AN ETHICS OF CLINICAL PRACTICE COMMITTEE: SHOULD EVERY HOSPITAL HAVE ONE?

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INTRODUCTION

Research ethics committees are a universally accepted part of clinical practice, but few hospitals in the UK appear to have a separate body that deals with ethical dilemmas in clinical practice. Such committees are common in the USA and indeed they form part of the requirements for hospital accreditation.[1] Modern health care increasingly provides ethical problems in relation to new technologies, costs and rationing, changing social values and relationships between health care professionals[2,3] and the rationale and scope for such committees is ever-increasing.

After discussion at the medical staff committee, the formation of a multi-disciplinary committee to review ethical problems arising in clinical practice was proposed in our hospital Trust. This paper details the experience with such a committee since its inception in November 1994.

TERMS OF REFERENCE AND RELATIONSHIPS OF THE ETHICS OF CLINICAL PRACTICE COMMITTEE

It was agreed that this new committee (ECPC) would not consider matters within the remit of the research ethics committee and also would not consider grievances and complaints about clinical care. The terms of reference are shown in Table 1.

The ECPC is independent of both the medical staff and hospital management committees. Its minutes are circulated to all consultant staff and to the hospital nursing forum by the director of nursing. Information about the committee has been placed in the hospital and local medical committee newsletter, and also promulgated to all hospital staff via the bulletin board on the hospital computer system. The announcement about the work of the committee has stressed that any member of the hospital staff can bring an issue or problem to the committee's attention, and strict confidentiality has been stressed.

Committee structure

Initially it was envisaged that there would be 12 members but this quickly expanded to 20 to ensure that the committee was fully representative and appropriately multi-disciplinary. The background to the current membership is shown in Table 2. Currently the composition includes several individuals from outside the hospital, nine female members and representation from two ethnic minorities. Eight resignations from the committee (six medical, two nursing) due to pressure of work have occurred in three and a half years and replacements have quickly been found.

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Meetings lasting up to one and a half hours are held in the early evening once a month, with the stipulation that other urgent meetings could be called if requested. This option has not yet been exercised. Meeting attendances are carefully monitored and poor attenders are replaced. No quorum has been specified in constituting this group as its function is discursive and advisory rather than directive. At least six members attend each meeting and often the attendance is greater. The meetings are chaired by a paediatrician. The vice chairman is a geriatrician. There is no payment for being on the committee or for attendance at meetings.

The minutes of each meeting contain a précis of the case brought before the committee, important points in

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.

TABLE 2
Current composition of Ethics of Clinical Practice Committee.

Hospital staff	**Outside staff**
Paediatrician (Chairman)	Professor of Social Studies
Geriatrician	Lecturer in Law
GenitoUrinary physician	Community Health
Cardiologist	Council representatives (2)
Nephrologist	General Practitioners (2)
Urologist	Director of Public Health
Transplant Surgeon	
Director of Nursing Services	
Ward Sister	
Nurse Practitioner (oncology)	
Hospital Chaplain	
Patient Care Facilitator	
Paramedical Services Manager	

(The religious persuasion or denomination of the committee members has not been addressed in any structured way. The hospital chaplain, a founder member, provides a multifaith religious centre in the hospital and would consult with colleagues on issues involving directly faiths other than his own.)

the discussion and the conclusions reached. Details of the case are filed and only the minutes are formally ratified and then sent out to the Hospital Medical Staff Committee and to the Nursing Forum.

Initially, committee members were seconded by asking for volunteers through the internal hospital information system and by nomination from the Director of Nursing. The local Community Health Council has nominated an initial representative. The chairman himself actually sought recruitment of non-hospital members such as the Professor of Social Studies, a lecturer in law, general practitioners and the Director of Public Health. If there is a retirement or resignation, an advertisement for a replacement is made or, after discussion with the Committee, a personal approach is made by the Chairman.

Problems discussed

Many ethical problems cross boundaries between different professions and specialities but examples of the problems discussed have included:-

Ethical issues arising from established or new policies in connection with patient treatment and care:

- **The in-patient hospital policy for 'Do Not Resuscitate Orders'.**
- **Guidelines recently initiated by the local ambulance service.**
- **Disposal of fetal remains.**
- **Resuscitation of patients exposed to radiation**
- **Transmission of results such as screening tests for haemoglobinopathy to counselling services outside the hospital.**
- **Consent to treatment policy.**

The committee's role is to discuss policies that are being revised or evolving, and not to direct the formation of new policies. A great deal of interest and debate centred around 'advance statements' or 'directives', and assisted conception and infertility but no policy documents have been issued. The committee sent comments to the expert committee on xenotransplantation.[4]

Items concerning individual patients and advice on moral issues when the clinician or professional asks for such assistance.

Neonatal intensive care is characterised by good multi-disciplinary team work and there is usually agreement between the staff involved on issues such as withdrawing intensive care from severely brain damaged infants.[5] However, problems can arise when there are discordant views expressed by different professionals. The committee has also given advice in situations where a neonate had inoperable bowel problems or a very poor neuro-developmental prognosis at birth. Other cases that were discussed have been the routine replacement of a pacemaker in an elderly dementing patient, parental pressure for children to have operations, and prophylactic treatment for patients after possible HIV exposure.

Staff from the genetics department have sought the advice of the committee. One such consultation centred on the ability to offer an increasing number of tests for inherited conditions. One dilemma related to the testing of a pre-symptomatic grandchild of a patient with Huntington's Chorea when the patient's parents refused to be tested themselves. A similar problem arose where a physician suggested testing a middle-aged woman for Huntington's Chorea but the son and daughter-in-law requested that their permission be sought first. Blood sampling for DNA storage from people with Alzheimer's disease, in order that the future risk to offspring can be considered, is a more recent example.

Other general issues which were discussed included the matter of levying charges for completing forms for private medical insurance in an NHS setting.

Issues of conflict between the wishes of the purchaser and provider in terms of patient care

One such matter related to families who have undergone extensive genetic counselling and who required *in vitro* fertilisation with egg or sperm donors in order to avoid transmission of potentially fatal conditions. IVF treatment was refused by a local consultant in Public Health on ethical rather than strict financial grounds. The committee supported the clinical genetics staff in contesting this opinion and treatment did proceed.

The ethics of rationing health care especially in the light of the child B case was another issue which was debated.[6] 'Child B' had suffered from leukaemia in 1995. Her father refused to accept the advice of doctors who counselled against further treatment. The father sued Cambridge and Huntington Health Authority for refusing to fund further chemotherapy and a second bone marrow transplant in the private sector.

Discussion

When the ECPC was formed a great deal of reservation was expressed about its purpose and usefulness. Others warned that it may take a long time for the members to feel as if they were accomplishing something concrete or having any direct effect on institutional attitudes or behaviour.[1] After three and a half years, the general impression of its members is that the committee does still have a useful role to play, and are enthusiastic about its continuation. The Medical Director and the Director of Nursing have continued to support the Committee.

Ethics committees should exist to serve patients and protect their interests. Although the committee has a discussive rather than a directive role, it has provided a forum for the review of hospital policies.[7] It is appropriate that these matters are discussed within a multi-disciplinary group which embraces both hospital, primary care and community input along with the valued contribution of academic and legal personnel. Indeed many of the issues discussed are at the ethical and legal interface, and a legal opinion as provided by a person versed in law is essential on the committee.

Few ethical and moral dilemmas concerning individual patients have yet been brought to the ECPC. Hopefully this reflects good teamworking and communication between health care professionals within the hospital. However, as recent ethical debates in the pages of leading medical journals have emphasised, there are plenty of examples of dilemmas involving the tension between what is perceived to be individual patient autonomy and responsibilities to family and society and these are likely to increase.

Ethics is a fluid and dynamic subject. One of the benefits of having a stable committee structure is that a group of individuals, none of whom consider themselves as ethical experts, are debating subjects where the ground may appear to be constantly shifting. The committee is increasingly able to refer to previous discussions and develop an 'ethical memory' which will be invaluable in future debates on subjects such as, for example, voluntary euthanasia. Hopefully ethical issues will form an increasing part of medical and nursing education, and will be carried out in joint forums. There is increasing scope to discuss health care ethics and not just medical and nursing ethics.[8]

Background tension in the health service is the ethics of rationing health care.[9,10] Providing a wider forum for this debate with the involvement of representatives from the Community Health Council, general practitioners and the local Director of Public Health might help members to come to better decisions as well as increase their understanding of the issues involved.[11] The formation of a multidisciplinary ethics of clinical practice committee in every hospital trust is therefore strongly supported.

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REFERENCES

1 Ross JW. *Handbook for hospital ethics committees* Chicago:American Hosp. Publ. 1986.
2 Medical ethics today. Its practice and philosophy. *BMJ* London 1993.
3 Hébert PC. *Doing right. A practical guide to ethics for medical trainees and physicians* Canada:Oxford University Press, 1996.
4 The Advisory Group on the Ethics of Xenotransplantation. *Animal tissue into humans* London:Department of Health, 1997.
5 Royal College of Paediatrics and Child Health. *Withholding or withdrawing life saving treatment in children: a framework for practice* London: Royal College of Paediatrics and Child Health, 1997.
6 Entwistle VA, Watt IS, Bradbury R, Pehl LJ. Media coverage of the Child B case. *BMJ* 1996; **312:**1587-91.
7 Doyal L. Advance directives. Like a will, everybody should have one. *BMJ* 1995; **310:**612-3.
8 Kellett JM. A nurse is suspended. *BMJ* 1996; **313:**1249-51.
9 Maynard A. Rationing health care. *BMJ* 1996; **313:**1499.
10 Øvretveit JA. Managing the gap between demand and publicly affordable health care in an ethical way. *Eur J Public Health* 1997; **7:**128-35.
11 Stronks K, Strijbis AM, Wendte JF, Gunning-Schepers LJ. Who should decide? Qualitative analysis of panel data from public, patients, healthcare professionals, and insurers on priorities in health care. *BMJ* 1997; **315:**92-6.