

The ethics of clinical ethics services

One function of such services is to help clinicians ask the “right” questions

The article by Gill and colleagues in this issue of the Journal (page 204)¹ raises the issue of the ethics of clinical ethics services and, secondarily, their potential legal liability. Expressly or by implication, the article points to many difficulties and pitfalls of such services, and certainly raises more questions than it answers. But, in doing so, it reflects a necessary and valid function of ethics services: to help those who should make the decisions ask as many of the “right” (ie, ethically relevant) questions as possible. It is not the function of ethics services to *make* those decisions.

The authors make some important points. Variability in decisions or failure to reach consensus does not mean ethics consultations are pointless — it is as important to highlight moral differences as to resolve them. When conducted well, clinical ethics services can be a valuable hospital resource and a powerful, critical voice contributing to ethical practice.

“Doing ethics” is an exercise of power, and power must be exercised ethically. But simply a desire to do good is not sufficient to ensure that. Our goal of doing good can blind us to the harm that is also unavoidably inflicted, and sometimes that infliction is unethical.

Doing ethics is a matter of both substance and process. Questions that help to provide insights about process ethics include: Who should decide? On what basis? Using which procedures? For what purposes? One of my “process” concerns about the Acute Clinical Ethics Service (ACES) described by Gill et al is that the ACES team does not necessarily include a person trained in applied or practical ethics and, moreover, that the authors do not recognise the need for doing so. I also have substantive or principle-based ethical concerns. For example, their “organisational principles” do not make it clear that, when values conflict, the basic ethical and legal presumption governing decision-making is that the patient’s values should take priority, and therefore that contravening them must be fully justified. Rather, these principles instruct the ACES to consider “the facts of the case and the values and preferences of all stakeholders”. Most ethical issues involve a conflict of values, which means values must be prioritised when not all can be honoured. Justifying the breaches of values that result is the essence of doing ethics. An important function of a clinical ethics service is to provide such justification or to comment on that provided by others. This allows the clinical ethics service to fulfil its advisory role in individual cases, to establish precedents that can guide future decisions and to serve a teaching function within the healthcare institution as a whole.

However, my purpose here is to address the broader ethical issues underlying an ethics service rather than the ethical issues raised by the cases presented by Gill et al, with whose analysis and conclusions I do not necessarily agree.

Committee decisions, as compared with individual ones, can spread the responsibility. A committee can make a decision that no one person — in particular, no committee member — acting alone would make. In all the cases described by Gill et al, the issue was that of shortening life (by either withholding treatment or aborting a fetus), and the physicians doing that were morally reassured by the ACES’s involvement. Might that have allowed the “caring team” to

implement decisions that their moral intuitions were indicating were unethical? While these decisions *may* have been ethical, we must always be aware that we ignore such intuitions at our ethical peril.

Could the ACES be legally liable for its advice?

A clinical ethics service could be held legally liable if it failed to act as a reasonably competent committee. In a Quebec Superior Court case,² the court held the ethics committee of a McGill teaching hospital liable for negligence in its review of the informed consent forms for a research protocol. The very remote risk of death was not disclosed. A subject in the research trial died from an anaphylactic shock reaction to the injection of a dye.

If the membership of an ethics service or committee is not reasonably constituted, it could give rise to a claim based on systems negligence for failure to establish a reasonably safe system for ethics review. Not having a trained ethicist as part of a service or committee, or at least available for ad-hoc consultation, raises this issue, although that absence may be able to be justified. Moreover, an ethics committee and a “single ethics expert” are not mutually exclusive alternatives, as often both are needed.

Ethics services or committees may have an obligation to report unethical and illegal actions. If they do not intervene at all, there may be no liability, but, having intervened, they may be liable for failure to take reasonable care when it is clear that that failure could result in harm to others.

Patient consent

The basic presumption concerning patients’ medical records is that they are subject to strict duties of privacy and confidentiality. Therefore, obtaining informed consent from the patient (or the legal representative of an incompetent patient) to consult the ethics committee is necessary. Acting without such consent would need to be justified. As presently drafted, the organisational principles outlined by Gill and colleagues could cause some confusion as to whether these rules apply. Once again, it should be made clear that, in situations in which values conflict, the basic presumption is that the patient’s values should take priority.

Characteristics of the members of the ethics consultation team

The relationship between an ethics consultation team and the hospital administration raises the issue of conflict of interest in those people who are both members of the ethics service and part of the hospital organisation. If their obligations or goals as members of a clinical ethics service *could* conflict with their duties as people holding hospital appointments, then there is such a conflict, whether or not in the particular circumstance a conflict arises in practice. Strong ethical sensitivity is required to identify and deal with such conflicts.

An assumption that people of good intention acting in good faith are competent ethics committee members — in particular, that they are, by virtue of those characteristics, sufficiently educated in ethics — is not valid. A recent US Institute of Medicine

report³ has recommended that substantial resources be devoted to such education.

Schools of ethics

Gill and colleagues mention various schools of ethics that “may assist with the resolution of ethical conflicts”. These schools can be looked at as different “lenses” through which one can view a situation that raises ethical dilemmas. When all reflect back the same response, one can be reasonably certain that acting in that way is ethical. But when conflicting responses show up, difficulties arise. These difficulties usually reflect an irresolvable conflict of values. In such cases, it is very important to give the reasons (ie, justification) for giving priority to one value or set of values and thereby contravening another value or set of values. Indeed, providing such justification is the essence of “doing ethics”.

Conclusion

The article by Gill and colleagues raises some very important issues, and the cases they describe may raise substantial controversy in relation to healthcare ethics services. Certainly, if North American experience holds true in Australia, many doctors may

feel, at least initially, that their professional autonomy is threatened by an ethics committee or even an ethicist. Many nurses, however, will see ethics committees and ethicists as empowering them to challenge doctors’ decisions that they believe are unethical. Junior members of the medical profession, especially students and residents, and a few of its leaders, will be the first to accept the benefits of properly constructed ethics consultation services and to promote their integration into the healthcare setting. As ethics services become more familiar, more people will recognise both their benefits and (as we should always keep in mind) their dangers. Like democracy, ethics committees and ethics consultations are not a perfect system, but they are better than the alternative of having no ethics consultation process at all.

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1 Gill AW, Saul P, McPhee J, Kerridge I. Acute clinical ethics consultation: the practicalities. *Med J Aust* 2004;181: 204-206.

2 *Weiss v Solomon* [1989] RJQ 731, 48 CCLT 480 (Sup. Ct. Que.).

3 Federman DD, Hanna KE, Rodriguez LL (editors). *Responsible research: a systems approach to protecting research participants*. Washington, DC: National Academies Press, 2003: 290. □

postoperative intensive care. There must be ongoing clinical governance so that expected outcomes match actual results.⁸

Not only are more and more octogenarians choosing to have cardiac surgery, but the chances of a good outcome are improving. Advances in surgical techniques in recent years mean that the risks of cardiac surgery, for all patients but especially those over 80 years, have been substantially reduced. The availability of "off-pump" technology (ie, doing coronary artery anastomoses without the use of cardiopulmonary bypass [CPB]), including mechanical aortocoronary anastomotic devices, allows CABG to be done not only without CPB, but also without manipulating the aorta, thus reducing atheroembolic risk.⁹ Furthermore, the duration of CPB and global myocardial ischaemia can be minimised by combining off-pump techniques with CPB (eg, valve replacement with CABG). Also, selective use of ventricular fibrillation (rather than cardioplegic arrest) when repairing a mitral valve avoids global myocardial ischaemia. Surgeons have several options for the technical performance of these operations. While there may be no surgical consensus on the optimal technique for a given patient, in my view a "one shoe fits all" surgical approach may prove hazardous.

It is important to prepare the patient optimally before surgery. This includes universal carotid screening and judicious use of prophylactic carotid endarterectomy, together with preoperative optimisation of renal function and maintenance of perioperative enforced diuresis.¹⁰ Although none of these innovations has been tested in randomised controlled trials, myocardial, cerebrovascular and renal complication rates are now low.

A critical factor determining surgical outcomes is whether the patient is in need of urgent surgery (ie, surgery required as a hospital inpatient because the patient cannot be satisfactorily stabilised with medical treatment).²⁻⁴ Delays in referring symptomatic patients are invariably associated with rapid clinical deterioration and poor results.

The role of percutaneous coronary intervention (PCI) versus surgery for coronary artery disease requires comment. Neither surgery nor PCI is benign.¹¹ For comparable patients of any age in experienced hands, the risks of inducing death, myocardial infarction, stroke or neurocognitive deficits are the same with either approach.^{12,13} With surgery, the failure rate is lower and there is less need for repeat interventions. However, surgery requires a sternotomy and graft harvest incisions on the leg.

A number of clinical factors are associated with increased risk of PCI failure (eg, left main coronary artery or multivessel disease, diabetes).¹⁴ Before PCI is undertaken, it is essential that the cardiologist and the surgeon carefully assess which procedure is optimal for a particular patient. If PCI fails, performing emergency surgery (ie, within 24 hours of hospital admission) is associated with markedly increased risks, particularly in octogenarians.

Which octogenarians should be offered cardiac surgery? Many, if not the majority, should be readily identifiable as unsuitable because of advanced comorbidities. However, the 20% of patients in our series who were advised not to proceed with surgery had no clear features distinguishing them from the 80% advised to proceed. It is impossible to provide unambiguous criteria for refusing surgery. Nor am I suggesting that all octogenarians be offered this treatment. What I am advocating is that age alone must not be a barrier to accessing cardiac surgery. We can be heartened that careful evaluation allows us to pick the right patients and that these patients are achieving acceptable outcomes. Patients should

be offered a choice. Those who have had cardiac surgery believe it is worthwhile and are very grateful.²

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