Medical practice in the past few decades has been thoroughly influenced by a multitude of factors. Rapid advances in medical technology, the advent of new forms of media, increasing knowledge of patients’ rights, all of these and more have contributed to the way that physicians, patients and society look at the application of clinical ethics in healthcare settings.

According to Jonsen et al. (1998), clinical ethics is defined as the “practical discipline that provides a structured approach to assist physicians in identifying, analyzing and resolving ethical issues in clinical medicine.

Its practice generally encompasses three aspects: the discussion of individual clinical cases where ethical issues have cropped up in the process of treatment or diagnosis, the review of existing guidelines and/or laws with respect to clinical ethics, and the education of the medical community with regards to clinical ethics.

The Clinical Ethics Committee (CEC), otherwise known as the Hospital Ethics Committee (HEC) of the United States, is a unit based in each individual hospital or healthcare institution. They comprise a range of professionals and lay people in any given ratio of physicians, nurses, lawyers, chaplains, philosophers, administrators or other competent public figures. Meeting regularly or whenever demanded by especially significant cases, the CECs form the basic operational unit in the application of clinical ethics within their own institutions. While the concept of a CEC had existed in the United States since the 1970s, European countries were reluctant to adopt the idea for several reasons. European CECs began operations in small numbers of hospitals from the mid-1990s.

This article seeks to understand the reasons for and against the development of CECs, using Western European countries...
as reference points, to analyze if these arguments should be taken seriously by the Asia-Pacific medical community.

In a similar fashion to their United States predecessors, the United Kingdom’s CECs developed largely from bottom-up initiatives (see case studies in Szeremeta et. al., 2001). That is, individual members of the medical community voiced the need for hospital staff to be supported by a formal operational structure dedicated to resolving conflicts of ethics in clinical settings. These individuals then acted on these thoughts with the approval of their respective hospitals. Setting their own terms of reference and operating under the auspices of their own hospitals (and independently of the National Health Service (NHS)), UK CECs have been able to choose their own areas of focus, ranging from case analysis, education or guideline advice, and develop and expand their roles at a comfortable pace of their own choosing.

In contrast, CECs in Belgium were established as a result of the Royal Decree of 12 August 1994. Most “CECs” were in fact existing Research Ethics Committees (RECs), which had previously focused on developing research ethics, and indeed continued to do so at the expense of clinical ethics. CECs are regulated by the Belgian Federal Committee on Bioethics, with composition of membership and terms of reference dictated by the central authorities.

As a result, Belgian CECs differ greatly from those in the UK in two ways. Firstly, the UK keeps CECs and RECs firmly apart, with each focusing on their own area of jurisdiction. This is similar to the US system of keeping their HECs and Institutional Review Boards (IRBs, the equivalent of RECs) separate. Belgium, on the other hand, sees its CECs suffering from a lack of focus, largely subsumed under existing RECs as they are, with “protocol review overburden[ing] the work of ethics committees so that clinical ethics risks being compromised” (Meulenbergs et. al., 2005). Secondly, UK CECs have the opportunity to expand their roles as and when they feel that they have matured enough to proceed from the education of their own members towards education of the medical community or towards playing more active roles in individual case analysis or reviewing hospital guidelines. In contrast, the Belgian CECs see their role and membership heavily regulated by the government, without much scope for any independent action.

These two countries represent the majority of the literature on CECs in Western Europe. It should be noted that in most other Western European countries, CECs can be grouped into these two categories – Norway and Spain follow the Belgian model of government supervision, while Italy, France and Sweden have CECs of more spontaneous origins, although not to the extent of the UK. It is only in Belgium where RECs are more or less synonymous with CECs, while roles are largely separated in most of the other countries. Also, France and Ireland have the Catholic faith looming large over the medical profession in matters of ethical practices and issues (Dooley, 1991; Régnier and Rouzioux, 1983).

With such diverse case studies, a detailed analysis of the reasons behind all of these differences, as well as a focused look at how these differences translate into similar or different outcomes, is not the object of this article. Rather, this article seeks to make some observations on the features of CECs and their usefulness, as well as list the reservations some may have regarding CECs.

First things first, one must discuss the composition of such a committee. There are two prevalent views on the issue. Belgium and Spain belong to the school of thought where medical staff, particularly physicians, dominate the CEC. This school believes that committee members should be well-versed in their work related to the medical field, and should have thorough knowledge of all subject matters in order to make more informed ethical decisions. On the other hand, the UK, Sweden and Denmark prefer to have more varied membership, including but not limited to a combination of philosophers, ethicists, hospital administrators, public servants and prominent members of the lay community. This is based on opinions that ethics “cannot be the territory of a particular social group” (Lebeer, 2005) and should have “the broadest diversity in viewpoints” (Lebeer, 2005).

One ventures that the latter viewpoint is more suitable to Asia-Pacific’s societies than the former. This is because Asian societies are known to be more community-minded, and have a large amount of respect for elders or seniors within the community. Having
representation from more viewpoints will be useful in preventing the committee turning into an overly hierarchical structure, as would be likely in a medical-dominated situation, where senior physicians and staff might intimidate younger ones and thus prevent active contribution. Also, high as the standard of medical education may be in terms of technical knowledge, the state of ethics and/or training within the majority of medical education establishments in Asia-Pacific is also unlikely to be up to Western standards. Having ethicists and legal representation on the committee, based on Western experience, seems to be highly recommended especially in the initial stages, as it fills in the gaps in ethical knowledge and theory until the medical community can be sufficiently well-educated on these issues.

Next, we discuss the terms of reference or the focus of CECs. As stated earlier, the three accepted roles of CECs are individual case analysis, education of the medical community and the review of hospital best practices and guidelines. With UK CECs demonstrating that at the start, each committee is left to decide its own role for itself, there appears to be no fixed standard on what is right or wrong for a committee to focus on at any point of its existence. However, in their appraisal of the state of clinical ethics in Belgium, Meulenbergs et al. (2005) are very firm in their views that RECs and CECs should be clearly separated, with each committee overseeing its own area of ethics.

The crucial question is, "Should Asia-Pacific adopt this approach?" It is clear that CECs will need to be set up with committee members who are not already engaged in the Asia-Pacific equivalent of RECs. Given the background of the region’s biotechnology, pharmaceutical and other medical research hubs in Singapore, Australia and China among others, the temptation will be strong to subsume CECs under RECs in the Belgian manner. Great care will be necessary on the part of the medical community to prevent this, especially in university hospitals where the official guidelines distinguishing healthcare from research may be less clearly defined. In terms of priorities, new CECs in Asia-Pacific would probably be well-advised to commence work on education of the medical community, for the same reasons stated in the previous point. Once enough
healthcare workers and physicians have been trained to a higher degree in clinical ethics, there will then be enough of them to form the necessary committees required for individual case analysis.

The nature of CECs in Western Europe is unanimously advisory — not prescriptive — and does not require every case to be submitted for consideration in the form of individual case analysis. Physicians are free to approach the committee as and when they wish to have a consultation regarding the ethical issues surrounding their case, but are not forced to do so. This is evident in the findings by Slowther et. al. (2001), where some CECs receive at least one request a month, while others only receive infrequent consultation requests. Also, in no circumstances are CECs to dictate a course of action to the physician in charge of the case. The Irish view is that “the doctor-patient relationship in Ireland, as in most other European countries, is premised mainly on a paternalist model.” The primacy of the doctor-patient relationship in clinical settings – between the physician and his/her patient. The debate on this issue has yet to be fully resolved even within Western Europe, with valid arguments playing on both sides of the issue. While one attempts to further the argument of the case in favour of establishing CECs, one will also provide an overview of the arguments against it, and leave the reader to make their own decision based on their own moral beliefs.

There are many opponents of the CEC who object to it due to its influence on the doctor-patient relationship. One of many writers on this subject, Gillon (1997) gives a precise and impactful analysis on the pros and cons of CECs. In his exposition, he points out that one of the key weaknesses is that of bureaucracy. In situations where hospitals require certain categories of cases to be forwarded wholesale to CECs, the CEC represents a new level of bureaucracy that might obfuscate and eventually delay the decision making process, which is in any case a tedious process in the medical world. To extend this point, even if timing was not an issue, the constant compulsory referral of cases to a CEC would have the undesirable effect of “erod[ing] the professional autonomy of doctors and undermin[ing] their responsibility and authority to act on behalf of their patients.” (Gillon, 1997) Other critics point in the other direction, believing that the presence of CECs will allow physicians to “take cover” behind their colleagues’ moral responsibility and authority to act on behalf of their patients. CECS themselves may also become overly cautious in their assessments in order to protect themselves from any recriminations should a doctor choose to implement a committee recommendation. Of equal concern is the fact that if physicians and healthcare workers have to spend time on CECs debating and discussing ethical questions, this diverts their time from the most important aspect of their work – saving lives.

Advocates of CECs propose many arguments against these criticisms. These committees guarantee more active discussion, compared to the typical “grand rounds” among departments where the senior physicians tend to dominate the discussion. With legal, philosophical and lay representation, they present a more holistic view of any given situation, since other members are not burdened with technical knowledge. The problem of bureaucracy can be solved by imposing time limits for deciding
cases, although Larcher et. al. (1997) does warn against “reaching a consensus too early”, while establishing clearly in the terms of reference that the physician in charge still bears final responsibility might solve the responsibility issue. Having physician committee members examine the patient in person, and meeting the family to explain the situation and discuss options, will prevent the problem of inaccurate information from second-hand knowledge. Patients and family members would be reassured that any ethical decision of a doctor acting on CEC advice would be “a carefully considered recommendation of the committee rather than of one individual” (Thornton and Lilford, 1995), and that where patients’ requests are of questionable permissibility, “patients may be pleased in the long run if the committee’s experience stops them harming themselves or others” (Thornton and Lilford, 1995). Saving lives can still be the paramount duty of physician committee members, with perhaps two committees sharing certain common members, with the non-physician members taking on most case analysis with a few physicians present, while the full committee, including physicians, devotes its resources to the less time-consuming business of education or ethical best practice review.

Judging from the complex situation in Europe and the plethora of arguments for and against CECs, it is clear that no matter what approach the medical community of Asia-Pacific chooses to adopt, caution will be the key to success. Institutions and governments will need to decide whether the benefits outweigh the detriments, then adopt selected aspects of CECs and incorporate them into the unique context of Asia-Pacific societies. In any case, it will certainly be a while before Asia is ready to take such a step forward in the field of clinical ethics.

References


About the Author

Aaron Tan is a freelance writer currently working at World Scientific Publishing. Having recently graduated from Raffles Junior College, Singapore, his intellectual interests lie in history, politics, the social sciences and ethics. His school essays on these topics were well-received, allowing him to make to the school’s Dean’s List on several occasions, with one essay being published in the school’s biannual essay collection, the Knowledge Skills Bulletin.