Letters

Is there a demand for a clinical ethics advisory service in the UK?

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Twenty years after their introduction in the US clinical ethics committees are beginning to appear in the UK. In 1996 Meslin described three recently established hospital ethics committees[1] and since then at least one more has been established. The editorial in the August 1997 edition of this journal commented that the introduction of clinical ethics committees in this country should be exploratory.[2] There are few data on the need for ethical advice, or the most acceptable form of delivering such advice, for clinicians. There are also few data, even from the US, on the effectiveness of clinical ethics committees. Larcher has demonstrated a desire for ethics advice and enthusiasm for the establishment of an ethics committee among staff in two London children's hospitals.[3] This finding may not be generalisable to other types of hospital in the UK.

We performed a questionnaire survey of all consultants in a single acute NHS Trust based in a district general hospital to determine the frequency with which they encountered ethical dilemmas, their willingness to use a clinical ethics advisory service (CEAS) for individual case assessment, and their preferred method of delivery of such a service. The questionnaire had a 90% response rate (56/62). All but one consultant had ethical dilemmas in their work.

Eighty-nine per cent discussed their dilemmas with other parties including consultant colleagues (79%), the patient and/or his or her family (68%), nursing staff (53%), junior medical staff (49%), a defence organisation (27%) and other health professionals (23%). Seventy-one per cent would refer cases to a CEAS if one was available. The projected demand for such a service, calculated from the frequency with which consultants said they would refer cases, was around 100 cases a year. Fifty-nine per cent of consultants would prefer delivery of such a service to be by a clinical ethics committee, 36% by a clinically qualified ethicist and 4% by an ethicist. Eighty-four per cent of consultants felt that a CEAS should contribute to clinical guidelines. Twenty consultants made specific comments about the provision of a CEAS. The most common themes were 1) that referral should be at the discretion of the consultant in charge of the individual case, 2) that the final decision should remain with the consultant and 3) that the CEAS provider should be adequately informed ethically, legally and medically in order to give appropriate advice. Other comments included the need for careful thought and discussion before the introduction of any such service and that if such a service was available it might be difficult to justify not using it.

This study provides further evidence for the desire for ethics advice in hospitals and the willingness of clinicians to make use of an ethics advisory service. The terms of reference of such a service are open to debate. In the US clinical ethics committees were initially established for individual case review, but this role has diminished and that of education and policy review has become the main activity of many committees.[4] There are a significant number of inactive committees in the US, up to 33% in one study,[5] and there is some evidence of a discrepancy between the perceptions of committee members and of hospital staff as to the value of the committee.[5] Further, more comprehensive studies are required to look at the perceived need for, and the effectiveness of, any system established to deal with clinical ethical problems before we can advocate the widespread introduction of clinical ethics committees in the UK.

References

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