

Clinical ethics committees in the UK

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Open a newspaper and, as like as not, you will find a story about medical ethics. Rationing and the use of Viagra look set to exercise the minds of government ministers and leader writers for some time to come; Diane Blood's baby was born at the end of 1998 after her much publicised legal battle to use her dead husband's sperm without his consent.

The stories that reach the papers can be quite esoteric: posthumous conception is not a common occurrence. Ethical issues, however, are a part of everyday medicine, whether at the bedside or for the health authority. Advances in medical science, and the higher costs of health care, only add to the number of ethical dilemmas. Increasing public awareness of medical ethics, pressure for greater public accountability of health professional decisions, and team-working together make it almost impossible for individual doctors to decide issues of ethics solely on intuition and a purely personal moral code.

Professional bodies such as the General Medical Council, the British Medical Association and the Royal Colleges address the problem by developing general codes of ethics and guidelines on specific issues. The Tavistock Group has published a 'shared statement of ethical principles for those who shape and give health care'¹, which aims to provide a set of ethical principles for all health care providers across professional boundaries as well as for users of the service. General principles are, however, of necessity non-specific, and even specific guidelines do not necessarily provide a solution in an individual situation. How do we bridge the gap between statements of principles and the application of those principles at the bedside?

One possible solution is the development of clinical ethics committees (CECs). Unlike local or regional research ethics committees, CECs consider ethical issues arising from clinical care, either at an individual case level or by developing ethical guidelines for use in the hospital or trust to which the committee belongs. They do not consider research proposals – indeed, they have no authority to do so. Such committees have long been a feature of hospitals in the US. Over the past few years several hospitals in the UK have set up their own CEC. Broadly speaking, these are multidisciplinary groups, usually with patient representatives, which consider ethical issues in the delivery of health care within the host institution. The three main functions of a CEC are:

- education
- helping to develop policy and guidelines in areas where there are ethical issues relating to health care delivery
- individual case review.

The dominant function depends on the particular committee. The Oxford Radcliffe NHS Trust CEC, set up in 1995, has developed guidelines on 'do not resuscitate' orders and living wills, and has discussed retrospectively individual cases which the attending doctors or nurses have found ethically difficult. One case involved the response of staff to the surreptitious taking of cannabis on the ward by a patient with multiple sclerosis. Another concerned a patient in need of surgery, but deemed incompetent to consent because of an acute confusional state, whose spouse asserted that the patient had previously stated that surgery would be refused in any circumstances. The committee has not considered 'active' cases, but many US committees give advice on current cases at the request of clinicians. At least one CEC in the UK has been set up with the express purpose of making decisions in ethically difficult cases (in this instance confined to obstetrics)².

Information regarding UK CECs is scanty. There is some published work suggesting a perceived need by health care workers for ethics support^{3,4}, but we are aware of only two published accounts describing established committees^{2,5}. No attempt has been made to develop a consensus on the structure, process or objectives of CECs developing in the UK.

In the US, the development of CECs was given impetus both by the recommendations of The President's Commission Report in 1983 and by the Federal Self-Determination Act of 1990 which requires hospitals to establish CECs to qualify for Medicare and Medicaid payments. Most hospitals in the US now have a CEC, but their structure and function vary. Many hospitals also use other forms of ethical support for clinicians, including small teams of consultants and individual ethicists.

Little has been published on evaluation of either CECs or other forms of ethical support. Some studies have shown differences in perception of the role of the committee between committee members and health care workers, as well as between different groups of health care workers^{6,7}. In 1996, Tulskey and Fox⁸, reporting a conference on evaluation of case consultation in clinical ethics in the US, commented that:

the rapid growth in ethics consultation has occurred without either consensus about its goals or rigorous evaluation of the effectiveness of various approaches to its delivery.

Many unanswered questions remain about the role of CECs, their effectiveness, and their legitimacy as a means of influencing ethical behaviour.

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There is a danger that the pressure to address the problem of ethical issues in health care will lead to precipitous development of CECs in the UK. Once the number of existing committees reaches a critical mass it is easy to see how the presence of such a committee in a hospital or trust may become mandatory. This could occur without any evidence to suggest that CECs are the most effective or appropriate method of providing ethical support and guidance in clinical medicine. The Nuffield Trust has recently agreed to fund a project that will look in depth at the current state of clinical ethics support in the UK, and the perceived need for such support among the various groups within the health services. This will, we hope, inform the development of existing and future services. Only through the evaluation of these services will it be possible to assess their contribution to ethical problems in clinical settings.

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Stroke Rehabilitation

Patient and Carer views

A Joint report by the College of Health in conjunction with
the Research Unit of the Royal College of Physicians

prepared by Marcia Kelson and Carman Ford

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