

## SELECTED SUMMARY

# Hospital ethics committees: time to move beyond the obvious

**ROBYNA IRSHAD KHAN**

Department of Anaesthesia, Aga Khan University, PO Box 3500, Stadium Road, Karachi 74800 PAKISTAN e-mail: robyna.khan@aku.edu

**Elliot B Tapper, Christian J Vercler, Deborah Cruze, William Sexson. Ethics consultation at a large urban public teaching hospital. *Mayo Clin Proc.* 2010 May; 85(5): 433-8.**

Hospital ethics committees (HECs) have come into vogue over the past quarter of a century, but subsequent to Joint Commission International Accreditation's mandate in 1992, they have become an essential part of all major hospitals in North America. These committees work on different models to address the clinical ethics needs of hospitals. Some hospitals have a fulltime clinical ethicist, while others use a multidisciplinary committee comprising clinical, administrative, religious and legal representatives. The primary role of a vast majority of these committees has been to provide consultation and help solve problems in clinical ethics. However, the scope of clinical ethics has become much broader over the last century and a half. Medicine, not too long ago, used to be an interaction between a patient and a doctor; it was mostly dispensed out of a black bag, and it was predominantly harmless, but often useless. Now, it has become highly technical, and complex, with care being provided by multidisciplinary teams. It is more effective but also associated with multiple ethical issues. Clinical ethics is the branch of ethics that deals with all these issues. It is the interface between providers and seekers of healthcare, and demands much more than passive case consultations.

It is now time that HECs seriously reconsider their mandate and take responsibility for developing a culture of ethics in medicine. They need to lay emphasis on the provider-patient relationship by paying attention to bedside ethics education; developing systems to minimise medical errors; honouring the concept of inherent respect for each person; developing patient care policies, and identifying and debating the newer ethical challenges posed by advances in biotechnology.

Second, they must address issues of organisational ethics, by developing fair and transparent systems of priority setting and resource allocation.

Third, the teaching of clinical ethics should include cognitive, behavioural and attitudinal elements, with proper evaluation and feedback. There is also a need to develop opinion leaders, effective teachers and role models for clinical ethics. Harnessing the informal curriculum is probably the biggest challenge in teaching clinical ethics. Measures to increase public education and involvement in clinical ethical issues are also required.

Fourth, HECs must conduct research in clinical ethics to identify the issues requiring emphasis in curricula, gaps in understanding these ethical issues, and ways to contextualise ethics with respect to local communities

Finally, ethics consultation should have as a goal the improvement of patient care and patient outcomes.

Tapper and colleagues published retrospective data on cases reviewed by their HEC after taking note of the pioneer ethicist Mark Siegler's plea (mentioned in their article) to carry out quantitative research in the field of clinical ethics. They collected data of all the ethics consultations provided by the HEC at a large public teaching hospital in the US during the calendar years 2004-2006. The process of consultation described is consistent with the process followed by a majority of HECs, with some small variations. They categorised the consultation process according to whether it was a "brief consult" where the question was answered by an informal conversation with the relevant personnel, or a "full consult" for which a large subset of the HEC or the whole committee had to be convened in order to give a recommendation. In their data, consultation with the hospital ethics committee was required for 0.16% of patients admitted in the hospital; 0.14% needed brief consultations while 0.016% received full consultations. For brief consults, the most common requesting teams were general medicine (43%), medical ICU (22%), and trauma ICU (10%), while the trauma ICU, medical ICU, and general medicine services had the highest consults per admission ratio. In their data, the ethical issues that led to various conflicts and dilemmas were related to the absence of advance directives, decisions about curative vs. palliative care, communication difficulties between patients or their surrogates and the healthcare teams, and non-compliance with a suggested course of action. Overall, in three years, their HEC spent a total of 60,368 minutes in providing these consultations.

The authors point out, and pertinently so, that more studies are required to determine whether some services intrinsically deal with more difficult ethical issues, whether some medical conditions predispose patients to more ethical troubles, and whether these represent opportunities for educational initiatives or proactive consultations.

The limitations of their publication, in their own opinion, include lack of data on in-house mortality and the effect of a consultation on the length of stay. However, this emphasis

on quantitative indicators obviously takes the focus away from the original aim of ethics consultation described by the authors in the article: "to improve the process and outcomes of patient care." There is no discussion of highly pertinent indicators such as the acceptance of their recommendations by the consult seekers, the satisfaction of the consult seekers or patients/family, the patients' comfort at the end of life, the help received in lessening suffering, the proper utilisation of medical resources, etc.

In the Indian subcontinent, formal clinical ethics structures are missing in a majority of healthcare institutions. There is a dire and urgent need to establish HECs and to give them a mandate that facilitates the achievement of all that is required. Keeping in view our limited resources, multidisciplinary committees will be more viable. A group of like-minded volunteers, representing all the clinical specialties, nursing, and administration, can bring about the development of an ethics culture that is required in healthcare today. Initiating a new endeavour requires a change in mindset, and the process can occasionally encounter hiccups. Members of a team can provide support for each other in these difficulties, pool their knowledge for effective decision making, encourage self education, share various responsibilities

with efficient time utilisation, and hence evolve together. This model will also be financially feasible, as personnel employed elsewhere will come together voluntarily, and hospitals will not require extra budgets to sustain them.

Mark Siegler and his colleagues wrote in their article titled "Clinical Medical Ethics" published in 1990: "When we review the field of clinical ethics a decade from now, we hope that the focus will have shifted from ethics courses, committees and consultants to an understanding on the part of most physicians and medical students that ethics is an inherent and inseparable part of good clinical medicine. We hope that clinical ethics will have achieved its rightful place at the interstices of relations between patients who are sick and physicians who profess to be able to heal or comfort them." (1)

Twenty years after this expression of hope, our part of the world is far from achieving the ultimate goal. Developing a culture of ethics, where everyone, at all levels, becomes an integral part of that culture, still seems like a dream.

#### Reference

1. Siegler M, Pellegrino ED, Singer PA: Clinical medical ethics. *J Clinical Ethics*. 1990;1:5-9.