



# Moral and legal uncertainty within medicine: the role of clinical ethics committees

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Several years ago one of us (Len Doyal) was giving a lecture to a group of medical students on a long-forgotten ethical issue in medicine. A student, who looked to be still in the throes of the previous night's party, waved his hand and asked, "Yeah, but what colour is a really interesting ethical dilemma". The answer that silenced him and brought laughter to the rest of the class was, "Grey"! Most of the time, clinicians do not have to worry about ethical or legal problems, unless they work in particular clinical specialisations where they are more common (eg, intensive care medicine). This is because the rights and wrongs of most clinical decisions are so obvious that there is uniform agreement about what to do, when to do it, and why. The basis of such agreement lies in the widespread acceptance of the clinical duties of care: protect life and health, respect autonomy, be fair and do all three to an acceptable professional standard. These duties are easily understood and in most circumstances they call for a "black and white" interpretation.

## Moral and legal uncertainty

However, really interesting ethical dilemmas in medicine are not like this. While the principles of moral and legal reasoning remain the same, their application to "hard cases" may be less certain, and possible answers come in shades of grey. A quick look at the established duties of care shows why. Consider the duties of protection and respect. Clinicians may strongly disagree about how to interpret these duties in practice. For example, surgeons are supposed to apply techniques that inflict minimum harm in order to obtain maximum benefit. Yet in specific circumstances (eg, treatment of prostate cancer), there may be disagreement between them about where this line

should be drawn. Equally, all clinicians are supposed to allow patients to exercise informed choice over the treatments they receive. This means they are morally and legally obligated to provide appropriate information about what they propose to do, why and with what risks. Yet how much information is appropriate for the satisfactory fulfilment of this duty? Again, in particular situations (eg, in A&E medicine), this answer may also be uncertain.

This lack of certainty becomes more pronounced when the duties of care are themselves in conflict and disagreement arises about which should receive the most emphasis. Ordinarily, competent patients can refuse to accept clinical treatment that they do not want. Here the principle of respect trumps that of protection. Yet what are the limits to what a patient can demand rather than reject? Suppose a woman demands a caesarean section on the grounds of convenience. Should her decision necessarily be respected? Equally, suppose a man questions a Do Not Attempt Resuscitation order. Should respect for his desire for cardiopulmonary resuscitation trump a clinical decision that this will almost certainly not extend his life? Again, such cases may be "hard" in that there may be disagreement about what constitutes acceptable "convenience" (eg, arranging to fly to Australia to see a dying brother) in the case of the woman and what is a "reasonable" attempt at unlikely survival as regards the man (eg, to say goodbye to his estranged brother who is on a plane from Australia). Interpretations of the duties of care can differ greatly in the face of such cases.

Disagreements may also arise when clinicians have different values that are rooted in even broader moral principles. This may then lead them to interpret the duties of care in different ways. Some argue, for example, that ethical judgments within medicine should primarily serve the public interest by maximising the common good rather than the rights and associated claims of individual

patients. Thus the patient who demands what will probably be futile cardiopulmonary resuscitation will be seen as wasting scarce medical resources which can serve the interests of others who need them more. Conversely, others argue that the rights of individual patients should be prioritised, even when the public good may suffer. They might maintain that the man demanding resuscitation has led a responsible life, paid his taxes, and deserves a final chance for emotional closure with his brother. Similar disagreements will occur in other areas of medicine. What are the boundaries of good practice in obtaining informed consent from patients whose mental capacity is limited, for example, or in deciding when not to provide, or to withdraw, life-sustaining treatment from permanently brain-damaged patients?

## Procedural principles for dealing with uncertainty

One thing is clear. Substantive moral principles that are in dispute will not provide the means by which such disagreements can be resolved. This is because it is precisely the conflicting interpretations of these principles—and subsequently of the duties of care—that pose the problem. It is sometimes argued that the moral virtue of individual and experienced clinicians might lead to such resolution. However, this is of little use because such individuals can and do disagree. Indeed this is standard practice in medical litigation in the debates between expert witnesses. The only hope for a way out of moral uncertainty in these circumstances is to accept that, in the face of some hard cases, doctors must alter their understanding of what a "right" answer is. They should put their trust in procedural rather than substantive moral principles, that will at least provide the basis for the most rational decision possible, given the clinical circumstances at hand.<sup>1</sup>

There is nothing original about this idea. Within both medicine and surgery, there are disputes between clinicians about the "right" diagnosis or "the most appropriate" treatment plan—about the correct interpretation of relevant principles of good clinical science. At their best, clinical management meetings, case conferences and grand rounds embody procedural principles designed to optimise rational decision-making about such differences. Rules of discussion and debate are designed to ensure that relevant expertise and evidence are heard, that

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the process is democratic, that corrupting vested interests are removed, and that bullying based on professional seniority and power is banned—all principles of good procedural ethics. Clinicians engaged in such exchanges of views understand that, whatever their disagreements about substantive principles behind the disputes, the best possible decision must be made either immediately or in a very short timeframe. Mistakes can still be made, but this is a price that is worth paying for procedures that will at least ensure that clinical deliberation is optimally rational.

The same principles of rational communication and debate need to be deployed to resolve potentially intractable disputes about what is morally rather than scientifically appropriate. Clinical ethics committees (CECs) have evolved to try to meet this need within a hospital environment.<sup>2</sup> In the USA, hospitals are federally mandated to have such committees, and they often play an important role in the work of their institutions. A recent and highly publicised example was the Ashley X case where it was proposed that a 6-year-old severely brain-damaged child with the approximate mental age of months be given a double mastectomy and hysterectomy on the request of her parents.<sup>3</sup> Against the background of much debate and conflicting moral values, a decision about whether or not to proceed was made by the CEC for the hospital concerned. The committee approved the surgery.

This does not mean that moral or legal argument about this or any other decision made by CECs about hard cases will stop. However, if it can be demonstrated that the original decisions reflected good procedural ethics, then this will constitute a strong defence of their rational and practical appropriateness.

It might have been expected that CECs would also have been integrated into UK hospitals, not only to help in the resolution of hard cases but also to perform important functions as regards the planning and management of clinical care. Working in conjunction with relevant legal departments, they can provide valuable input in the formulation and evaluation of various hospital policies

(on consent, confidentiality or resource allocation for example), as well as providing ethical and legal education and training for hospital staff.

### Potential problems with CECs

However, the level of CEC development within the NHS has been very low. While many hospitals do now have such committees, it is clear that they are not as integrated into hospital life as well as they might be.<sup>4</sup> In this issue (*see page 451*), Whitehead *et al*<sup>5</sup> describe some interesting research suggesting that very few clinical dilemmas are actually sent to CECs. Building on the work of others, they outline some of the reasons for this: lack of sufficient institutional support from hospital management, inadequate publicity about the work of established committees and concern on the part of hospital staff that, were cases to be sent for review, this might pre-empt clinical discretion and control. Under these circumstances the authors mention a possible alternative strategy for dealing with moral indeterminacy: individual hospital ethicists to provide advice and support concerning hard cases. They rightly suggest that this alternative needs further exploration and research.

One of us (Len Doyal) worked as an ethicist in a hospital environment for many years. In the course of this, he did find that individual clinicians were more inclined to consult him than to go to the CEC which he had helped to establish. Yet much of this contact concerned straightforward ethical and legal issues that were subject to little controversy. Personal experience suggests that an individual ethicist confronted with a hard case will have the same problems of moral and legal indeterminacy that clinicians themselves face. Ethicists (notoriously) disagree with each other about the interpretation and application of principles to practice, just as clinicians do. Where hard cases rule, so to speak, there will continue to be no substitute for procedurally appropriate collective debate and discussion in the form of CECs. Without them, individual ethicists will be left to do their best to replicate good procedural practice

on an ad hoc, and sometimes unsatisfactory, basis.

Hospital managements in the UK and elsewhere should be mandated to recognise this point. With some of the North American experience in mind, they should more actively promote and support CECs within the clinical environments for which they are responsible. Provided that clinicians are convinced that the terms of reference of such committees are advisory rather than directive, it seems likely that they could be welcomed and more frequently utilised. Of course, this presupposes that the performance of such committees sustains a high standard, and it is clear that standards will vary among committees just as they do among ethicists! More must be done to ensure uniformity in this regard. Clearly low standards of ethical consultation are no more acceptable within an institutional context than they are within clinical practice at the coalface.<sup>5</sup>

The *Postgraduate Medical Journal* welcomes further debate about the resolution of moral uncertainty in medicine and comments about the role and effectiveness of CECs. We are particularly interested in reports from clinicians about successful and unsuccessful experiences of such committees and how any problems could best be solved. We look forward to hearing from you.

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