

THE NEW ZEALAND MEDICAL JOURNAL

Vol 117 No 1205 ISSN 1175 8716



The Auckland Hospital Ethics Committee: The first 7 years

Ralph Pinnock, Jan Crosthwaite

Abstract

We describe the establishment and development of the Clinical Ethics Advisory Group (CEAG) at Auckland Hospital. The CEAG provides a case-consultation service for clinicians and managers and on request advises on policies and guidelines. Relatively few cases have been referred for consultation despite the fact that 82% of doctors and 98% of nurses see a role for the CEAG in helping to resolve dilemmas in clinical practice. Most clinicians (80%) who have consulted the CEAG have valued the opinions they were given. The majority of doctors (81%) and nurses (76%) indicated that they would value further education in ethics. Based on our experience and a review of the literature, we recommend that all healthcare workers should have access to ethical expertise.

Clinical ethics committees have developed in response to doctors and other health professionals becoming increasingly aware of the ethical decisions they are required to make. They have been defined as:

'A group established by a hospital or healthcare institution formally charged with advising, consulting, discussing or otherwise being involved in ethical decisions and policies that arise in clinical care'¹

The committees are multidisciplinary with at least one (and often all) of the following functions:

Review of ethical issues arising in particular clinical cases.

Education in the area of ethics, at least of their own members and often more broadly within and beyond the host institution.

Assistance in the development of institutional policies that involve clinical ethical issues.

These committees differ in function and constitution from Research Ethics Committees the purpose of which is the ethical review of research on human subjects.

We describe our experience with the clinical ethics committee at Auckland Hospital.

Hospital Ethics Committees in New Zealand

In 1997, we surveyed the 23 Crown Health Enterprises (CHEs). Three had established clinical ethics committees, two were being established, and two CHEs used other clinical committees of senior staff to help resolve ethical dilemmas. Since then, we have become aware of the establishment of at least one more committee.

The Report of the Inquiry into National Women's Hospital (1988)² recommended establishment of Ethics Committees independent of healthcare providers, with 50% lay (non-health professional) membership, and chaired by a lay person to deal with the ethical review of research proposals and other issues. There are 15 such 'Health and Disability Ethics' committees currently in New Zealand, established and

functioning under national guidelines (Operational Standards for Ethics Committees, 2002)³ and accredited by the Health Research Council Ethics Committee for the ethical review and approval of research. While these committees can and do address clinical issues, the public nature of their deliberations and their identification as primarily research-oriented (particularly in Auckland) has appeared to leave an unmet need for clinical ethics advice.

The Auckland Hospital Ethics Committee

Establishment and development—In 1995, the Medical Advisory Committee (comprising senior doctors) from Auckland Healthcare considered that there was a need to establish a committee to provide a forum for clinicians to discuss ethical dilemmas arising in everyday clinical practice. The Committee would not consider resource allocation because that was viewed as too politically sensitive. The group had access to ethical expertise but an ethicist was not appointed as a permanent member because as it was feared that this could lead to protracted, and unproductive discussions.

The first meeting of the Clinical Ethics Committee was held on the 11th March 1997. One of the authors (RP) was appointed chairperson. The other members present were a nurse, a Maori advisor, social worker, a lay person (who was a lawyer), and a senior doctor from outside Auckland Healthcare.

One of our first activities was to review the literature on clinical ethics committees, and, in a changing context institutionally and socially, reflection on its own composition and role has remained a regular part of the committee's activities. The initial 'terms of reference' dictated that the Committee was to act as 'a sounding board for clinicians with ethical dilemmas'. The Committee's decisions would not be binding and clinical decisions remained still the responsibility of clinicians.

'Hypothetical situations' would not be discussed. The Committee would not provide ethical approval for research, as this is the responsibility of the Regional Health and Disability Ethics Committees accredited for that purpose. Within 12 months, a representative from management and the Chair of the Medical Advisory Committee joined us. At about the same time, approval was sought and granted for the formal inclusion of an ethicist in the membership of the committee, as it soon became apparent that it was impossible to engage in discussions on ethics without an expert present.

Members were initially appointed for a term of 3 years but this was to be varied to ensure continuity and succession. The Clinical Board of Auckland Healthcare appoints the members from nominations by the ethics committee.

Initially the Committee reported to the Medical Advisory Committee, later to the Clinical Quality Council (a multidisciplinary group) and finally following the latest restructuring in management to the Clinical Board.

As the Committee gained credibility, its 'terms of reference' were altered so that any clinician or manager could consult the group. Fostering education of staff in ethics also became a legitimate function.

In 2000, the Committee changed its name to the Clinical Ethics Advisory Group (CEAG) as we considered that this more accurately described its function, and

provided further differentiation from the Regional Ethics Committees responsible for the review and approval of research

The CEAG meets once a month, but can meet at short notice at other times to consider urgent cases.

Referral process—The referrer submits a written request for review of a case to the Committee and this is then forwarded to committee members (often with further relevant information pertaining to the cases; eg, copies of relevant journal articles) before the meeting.

Often an informal approach is made to the chairperson in the first instance but formal written requests for an opinion are always required. Clinicians or managers who consult the Committee are asked to present their case in person so as to provide an opportunity for members to ask questions and seek further information and clarification of the issues involved. We believe this to be important as some members come from a non-medical background, and as some cases involve highly specialised information.

After the referrer has presented the case and answered any questions, the Committee discusses the case. This is done in the referrer's absence to allow committee members to discuss the case without revealing their individual opinions. The discussion usually lasts about an hour but sometimes longer. On occasions, the matters are so complex that an additional meeting is arranged.

Once the Committee has reached a decision (usually on the same day that the case was presented), the Chairperson contacts the referrer by phone to inform him/her of the opinion. This is followed by a written opinion, which clearly states the reasons for the decision. The opinions of the Committee are not binding, and the clinician is still responsible for making the final decision.

Activities and types of dilemmas considered—For each year (1997–2003), the Committee reviewed five to nine cases (average=7).

The cases considered spanned the breadth of medical practice. They included cases of withholding and withdrawal of treatment, dilemmas in medical genetics (genetic testing of children, pre-implantation genetic diagnosis), issues related to consent (sterilisation of a mentally retarded adolescent, refusal of parental consent for a child requiring life-saving treatment, sterilisation of single use medical devices), access of non-residents to medical care, issues related to organ transplantation, patients with HIV infection, confidentiality (storage of serum samples, adolescent sexual abuse), and potentially fatal cross-infection of medical staff.

In addition to case consultation, the Committee was invited to comment on the ethical aspects of some areas of Hospital policy, particularly where policy documents were under review. It also produced papers for the hospital management on the treatment of non-residents, patient-requested treatment, and possible conflicts of interest when doctors give expert opinions.

User satisfaction—One of the concerns regarding clinical ethics committees is the inability to vigorously evaluate them.⁴ Attempts have included subjective assessments by chairpersons or comparison of the consistency of opinions on identical hypothetical research protocols submitted to different committees.^{5,6}

Little has been done to formally evaluate ethics consultations, and there is no agreement on how they should be assessed.^{7,8} Indeed, as our Committee was primarily established to aid staff, we considered that the most practical way to evaluate our performance was to assess the perceived usefulness of our opinions to those who consulted the Ethics Committee.

At the end of each year, those persons who had consulted the Committee were asked to complete an anonymous questionnaire. They were asked to rate the usefulness (on a scale of 1=very unhelpful to 5=very helpful) of the consultation, and also whether they would recommend the Committee to colleagues (1=never recommend to 5=strongly recommend). Respondents were also encouraged to add any other comments.

Over 80% of those persons surveyed, responded. Most responses to both questions posed were rated between '4' and '5'. Even those persons who did not agree with the Committee's opinion had found the consultation helpful. Numerous positive comments were made. The only negative comment was from a clinician who referred a matter related to research and was annoyed at having sent his ethics application to the wrong committee. Clearly we are dealing with small numbers and it would be presumptuous to draw firm conclusions.

Survey to assess awareness and usefulness of Clinical Ethics Advisory Group—
Three years after the Committee was formed, the medical and nursing staff at Auckland Hospital were surveyed to assess the awareness and utility of the group.

Methods

With the permission of Dr I Kerridge, we used a modified version of the questionnaire used by the Clinical Unit in Ethics and Health Law at John Hunter Hospital.⁹ We surveyed doctors and nurses as we considered that these groups were most likely to use the CEAG. A sample of doctors (22%) and nurses (7%) was randomly selected from a list supplied by the Humans Resources and Payroll Departments. Seven of the questionnaires sent to the doctors and five questionnaires sent to nursing staff were erroneously sent to other employees and had to be omitted from analysis

Results

Results are summarised in the following tables.

Table 1. Response rate

Respondents	Questionnaires			Response (%)
	Total	Sent	Returned	
Doctors	1096	230	91	40%
Nurses	3298	227	99	44%

Table 2. Median years in practice

Respondents	Median number of years in practice
Doctors	10 years
Nurses	14 years

Most doctors and nurses surveyed were aware of, and believed there was a role for, the Ethics Committee. (Table 3)

Table 3. Awareness and role for Committee

Variable	Doctors	Nurses
Aware of the existence of Committee	67%	60%
Believed there was a role for the Committee	82%	98%

The doctors and nurses were asked to select (out of a total of 16) areas of ethical dilemmas commonly encountered in practice. (Table 4)

Table 4. Common ethical dilemmas encountered in clinical practice
(ranking is for frequency or commonness of encounters with problem area)

Ethical dilemma	Doctors	Nurses
Informed consent / Patient autonomy	1	1
Resource allocation	2	5
Confidentiality and record-keeping	3	4
Assessment of competence	4	6
End-of-life issues	5	2
Conflicts between health professionals	6	3

Respondents were also asked how they currently dealt with ethical issues (Table 5) and who should be able to consult the Ethics Committee. (Table 6)

Table 5. How staff currently deal with ethical dilemmas
(respondents were able to choose more than one option)

Action	Doctors	Nurses
Consult with peers	66 (73%)	66 (66%)
Consult with supervisor	20 (22%)	44 (44%)
Consult with senior colleague	36 (39%)	55 (55%)
Refer to Ethics Committee	8 (9%)	4 (4%)

Table 6. Who should be able to consult the Ethics Committee
(respondents were able to choose more than one option)

Who can consult the Committee?	Doctors	Nurses
Health advocates	46 (50%)	75 (76%)
Patients	39 (43%)	66 (67%)
Family members	35 (38%)	67 (68%)

Both doctors and nurses were interested in receiving further education on ethics. They were asked to choose from a total of 16 possible topics (Table 7).

Table 7. Topics for further education

Topic	Doctors	Nurses
Making “Not for Resuscitation” orders	52%	48%
Provision/withdrawal of life-saving treatment	58%	58%
Ethical issues of HIV infections	35%	26%
Parent’s refusal to consent to treatment for children	68%	51%
Principles of clinical ethics	52%	62%
Informed consent	63%	61%

Table 8. Should the Committee be involved with clinical case consultation/review?

Respondent	Yes	No
Doctors	49%	10%
Nurses	58%	3%

Discussion

With a response rate of 40% to 44%, it is not possible to generalise these results. However, the type of ethical issues that caused concern (Table 4) and the major role for the Ethics Committee in education (Table 7) were also found in Australian surveys.^{9,10}

Though most of the doctors and nurses were aware of (67% and 60%, respectively) and recognised a role for the Committee (82% and 98%, respectively), only 10% of doctors and 6% of nurses had consulted it. The reasons for this were not investigated in our survey. A survey in the United States however, assessed this and found that some physicians were not referring to Committees because of fear of loss of control, intrusion into the doctor-patient relationship and misperceptions about what ethics committees can offer.¹¹ We speculate that similar reasons may have inhibited our clinical staff from consulting the CEAG.

More doctors and nurses believed there was a role for the Committee than were aware of its existence. (Table 3). It is clear that the Committee should make its presence more widely known.

Both groups thought that the Ethics Committee should be involved in clinical case consultation/review (Table 8). Forty-nine percent of doctors and 58% of nurses held this view. Only 10% of doctors and 3% of nurses believed that the Ethics Committee should have no role in case reviews.

Many staff would like further education on ethics. (Table 7). The most common areas selected by both groups are similar. The most overwhelming area of concern for both groups was informed consent /patient autonomy issues. (Table 4)

Unfortunately because of limited resources the Committee has only been able to make a very modest contribution to education in ethics. We were invited to meet with two specialist groups where participants discussed common ethical dilemmas with the Committee. Grand rounds and the regular departmental clinical meetings would be suitable venues to further education in ethics.

The development of clinical ethical committees worldwide

The development of the CEAG follows a worldwide trend.

The United States—One of the earliest proposals for the development of such committees was the 1971 Medico-Moral Guide of Canadian bishops.¹² The purpose of such committees was first and foremost to assume responsibility for educating all clinicians concerning the development of medical-moral trends in healthcare.

Members were to be drawn from administration, the board of trustees, medical and nursing staff, social workers, pastoral care workers, legal counsel and moral theology. The need for such committees was also advocated in the first issue of *The Journal of Medical Ethics* though emphasis was given to consideration of research as the primary objective.¹² A few hospitals in the United States developed such committees in the late seventies, but by 1982 they had been adopted by only 1% of hospitals.

Doctors and other health professionals often dominated these early committees. It was strongly recommended that all committees should have ethical expertise in their membership. Initially, as the guide of the Canadian bishops indicates, this was often thought of as provided by the clergy, though increasingly professionally trained ethicists or bioethicists fill this role.

The first national conference on Institutional Ethics Committees was held in 1983 in Washington.¹² The credibility of these committees was a concern from inception. It was recognised that such committees ‘face a complex task in winning acceptance and in learning how to mediate fairly among competing interests’.¹²

In 1984, the American Medical Association and the American Hospital Association endorsed the development of these committees. Their tasks were viewed as encompassing several areas (including education in ethics) and guiding hospital policy, but the prime and most innovative objective was to make recommendations in individual cases.¹² There was vigorous debate over the value of these committees.¹³

Inherent dangers were seen to include some committees having too much political power and the adverse effects of group dynamics including ‘groupthink’. This occurs when groups within the committee undermine the value of committee review, by unconsciously manoeuvring to minimise conflict and controversy by downplaying of risks, limiting alternatives and a coercive push to reach consensus.^{13,14}

As professionally trained ethicists became available they were seen as complementary to but not substitutes for the committees.¹⁵ The committee model was seen to best represent the conviction that moral debate was a community enterprise that should not be relegated to experts.¹⁶

By 1987, the number of hospitals with ethics committees had increased to 60% and by 1990 hospitals were required to develop clinical ethics committees in order to qualify for Medicare and Medicaid payments.¹² In 1991, the Joint Commission for Accreditation of Healthcare Organisations required healthcare organisations in the United States to have ‘a mechanism for the consideration of ethical issues arising in the care of patients’.¹⁷

The United Kingdom—Clinical Ethics Committees have developed more slowly in the United Kingdom.^{7,18} The Clinical Ethics Forum at Great Ormond Street Hospital formed at the request of staff has published its experience.¹⁹ Their Forum is valued by

staff.²⁰ A survey of National Health Trusts in 2000 indicated that 18% had some formal method of addressing ethical issues that arise in clinical practice.²¹ As in the United States, these committees varied in their focus.²²

Australia—Clinical ethics committees have developed in Australia but the vast majority of institutions do not have access to them.²³ The Committee at John Hunter has documented their experience.⁹

Other countries—Clinical Ethics Committees in France,²⁴ Israel,²⁵ Italy,²⁶ and Ireland²⁷ have reported their experience.

Conclusion—Several concerns have been expressed regarding clinical ethics committees. These include interference with the doctor-patient relationship, erosion of the professional autonomy of doctors, reduction of the patient's freedom of choice, and fear that they will create a further layer of bureaucracy in hospitals.

These criticisms are unfounded if it remains the clinician's decision to consult the Committee, and if decision-making responsibility is not shifted to the committee. None of the clinical ethics committee, which have reported on their activities, considers that their opinions should be binding.

We believe that these committees are here to stay and with time will play a significant role in patient care.

Challenges for the future include more objective assessments of effectiveness and the ethical education members of such committees require. Within the New Zealand context, the relationship of these committees to the national structure and guidelines for ethics committees remains to be resolved. Some requirements appropriate to any committee reviewing and approving research may be unnecessary or inappropriate in the context of advice on individual clinical situations.

However it is desirable that there be common understanding of the role and composition of such committees, and opportunity to share expertise and experience gained in their work.

Recommendations

Based on our own experience, and that of others, we would recommend that:

- All healthcare practitioners have access to a clinical ethics committee—the employer should provide this access. Smaller centres could gain access to ethicists/clinical ethics committees via teleconferencing.²⁸
- Clinical ethics committees should be multidisciplinary. Membership should represent the major clinical activity areas. It is essential that committees include awareness and representation of cultural diversity, ethical expertise, and legal expertise. It is desirable also that some health professional members should be external to the institution, to avoid parochialism.
- All healthcare practitioners should have access to education regarding ethics—by distance learning if necessary.
- Clinical ethics committees should attempt to assess their effectiveness and keep abreast of developments in this area.

- Opportunities at a national level for committees to communicate and recognise one another (through a colloquium of chairs, for example) would be helpful to increase expertise and for consistency of practice and procedure.
- All healthcare professionals should have a strong grounding in ethics during their undergraduate training. Providers of postgraduate training and continuing education should regularly include ethics in their programmes.

Author information: Ralph Pinnock, Paediatrician, Starship Children's Hospital, Auckland; Jan Crosthwaite Associate Professor in Philosophy, Department of Philosophy, University of Auckland, Auckland

Acknowledgements: We acknowledge the important contribution that all members of the Committee have made to the establishment and development of the Auckland Services Clinical Ethics Advisory Group. The development of this group would not have been possible without strong support from management. We wish to pay particular thanks to Raewyn Wolcke.

Correspondence: Ralph Pinnock, Starship Children's Hospital, Auckland. Fax (09) 307 8977; email: ralph@adhb.govt.nz

References:

1. Johnstone M. Bioethics a nursing perspective 2nd Edition WB Saunders; 1994, p481.
2. The report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters, Auckland NZ. The Committee; 1988. Available online. URL: <http://www.womens-health.org.nz/cartwright/reforms.htm> Accessed October 2004.
3. Operational Standard for Ethics Committees. Wellington, NZ: Ministry of Health; 2002. Available online. URL: <http://www.moh.govt.nz/moh.nsf/0/ffc06a2c2009deecc256b9400787b61?OpenDocument> Accessed October 2004.
4. Slowther A, Hope T. Clinical ethics committees: they can change clinical practice but need evaluation. BMJ. 2000;321:649–50.
5. McGee G, Spangole J, Caplan A, et al. Successes and failures of hospital ethics committees: A national survey of ethics committee chairs. Camb Quart of Healthc Ethics. 2002;11:87–93.
6. Scheirton L. Measuring hospital ethics committee success. Camb Quart of Healthc Ethics. 1993;2:495–504.
7. Slowther A, Hope T, Bunch C. Clinical ethics committees in the United Kingdom. J R Coll Physicians London. 1999;33:202–3.
8. Hardinge J, Ummel M. Evaluating the work of ethical review committees: an observation and a suggestion. J Med Ethics. 1989;15:191–4.
9. Kerridge I, Pearson S, Rolfe IE. Determining the function of a hospital ethics committee: Making ethics work. J Qual Clin Practice. 1998;18:117–24.
10. McNeill P, Walters J, Webster I. Ethical issues in Australian hospitals. Med J Aust. 1994;160:63–5.
11. Davies L, Hudson L. Why don't physicians use ethics consultation? J Clin Ethics. 1999;10:116–24.
12. Rosner F. Hospital Medical Ethics Committees: A review of their development. JAMA. 1985;253:2693–7.

13. Lo B. Behind closed doors: Promises and pitfalls of ethics committees. *N Engl J Med.* 1987;317:46–50.
14. La Puma J, Toulin S. Ethics consultants and ethics committees. *Arch Int Med.* 1989;149:1109–12.
15. Loewy E. Consultants and Committees: A cooperative and mutually educational enterprise. *Camb Quart Healthc Ethics.* 1994;3:478–82.
16. Swenson M. Ethics case review in health care institutions. Committees, consultants or teams. *Arch Int Med.* 1992;152:694–7.
17. Spencer E. A new role for institutional ethics committees: Organisational ethics. *J Clin Ethics.* 1997;8:372–6.
18. Thornton JG, Lilford RJ. Clinical ethics committees *BMJ.* 1995;311:667–9.
19. Larcher VL, Lask B, McCarthy J. Paediatrics at the cutting edge: do we need clinical ethics committees. *J Med Ethics.* 1997;23:245–9.
20. Larcher VL. Role of clinical ethics committees. *Arch Dis Child.* 1999;81:104–5.
21. Slowther A, Bunch C, Woolnough B, Hope T. Clinical ethics support services in the UK: An investigation of the current provision of ethics support to health professionals in the UK. *J Med Ethics.* 2001;27:12–18.
22. Szeremets M, Dawson J, Manning D, Watson A. Snapshots of five clinical ethics committees in the UK. *J Med Ethics.* 2001;27:19–30.
23. Kerridge I, Savulescu J, Kamesaroff P. Is there a future for clinical ethics services in Australia? *Med J Aust.* 2001;175:211–3.
24. Mimi J. Hospital ethics committees in Paris. *Camb Q Healthc Ethics.* 2000;9:424–8.
25. Wenger NS, Golan O, Shala C, Glide S. Hospital ethics committees in Israel. *J Med Ethics.* 2002;28:177–82.
26. Incovarti G. Bridging problems and models in medical ethics: four images of local ethics committees. *Bull Med Ethics.* 2000;164:13–17.
27. Manning P, Smith D. The establishment of a hospital clinical ethics committee. *Ir Med J.* 2002;95:54–5.
28. Eiser AR, Schede S, Anderson-Shaw L, Murphy T. Electronic communication in ethics committees: experience and challenges. *J Med Ethics.* 2001;27:i30–2.