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Editorial

Clinical ethics committees – pros and cons

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In this issue of the journal a nursing sister, a psychiatrist and a paediatrician from London's Great Ormond Street Hospital for Children report that their inquiries at the hospital show both a need for, and a willingness amongst respondents to have, a clinical ethics committee.[1] While American readers will doubtless raise amused eyebrows at this acceptance of an idea that they have implemented years ago, in the UK and in much of Europe, as in many other parts of the world, clinical ethics committees are rare and have so far not found much favour amongst clinicians, especially hospital doctors.

What are these committees, and do countries that do not have them need to look seriously at the pros and cons of having them?

Clinical ethics committees (CECs), or as they tend to be called in America, Institutional Ethics Committees (IECs) or Healthcare Ethics Committees (HECs) are multidisciplinary groups established within hospitals and various other sorts of health care institutions such as nursing homes, with at least one and often all of the following functions: review of ethical issues arising in particular clinical cases, both prospectively and retrospectively; education, at least of their own members, and often more broadly within and beyond the host institution, in relevant bioethics issues; and assistance in the development of institutional policies that involve clinical ethical issues. These committees are different from Research Ethics Committees (or Institutional Review Boards as they are known in America and certain other countries), whose brief is the ethical review of research on human subjects.

What are the benefits of CECs that might lead a hospital or other health care institution to set one up? Dr Larcher and colleagues point to the occurrence of difficult ethical problems arising in clinical treatment and dissatisfaction among staff about the way these are dealt with. Thus specific areas of ethical concern identified at the paediatric hospital surveyed included adequacy of information – given to both parents and children; inadequate involvement of children in decision-making on their behalf; excessive orientation to "treatments which were distressing, heroic, experimental or futile and their continuation even in the face of a poor prognosis" and conversely inadequate readiness to offer "routinely and sensitively, terminal care as an alternative", problems of confidentiality, and fair allocation of inadequate resources.

Problems identified for existing methods of confronting such issues included the *ad hoc*, unstructured and time-starved nature of "the unit or psycho-social meeting" at which such issues were discussed; the acute setting for such discussions; and the tendency for such discussions to be in practice restricted to members of the same discipline who have the same ranking within a discipline, with resulting tensions, including hierarchical and interdisciplinary tensions, often being left unresolved. Another implicit criticism of existing arrangements by their respondents was that nurses had, and had access to, considerably more formal training in health care ethics than doctors.

Clinical ethics committees, argue Dr Larcher and colleagues, can remedy such problems, by providing multidisciplinary consultation (but not, they are clear, "prescriptions" for action) concerning clinical ethics issues, whether case-related or more general – and in doing so benefiting patients, families and carers, and health care staff; by participating in the development of ethical guidelines in ethically contentious areas of clinical practice; by educating not only themselves but also other members of staff in relevant aspects of clinical ethics; and by providing time and the relevant shared objectives for recurring and regular opportunities for reflection on ethical matters away from the acute clinical setting.

Various other advantages have been claimed for CECs. One is the very practical one of reducing litigation against hospitals and their staff by helping to diffuse conflicts, or by preventing their escalation, between patients and/or their relatives or carers on the one hand, and hospital staff on the other.[2] At the other end of the spectrum, and anticipating an ever greater readiness to call on health care institutions to remember and avow their moral purposes,[3] the role of the clinical ethics committee has been seen as "the representation of those values and practices that define the health care institution as a moral community . . . first and foremost a community of caring". In this role, the CEC functions "to preserve the moral community:

first by insuring that the hospital remains conscious of itself as a moral community (and not simply a commercial enterprise); second, by exploring and articulating those boundaries of conduct that define the moral character of the hospital".[4]

On the other hand a variety of worries about clinical ethics committees are sometimes expressed. Among these are: that they will interfere with that delicate and invaluable component of health care, the doctor-patient relationship, and further erode the professional autonomy of doctors and undermine their responsibility and authority to act on behalf of the their patients[5]; that they may actually reduce the patient's freedom of choice, and or, by having too many competing concerns, including the interests of the hospital and of its staff, will risk undermining rather than promoting patients' interests; that they will create a further layer of administrative bureaucracy in hospitals that are already overburdened with such bureaucracy; that they will further diminish the already inadequate time available for clinical care; that they will create unnecessary moral and even political dissent[6]; that they will tend to excessive caution in their analyses and recommendations partly to protect themselves[7]; and even that they are potentially tyrannical, via perhaps the "tyranny of the God squad".[8]

Given the variety of such concerns it seems clear that any introduction of CECs should be exploratory, with the intention of actually investigating the pros and cons of such committees in particular institutions and contexts, as well as investigating which characteristics tend to produce a useful committee and those which tend to impair its functioning. Some survey evidence suggests that certain commonsense assumptions are justified, including the benefits of committees that are inquiring, open-minded, non-hierarchical and which include members with some education in bioethics.[9–11]

Even though the American experience of CECs is so much greater than that in most other parts of the world it is clear that there is disagreement on many aspects of their function. Which occupational groups, and in which proportions, should be members? Should their ethical review include resource allocation decisions and business decisions of the hospital in so far as these impinge on clinical ethics? Should the time of committee members be paid for? What if any responsibility do CECs have to the communities within which their hospitals function? How much should skill in diagnosing and modifying the effects of group dynamics ("microsociology") within the CEC be required of at least one of its members? How much should expertise in communications and in mediation and in law be necessary components of a CEC?

As a counterbalance to such questions an evocative account of the role of CECs is worth relating – that of the clinical ethics committee as Greek chorus.[12 13] Whether or not the more specialised functions indicated above are necessary for a CEC, these authors remind us that clinical ethics committees often function in the realms of human fate and human tragedy. In such contexts a committee's role may be that of the chorus in a Greek tragedy. It does not act, but instead "the chorus offers advice and history and support for the protagonist . . . establishes a moral resonance for the hero's fate. Its virtue is its presence and its sympathy and its clear meditation on his or her predicament in a social and historical context. . . . Beyond the tragic ending, we imagine, the chorus will store up the memory of the struggle just ended, and this will in turn be the stuff of moral reflection on some future occasion". This view of the role of CECs is unlikely to appeal to tough-minded seekers of quick decisions. But as Dr Fleetwood and colleagues pointed out about such committees in these pages,[14] the process is more important than the specific outcome. A coin toss would provide a rapid choice between alternatives in a moral dilemma. Clinical ethics committees are obliged to confront all the ambivalence and uncertainty that made the decision difficult in the first place – that would be their value.

References and notes

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