

The value of clinical ethics support in Australian health care

Clinical ethics support may benefit professional practice, and we should evaluate it in Australian health care

Professional practice in health care inevitably involves difficult ethical considerations that are often embedded in universal events: birth, periods of ill health, and death. Clinicians may be unsure in these situations about what exactly they should do. In light of this circumstance, ethics should no longer be an implicit component of Australian health care, but instead be explicitly recognised and practised. Clinical ethics support (CES) would help to optimise the ethical delivery of patient care.

The aim of CES — whether it is provided by a clinical ethics committee, an ethics consultant (a trained ethicist who supports professionals or institutions), or a combination of both — is to assist ethical decision making in health care. CES is often invited when a specific need for ethics advice arises in the context, for example, of a difficult clinical case or problem, an educational need, or a gap in policy.

“The development of [clinical ethics support] in Australia currently lags well behind that in other countries”

Ethics is included in Australian medical training curricula, such as the Royal Australasian College of Physicians’ Professional Qualities Curriculum, and is expected to inform individuals’ medical practice. Medical education, however, may not be sufficient, and professional clinical practice may not always allow detailed ethical deliberation. While the Australian Health Ethics Committee recently endorsed CES,¹ there are currently few alternative dedicated mechanisms for considering ethical issues in Australian health care, and this limits individual and institutional development and professional practice in this area.

This does not mean that Australian clinicians are unethical, or that they are ignorant about ethics. In this issue of the Journal, Doran and colleagues explore ethical practices and decisions,² and suggest that ethical practice in Australian health care is “mostly right”. However, their research also detected a phenomenon that can be termed silent “moral disquiet”. Australian health professionals appear to have persisting concerns about ethical aspects of their practices, but there are few appropriate forums for explicitly discussing them. This puts them at risk of “moral distress” — the stress that arises when a clinician feels unable to act ethically.³ CES has the potential to alleviate this situation.⁴



How does clinical ethics in Australia compare with overseas?

The development of CES in Australia currently lags well behind that in other countries. CES has been available for more than three decades in the United States⁵ and for more than two decades in the United Kingdom.⁶ CES has also been established in other countries, including New Zealand.⁷ In contrast, there are no current surveys of Australian CES services, and earlier analyses had methodological problems.⁸ Only a few Australian CES services have been described in the literature.^{9,10}

In the US, almost all hospitals have a clinical ethics committee and many also have clinical ethics consultants. CES services are well integrated into the clinical setting, and can often, for example, be contacted through the hospital bleep service. In addition to individual case consultations, many CES services also offer “ethics rounds” conducted by an ethics consultant in a specific ward, such as an intensive care unit or a geriatric patient ward, to discuss pertinent ethical issues. Ethics consultants are also permitted to write in patient notes (personal observation). A professional code of ethics for clinical ethics consultants has recently been introduced in the US.¹¹

In the UK, there are more than 70 clinical ethics committees in a variety of health care settings, including primary care, mental health and tertiary hospitals, many of them providing case consultation. An emerging national network links clinical ethics committees and individual consultants across the country. The UK also benefits from access to a network of clinical ethics practitioners in the European Union, allowing ready comparison of practice and policy between countries (personal observation).

CES services in countries such as the US and UK may help with cases or broader discussions in areas such as end-of-life care, confidentiality and its limits, pandemic planning, termination of pregnancy and refusal of treatment by minors. Some have excluded certain questions from their remit, such as resource allocation decisions (personal observation).

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Australia, in contrast, has fewer CES services,^{9,10} with no professional organisation or standards, and “implicit ethics” are more typical for medical practice here. Clinicians need to be able to justify decisions on ethical as well as other grounds, but support for ethical decision making should not just be left to individuals. Opportunities to discuss ethics with colleagues can be helpful. If CES is not introduced more widely in this country, we risk increasing the levels of silent moral disquiet and moral distress in our medical staff, together with the disruption and disaffection that this may cause. We should look to examples of successful CES overseas and assess their suitability for adoption into Australian clinical practice.

Challenges for clinical ethics support

Successful CES is subject to several challenges. Overseas CES processes may not be immediately translatable to Australian health care contexts and further practical challenges are also likely to arise. For example, not every hospital in Australia may have the means or demand to sustain local CES services, particularly those in rural and remote areas. Other factors relevant to how CES would be organised and implemented include the organisation and funding of health care in Australia, the cultural mix of Australian society and the role of CES in hospitals with particular religious affiliations. These, however, are not impediments to the implementation of CES, but simply highlight that Australian CES will need to be tailored to the population it serves.

An institution that introduces CES will also need to endorse and promote it; otherwise it will eventually struggle or even flounder entirely. To prevent this, an institution must commit itself to financial and practical support of its CES over a sustained period of time. Endorsement and oversight of clinical ethics at state and national levels would be even more preferable.

CES can struggle to generate conditions or a culture in which referrals for case consultation, educational provision or policy work are more likely.⁶ How such conditions can be achieved remains an open question. The concept of specific CES itself is also subject to critiques of the “place” of clinical ethics in decision making,¹² and the appropriate role of patients in CES processes.¹³

Is there a place for clinical ethics support in Australia?

One aim of CES is to support professionals and families. This should not be misunderstood as “telling health professionals what to do”, hunting for “poor practice” or “taking sides.” Using CES should not be compulsory, nor should it replace “everyday ethics” in clinical decision making. CES offers a mechanism that facilitates sound and reasoned decision making in ethically contested situations, supported by ethical

experience, training and research into what facilitates appropriate ethics support. Clinical ethics can also assist clinical professionals to help themselves and each other, proactively encouraging a reflective culture of health practice.

Australian health professionals may be sceptical about CES, as I recently found after presenting my overseas experience of CES to such a group. Many were perplexed and unsure of its potential benefits. If they were competent clinicians, should they not be able to do this kind of reasoning as part of their everyday work? This exemplifies the “settled morality” discussed by Doran and colleagues¹ in which ethics becomes “part of the fabric” of clinical work, leading to its invisibility. This works when there is no silent moral disquiet, but, as Doran et al claimed, we should be wary of “overlooking rather than tackling difficult but important ethical issues”.

The sceptical view also misses the point of CES. When implemented well, CES optimises decision making in difficult circumstances, and enhances a culture of sound ethical practice at the institutional and system levels (through, for example, regular ethics grand rounds). A clinical ethics service can also help avoid having to resort to legal means to solve problems — although this point needs more investigation.

A separate teaching session with the same group of health professionals I mentioned earlier helped resolve some of the uncertainty many of the clinicians felt about CES. Acting as a mock clinical ethics committee, and using a trained chair, a difficult published case was explored to simulate how CES might work in practice. We discussed the complexities of the case and possibilities for its resolution from a variety of perspectives, questioning our assumptions after hearing from colleagues with other viewpoints. The session ended with the group enthusiastic about and appreciative of the process, having developed a proposed course of action that was both based on ethical reasoning and practicable within a health service.

Conclusion

Australian CES is still in its infancy. It will be subject to practical, political and professional challenges. International experience with CES across a range of jurisdictions and health care systems suggests, however, that, when appropriately implemented, CES benefits clinical practice, health professionals, patients and their families. Ethics is already integral to clinical practice in Australia, but it is often not overtly discussed. It is assumed, but not critiqued, practised, but not reflected on. CES should be introduced and evaluated to determine if and how it strengthens the delivery of ethical health care.

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