# Let's Not Forget about Clinical Ethics Committees!

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**ABSTRACT**

The aim of this article is to highlight the under-recognized merits of clinical ethics committees (CECs), to help ensure that the development of roles for clinical ethics consultants do not unwittingly compromise the valuable contributions that CECs can continue to provide.

I argue that CECs can offer distinctive contributions to the clinical ethics consultation process that can complement and enrich the input provided by a clinical ethics consultant. These distinctions and complementarities should be further examined and developed. This will help to optimize the synergistic contributions that CECs and clinical ethics consultants can make to promote the ethical treatment of patients and their families.

Clinical ethics committees (CECs) have played, and continue to play, a valuable role in the development and practice of clinical ethics. Most clinical settings, in the past and to this day, have been unable to hire a clinical ethics consultant. This may be due to financial constraints or the limited availability of adequately trained experts to assume such a role, among other reasons. CECs have therefore served as a valuable resource for: (1) developing ethics-related policies, (2) promoting clinical ethics education, and (3) providing advisory support to clinical teams through clinical ethics consultations.[1]

Alongside this important work, many settings have developed clinical ethics consultant roles; one or more individuals with clinical ethics training who can be called to provide consultations for clinical cases that raise ethical concerns.[2] These individual consultants can also be helpful resources for clinical ethics education, which they may provide formally and informally. Some informal educational involvement (for example, unit-based rounds) can also provide pro-active input into a current case that can help pre-empt escalation into a "full-blown" ethical dilemma.

Despite the long-standing existence of these two clinical ethics practice models (that is, CECs and clinical ethics consultants), the literature has provided little substantive analysis of the relative merits of the two models. The aim of this article is to highlight the under-recognized merits of CECs, to help ensure that initiatives to promote the development of clinical ethics consultant roles do not unwittingly compromise the valuable contributions that CECs can continue to provide alongside clinical ethics consultants. In writing this, I am drawing on more than 17 years of experience as chair of a CEC (even longer as a member), clinical ethics consultant, educator, and researcher.

Some literature has already discussed ways in which CECs and clinical ethics consultants can function "side by side."[3] As an advisory body, a CEC can offer a rich diversity of perspectives, given the com-

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mon interprofessional composition of such committees, providing a scope of considerations that would be difficult for a single ethics consultant to provide. On the other hand, a consultant can offer a more expedient response to emerging concerns and engage in pro-active discussion and educational activities that would be difficult for a committee to perform. Moreover, an individual ethics consultant can sometimes provide a clearer response to a presenting concern because the consultant will articulate one opinion, based on an advanced expertise in clinical ethics. A CEC consultation can sometimes appear more cumbersome and less coherent. It can consist of somewhat diverse, sometimes even conflicting, viewpoints, drawing on varying orientations toward clinical ethics within the CEC, which on occasion may be difficult to bridge into a consensus.

Given this common distinction between the relative merits of these two models, it is understandable that some may conclude that the individual consultant is the optimal model. However, this kind of distinction may draw largely on a caricature of CECs that conceals the diverse interprofessional perspectives on the presenting case that can illuminate complex underlying ethical dimensions of the case, as well as more richly informed strategies for addressing the case. (Please note that this presumes that CEC members have at least a basic to midrange level of preparation in clinical ethics, and that the CEC functions in a manner that seeks to elucidate and bridge these diverse perspectives.) Moreover, an interprofessional CEC, with members who have some clinical ethics education and background experience acquired through the activities of the CEC, can provide profession-specific guidance on questions emerging from a particular case that a sole consultant would be less adequately prepared to provide. (That is, even if settings have access to more than one ethics consultant, the input of the consultant would be enriched by the broader, interprofessional perspectives of a CEC.[4])

CECs and individual consultants can develop a complementary synergy in the support they provide to clinical services. This complementarity is optimized if (1) the CEC chair is not the setting's clinical ethics consultant, to help ensure that the former does not simply replicate the orientation and activities of the latter); and (2) any member of the CEC can be approached with an ethical concern, fostering an "inclusive" view of what counts as an ethical concern, facilitating the recognition of less dominant ethical discourses, such as the perspectives of nurses and social workers as well as patients and families. For example, there is a growing acknowledgment of the complex ethical challenges confronted by nonphysician health professions that have been under-recognized by clinical ethics,[5] which interprofessional CECs can help reconcile. CECs should develop policies and procedures to inform staff and members of the patient community about processes for seeking a consultation and ensure clear communication pathways among CEC members, the CEC chair, and the clinical ethics consultant.[6]

To illustrate, consider a case involving a newborn with hypoxic-ischemic-encephalopathy, in which the parents have asked to have all life-sustaining treatments withdrawn (including enteral nutrition and hydration) if the child is likely to survive with significant disability. Such a case raises complex questions regarding diagnostic and prognostic certainty, the thresholds for evidence that are required for making life-and-death decisions, the extraordinary vulnerabilities of "imperfect babies," conceptions of best interests for these newborns, decisional authority for determining a child's best interests, and how the latter should be reconciled with the potentially conflicting interests of others involved in the case (for example, siblings, parents, healthcare professionals, and hospitals with limited resources). Family members and healthcare professionals bring their own particular "moral orientations," which a clinical ethics consultant can help elucidate and relate to relevant ethical and legal norms.

A CEC can enrich this process of analysis and decision making by promoting rich interprofessional examinations—fostered through the active engagement of clinical-ethics-prepared physicians, nurses, social workers, mental health professionals, chaplains, lawyers (among others), as members of the CEC seek to help define good practice from each disciplinary perspective. This can be further complemented by the participation of nonprofessional CEC members (for example, a patient or family representative, community member, and so on).[7] Individual members of the patient's treating team as well as the patient and family can benefit from more richly-informed consultations. Given the logistical challenges in conducting this form of CEC consultation properly, this consultation process may be reserved for particularly complex cases.[8]

In conclusion, future developments in clinical ethics consultation models should not focus merely on "which is better: a CEC or an individual consultant?" Rather, they offer different and potentially complementary clinical ethics practice models, with some operational overlap, yet significant distinctions

that should be further examined and developed. This will help optimize the complementary contributions that each model can make toward promoting the ethical treatment of patients and families.

**NOTES**

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3. Gaudine, Thorne, LeFort, and Lamb, "Evolution of hospital clinical ethics committees in Canada," see note 1 above; Hester, *Ethics by Committee: A Textbook on Consultation, Organization, and Education for Hospital Ethics Committee,* see note 13 above; McLean, "What and who are clinical ethics committees for?"see note 1 above; Slowther, Johnston, Goodall, and Hope, "Development of clinical ethics committees," see note 1 above; Mercurio, "Pediatric ethics committees,"see note 1 above.

4. Mercurio, "Pediatric ethics committees,"see note 1 above.

5. J.L. Storch, P. Rodney, and R. Starzomski, eds., *Toward a moral horizon: Nursing ethics for leadership and practice*, 2nd ed. (Toronto, Ont.: Pearson Education Canada, 2012); A.E. Barsky, *Ethics and Values in Social Work: An Integrated Approach for a Comprehensive Curriculum* (Oxford, U.K.: Oxford University Press, 2009).

6. Hester, ed., *Ethics by Committee: A Textbook on Consultation, Organization, and Education for Hospital Ethics Committees,* see note 1 above; Hester and Schonfeld, ed., *Guidance for Healthcare Ethics Committees,* see note 1 above; Mercurio, "Pediatric ethics committees,"see note 1 above.

7. Mercurio, "Pediatric ethics committees,"see note 1 above; Mercurio, "The role of a pediatric ethics committee in the newborn intensive care unit," see note 1 above ; American Academy of Pediatrics, Committee on Bioethics, "Institutional ethics committees," see note 1 above; F.A. Carnevale, "Ethical care of the critically ill child: A conception of a 'thick' bioethics," Nursing Ethics 12, no. 3 (2005): 239-52.

8. Hester, ed., *Ethics by Committee: A Textbook on Consultation, Organization, and Education for Hospital Ethic*s Committees, see note 1 above; Hester and Schonfeld, ed., Guidance for Healthcare Ethics Committees, see note 1 above; Mercurio, "Pediatric ethics committees,"see note 1 above.