What are clinical ethics advisory groups for?

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Calls for greater ethical support for clinicians have been reinvigorated over recent years. However, it is worth bearing in mind that New Zealand, via the research ethics committees established under the Regional Health Authorities, used to have a national network that could give clinical ethics advice. This might mean that the indifference to clinical ethics that Dai and Ballantyne identify is not a new issue and it also seems relevant to note that calls for clinical ethics support have waxed and waned in other countries.

Dai and Ballantyne point out the importance of clarifying for clinicians what Clinical Ethics Advisory Groups (CEAGs) can do. Whether or not CEAGs offer something valuable, over and above discussion with peers, depends upon the nature of the discussion with that peer. It might be that a colleague asks critical questions that challenge assumptions, that they have a good knowledge of the legal context or that they are particularly experienced with this kind of presentation. On the other hand, there is a risk when seeking the advice of a colleague that their thinking is too close to yours to offer more than reassurance, that there are issues that someone from another specialty or health profession would notice or that you share a blind spot with respect to the law or policy. So whether or not a CEAG offers clinicians ethical advice that is better, depends upon whether or not that peer offers good advice and what constitutes good clinical ethics advice. A number of ethicists have considered what constitutes ‘clinical ethics’ and suggested structures for how we can improve ethical deliberation.

What is clinical ethics?

Jonsen and Siegler claim that “Clinical ethics is a practical discipline that provides a structured approach to assist physicians in identifying, analysing and resolving ethical issues in clinical medicine”. This implies that an essential skill is to be able to see the ethical issues in clinical practice. While this might appear to be obvious and something that we all do, there is a risk when talking to peers that they see the same issues as us. But when a clinical situation is discussed with colleagues from a range of specialties, as would be the case with a CEAG, it’s likely that any ethical issues are more fully identified and understood in a better way. It could also be that engaging with other specialties will help to clarify any unconscious bias that may have entered into identifying the relevant issues. Likewise, some expertise in the law or policy will result in a more complete range of issues being identified than might be the case via a peer discussion.

Analysing the issues identified can be done in a number of ways and there are some useful resources available for clinicians and medical students that explore this further. All other things being equal, a CEAG is more likely to have a structured approach for working through the issues in a complex scenario than would be the case with a peer discussion. Following through the likely and possible consequences of various courses of action is part of analysing issues, and clinicians are likely to find the assistance of a CEAG a valuable supplement to the advice of peers when they are faced with ethically complex situations.

While a structured approach to clinical ethics won’t always ‘resolve’ ethically challenging situations, Jonsen and Siegler are correct that ‘assisting’ clinicians in working toward this should be the core aim. Others have suggested that the final step in a structure approached to a challenging ethical case should be to make a justified decision, which is the decision a clinician makes after weighing alternate course of action and being clear about why they are choosing a specific course of
action. So a key thing that a CEAG should be able to do well is assist a clinician to weigh the relevant considerations so as to justify a decision when there might not be a consensus about the best way forward.

What Clinical Ethics Advisory Groups can do

It might be that a common misconception is that a CEAG fulfils a similar function to a research ethics committee: a group of people outside of your area deliberate about something you are planning on doing and then tell you whether or not you have ethical approval to proceed. There might be instances where CEAGs have operated in this fashion, but that should not be their central function and is likely to detract from the more useful contributions to good clinical ethics a CEAG can make. Supporting clinicians to take an evidence based, structured and well justified approach to clinical ethics is where a CEAG can be the most useful and it is usually built into their terms of reference. For example the Capital and Coast DHB CEAG says it aims “To provide a consultative, advisory and supportive mechanism to assist healthcare professionals to make informed ethical decisions in their management of patients”. The emphasis here is clearly upon supporting and enabling clinicians to make the best decisions they can, which implies providing them with a structured approach to clinical ethics rather than ethical approval.

The majority of ethically tricky situations will continue to be handled well by experienced clinicians after discussion with their peers. The extra time that will unavoidably be added by involving a CEAG is likely to mean that it is cases which are ethically novel, already complicated and contested, or involve innovative therapy where additional support is requested.

Where to next?

Clarifying what a CEAG can do will help, but they also require support from senior clinicians in the relevant institution. Without that leadership, the trust and relationships that are required in order for a clinician or DHB to openly discuss a situation where things have not gone as well as they might, are much harder to create. A first step for institutions that wish to build their network of clinical ethics support could be to review events that have not gone well, to learn from them and prepare for similar ethically challenging events in the future. That too requires trust, and DHBs are (understandably) cautious in the current environment, yet it seems a way that the value of discussions of this kind can be nurtured after the event and without the pressure that results from the need for a decision to be made.

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