and support in the NHS. Is it a watchword for genuinely critical ethical reflection? Or is it merely another buzzword, a piece of trendy newspeak designed to create the illusion of innovation and reform? I cannot give any definitive answers to these questions at this stage, since the changes proposed are only just beginning to be put in place. Thus what I say is largely speculation, based only on what has been stipulated so far in government directives on the topic. I shall begin with the term "governance" itself, since this is an interesting, though largely unnoticed, metaphor; then I shall try to analyse the current proposals, in particular their stress on developing quality improvement; finally I shall discuss how, if at all, clinical governance might improve the ethical character of health care delivery.

The metaphor

The term "governance" has both a very modern and a very ancient resonance. Its modern cousin is "cybernetics", the science of control in a computerised environment, but behind both terms lies an ancient metaphor of seafaring. The Greek root, *gubernator*, means the helmsman. It seems we are being offered an image of battling with elemental forces, of charting a course through a mighty, confusing and often frightening ocean. Both the modern and the ancient associations suggest continuous difficulty, complexity and the need for highly skilled control of the potentially chaotic. These images are at least partially seen by the advocates of clinical governance in the NHS. The chief medical officer, in an article in a primary care magazine, has reported the following comments from one group of primary care providers who are trying to implement the changes: "It feels at present as if the NHS and Primary Care, is being buffeted by a series of tidal waves . . . to us clinical governance is a means by which we can collectively preserve our core values, seize the initiative, and ride the waves".[3]

We are dealing, then, with a metaphor that combines vision with control. The helmsman saves the ship from being overwhelmed by the forces of wind and wave, harnessing them instead to traverse a course ordered by the captain. Governance has no purpose without a charted course: it is merely control for its own sake. But the orders are quite useless, if there is no one with the skill to keep the

vessel on course. The demand for clinical governance combines a quest for values with a pressing need to make everyone feel part of the endeavour. It is a much more ambitious project than mere risk management, the weeding out of the most egregious miscreants. It aims for a sense of shared goals and the experience of real progress in achieving them.

The miasma of quality

What then is the shared goal, the agreed course for the good ship NHS? Here matters become distinctly hazy. The term "quality enhancement" is used, as though its meaning were self evident. But, in the absence of specification, the term is as empty as "quantity"—it refers merely to a dimension for measurement. Unless we know the nature of that being assessed and the means of defining improvement we know literally nothing about quality enhancement (or deterioration). Much of the language in government circulars seems merely rhetorical at this juncture. Take, for example, this passage from a Department of Health circular:

"The vision emphasises the need for a move to a culture of learning—an open and participative culture in which education, research and sharing of good practice thrive . . . . It reinforces the importance of multidisciplinary team working, and the need for clear accountability to and by the NHS Trust Board. It also makes the important link to the need to work with users, carers and the public."[1]

The problem with such writing is that it deals entirely with means and not at all with ends. In this it betrays its origins in business management theory. In a business, the end or purpose is not in question: it is to maximise profit, by creating an effective and cooperative work force in order to produce a product which satisfies the consumer in terms of the trade-off between quality and price. In the manufacturing industry (and to an extent in many service industries) quality is fairly easy to define, since it is closely related to what the consumer requires for her purposes. Thus customer satisfaction is a fairly good guide to the achievement of adequate quality to sell the product. None of this can be directly applied to the work of health professionals or to the institutions within which they practise. The services provided by the NHS are entirely unrelated to questions of profit and are only partially related to consumer satisfaction. Many patients who have been badly treated by unscrupulous health professionals have been entirely satisfied, indeed grateful, since they were wholly unaware of the poor quality of the service provided. The goals to which the health service is directed relate not merely to the wants or demands of patients, but to their needs, and at times even these may be left unmet by a public service, in the interests of justice to the needier members of the community. Thus the goals are complex, not easily defined and essentially evaluative in character. They will not be met merely by having effective teamwork, though clearly this is one necessary condition for their full achievement. The enhancement of quality in the NHS requires a continuing dialogue about its fundamental moral commitments and about how these are to be achieved in practice. The NHS circular describes a change in the culture of the organisation, which could certainly facilitate such a dialogue, but more is required. What is needed is a critical ethical edge to the assessments of quality. We need that spirit of fearless enquiry about fundamental assumptions represented by Socrates.

Clinical ethics committees—in search of the Socratic?

How then might the establishment of clinical ethics committees relate to the emergence of mechanisms for clinical governance? There is ample scope for confusion on this issue, and it will be vital to ensure that managers do not confuse the roles of such committees with those of the various other committees they have to establish for clinical governance. I begin this section with the official definition of clinical governance in the NHS circular, *Clinical Governance: Quality in the New NHS:*

"A framework through which NHS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."[2]

There is ample guidance in this document about how this aim is to be achieved. Clear national standards will be set by the national service frameworks and by NICE. Three national initiatives, a patient and user survey, a National Performance Framework and the Commission for Health Improvement, will monitor the delivery of these standards. At local level clinical governance arrangements will have to be put in place, with identified leadership and with an agreed baseline of current quality from which improvements must be made.

All this is admirable, and if it can be made to work throughout the NHS it should noticeably raise the standard of care and ensure greater protection of patients from inadequate services or professional malpractice. But how does it all relate to ethical support and appraisal? Misunderstandings will easily arise. For example, managers may see clinical ethics committees as part of risk management and so expect them to reduce the incidence of unethical practice. There is no prospect of this happening, even if it is a desirable or appropriate role for clinical ethics committees. Ethics committees perform a consultative, not a managerial, role in health institutions. It is unimaginable that they could, or should, seek out unethical practice and try to remedy it. Indeed, the most likely people to consult such committees are the most ethically conscientious of the professional staff. The practitioners whose practice is of concern ethically are not at all likely to submit their clinical decisions to ethical scrutiny! Moreover, at a deeper level, the task of ethical analysis and advice is not to

offer incontestable moral judgments on the decisions or practices of individual practitioners. Not infrequently there may be diverse views of the right course of action on the committee itself, and usually the task of the committee is to air the debate, leaving the individual practitioner or treatment team to reach a considered judgment on their own responsibility. Committees may help to produce more thoughtful, educated and self critical practitioners, but the end result could be an increase, not a decrease of risk to the institution from such independently minded practitioners. The search for the Socratic is often the search for the controversial, and it should not be forgotten that Socrates himself was found guilty of (educational) malpractice by an Athenian court.

Health professionals may also misunderstand the role of ethics appraisal in the new, endlessly monitored, NHS. Increasingly they may look to a clinical ethics committee as a professional haven, offering a sympathetic ear, and perhaps some conceptual weight, to their complaints that the management's or the government's "obsession" with standards and with quality assessment is impeding their ability to spend time with patients, and so is unethical. This is, again, a misunderstanding of the nature of modern ethical review. A genuinely independent committee will not support a solution which suits the practice style of one professional group, or which favours the patients of the more politically powerful specialties. Of course, the balance between delivering a service and having it adequately monitored must always be a matter of concern, especially if resources to enable both are inadequately provided. In that situation, a priority could well be to focus on patient care at the expense of management functions. But this can be only an interim solution. It cannot be an ethical aim merely to deliver a service, with no adequate checks on its quality.

So if ethics appraisal suits neither the management nor the agenda of some health professionals in clinical governance, of what relevance is it? I return to the difficulty of defining quality, discussed in the previous section. Clinical governance will eventually be based on national benchmarks, based on comparisons between institutions in their performance measured against a complex set of criteria. Some of these criteria will be evidence based and will be defined by NICE; others will be derived from the government's requirements as laid out in national service frameworks or from the recommendations of CHI. All such national criteria depend on value judgments. They are not merely "objective" in some narrow sense, and they are certainly not self evident. They entail deciding what the priorities of a national health service should be and arguing for interventions which fulfill the basic moral goals of the service. To describe a treatment as "effective", for example, entails some assumptions about what outcomes should be achieved, and since many medical treatments do not achieve only beneficial results, some balance of burdens and benefits must be calculated. Equally, the definitions of health improvements in target-setting entail assumptions about the relative importance of interventions, which save or prolong lives and those, which improve quality of life.

The "product" of the NHS is incredibly complex and assessments of how it is to be achieved must be the outcome of sustained debate, involving a wide range of people within and outside its institutions. I regard a clinical ethics committee as a natural location for, or initiator of, such debates at the local level. Since every trust and health authority must produce its own clinical governance documents, including a local benchmarking that will determine the nature of the improvements required, I would suggest that, where clinical ethics committees exist, they should be invited to comment on the ethical assumptions implicit in the quality improvement plans endorsed by the local institutions

In conclusion, we should not underestimate the importance of establishing clinical ethics committees within the institutions of the "new" NHS. I have argued that their relationship to clinical governance is indirect and that they must not be seen as merely tools of the new emphasis on quality improvement, or as bastions of the defenders of professional power. They can indirectly improve the quality of care by providing support to clinicians and managers as they face difficult clinical decisions; and they could help to create the kind of reflective and self critical culture within the NHS which will be essential for clinical governance to be a genuine, rather than a cosmetic, change. To achieve this they must be independent of both management and clinical staff, yet carry authority with both—no easy task!

But, finally, ethics committees themselves should not be exempt from the sustained and planned scrutiny of clinical governance. Do they provide a service that meets national standards of professional ethical consultancy? How do they audit their own performance? And what measures are they taking to remedy deficiencies in their own procedures? If—to return one last time to the maritime image of governance—they see themselves as part of the good ship NHS as it tries to chart its somewhat perilous voyage, we need to know that they are professional and trustworthy members of the crew.

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