Ethics in practice

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Concerns about ethics in medical practice go back almost as far as medicine itself. The Hippocratic tradition originating in ancient Greece is remembered in the Hippocratic Oath, dating between the fifth and third centuries BC; while Plato's *Gorgias* portrays medicine as having its contribution in understanding human nature. In Britain, the modern era in medical ethics dates from the eighteenth century which produced a new body of writings on medical ethics. Perhaps this was a reflection of anxieties about status, as Porter suggests;[1] perhaps it was the industrial revolution that increased our sensibilities – the horsepower of the machine creating consideration for the horse.[2] John Gregory's *Lectures on the duties and qualifications of a physician* of 1772, for example, led to Thomas Percival's more famous *Medical ethics* in 1803. Discussion on end-of-life care increased as the nineteenth and centuries centuries progressed. Advancing technology, the onward march of applied science with longer life and rising costs of healthcare led to other debates on the gap between what we should do and what we could do. In 1968, Black could write:

> *It is not callous to ask how much, in terms of lives prolonged, can be achieved by one form of expenditure (say, cardiac intensive care) as compared with another (say, renal transplantation). Medicine is a free profession, and there must be no restraint on the pioneering of new techniques in all fields of medicine; but this is not quite the same thing as to say that these techniques, however expensive in money and skill must then be made universally available, without regard to their impact on other medical needs.*[3]

When the Royal College of Physicians published its guidelines for research ethics committees in 1984,[4] there were still sceptical voices who doubted the wisdom or necessity of formal mechanisms to review research. A quarter of a century later, these guidelines (now in their third edition)[5] stand out as one of the most important documents contributing to the ethical review of research in the UK. By contrast, the ethical review of clinical practice has developed more slowly and more haphazardly:[6] there has been no equivalent of the Nuremberg Code to concentrate minds,[7] nor the same need for the local regulatory function that research ethics committees offered. The contrast is instructive. In research ethics, committees developed in response to central guidance, notably from the Royal College of Physicians, the Medical Research Council and, eventually, the Department of Health. The ethical review of clinical practice, however, has developed in response to individual clinicians perceiving a need: 'bottom up'.

Debates about concerns such as the allocation of resources highlighted by Black above are no longer the preserve of professionals alone. The power of the 'consumer' is here to stay. So there now exist a variety of mechanisms for reviewing ethical questions, at both national and local level. One of these has been the ethicist, another the clinical ethics committee; and, of course, there are national bodies like the medical Royal Colleges, the British Medical Association and the General Medical Council (GMC) publishing advice and responding to problems. The development of the clinical ethics committee in particular led to a report sponsored by the Nuffield Trust in 2001.[8] Five years on, there was a perceived need for a professional body to review developments and to recommend future directions. This has now been done by a working group from the College's Committee on Ethical Issues in Medicine.

The report, *Ethics in practice: background and recommendations for enhanced support*,[9] is based on a series of discussions within the working group, interviews with key figures, written submissions, visits to two hospitals (one with and one without a clinical ethics committee), and a survey of specialist registrars in medical specialties. The result is open ended in that the prescription leaves many issues to be studied further. Nevertheless, it provides ample food for thought as well as some more definite recommendations for action.

Wherever healthcare is provided, arrangements should be in place for timely and informed formal ethics support. No longer should this depend on the whims or enthusiasms of individuals. If this recommendation is a clear call for action in many hospitals,

the report leaves open what form such support should take. It is acknowledged that there is widespread concern about the establishment of what may be perceived as yet another regulatory body and there are grounds for scepticism about 'another committee'. Clinical ethics committees (CECs) will fulfil the need for local ethics support in many cases, but the report acknowledges that evidence is lacking to mandate their establishment in all institutions. The question of assessing the value of the CEC provides one of the most challenging problems: how does one assess quality? 'What is the evidence that it (the CEC) is effective?', the authors ask. The report acknowledges that patient, family or professional satisfaction are not entirely adequate measures; nor are controlled trials based on length of stay or time to death in intensive care units, where treatment withdrawal decisions may arise. An evaluation based on speed of a clinical decision or the effectiveness of treatment may be worse than no evaluation at all. Qualitative research may have much to offer and is needed before the CEC can become universal. Certainly, without enthusiastic local clinicians willing to devote time and effort to the CEC, without management encouragement and, preferably, involvement and without administrative support, other mechanisms may be needed. It is acknowledged that some CECs have folded when key members have moved on. The alternatives to CECs are therefore explored.

Despite these reservations, the report focuses on the CEC. Given that its credibility will depend on expertise, not only is training for its members necessary, but there is a need for an agreed statement of the core competencies. Enthusiasm and interest are not enough. The report suggests how competencies might be defined. There is no simple yardstick for the *phronesis* or practical wisdom advocated by Aristotle, but at least one helpful approach is to seek different perspectives on a problem. Multidisciplinary membership, including independent lay members, are therefore strongly advocated with descriptions of what this might mean and of the implications – including confidentiality and indemnity. In addition, at least one CEC member should have had a formal training in ethics.

Numerous other issues are discussed. These include the extent of the CEC's role and the standing of its advice in law, given that it should be assessing options and not prescribing solutions. How should its advice be accessed? This question raises practical issues, such as the referral procedure, and whether all members of the institution should be able to refer to it, including patients. Audit of its performance should be attempted through systematic records of its deliberations and an annual report. Timeliness in responding to urgent situations is another concern. This may be difficult for a committee of 12 or more members. There is no prescription for dealing with the urgent case, but innovative mechanisms to enable a response in an emergency are acknowledged. The recording of its advice and the CEC's position within the structures of clinical governance are also discussed. The relationship or availability of a clinical ethicist is considered, although it is acknowledged that realistically this role is likely to be restricted to large teaching units or specialised units where ethical problems may arise more frequently (eg palliative care, clinical genetics).

Finally, the survey of 3,564 registrars produced the finding that nearly one-third believed that they had received no ethics education at all. This is alarming for it implies either that education in medical ethics is not taking place or that it is ineffective. Whatever the recommendations of professional bodies, including the GMC, for undergraduate and postgraduate education, there is an unfulfilled need demanding a cadre of teachers, themselves qualified in the field. Almost certainly, there is a shortage of suitably qualified individuals at the moment, even with education in a multidisciplinary framework.

No member of the working party would pretend that the report provides the final statement on the development of clinical ethics support. What is does offer in its text and its 42 recommendations is a signpost along the way. It is one that is worthy of study wherever medicine is practised.

References

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