



Short report

How do national guidelines frame clinical ethics practice? A comparative analysis of guidelines from the US, the UK, Canada and France

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ABSTRACT

International policies regulating clinical ethics committees' (CEC) roles are non-existent. Nonetheless, CECs have established themselves in several countries and there exist striking differences in the way these work. This international practice variation stems from the ways CECs developed, within particular legal, political, social and professional contexts. National guidelines and normative documents have been published in many countries regarding CECs. To better understand CECs' evolution and differences in various countries, we reviewed guidelines, position statements and normative papers which describe and frame the development of CECs in the United States, the United Kingdom, Canada and France. Systematic content analysis addressed guideline development, CECs' roles, consultation methods and CEC members' education requirements. Differing contexts informed the ways in which guidelines were developed. American CECs, established within a strongly litigious context are perceived to play strong decision-making roles, whereas British CECs, encouraged by clinicians, endorse a more supportive model. Canadian guidelines focus on the role of the ethicist, while the French model is interested in a theoretical interdisciplinary approach. This analysis shows important challenges facing the implementation of accountable CECs in different contexts and can help inform future policy development.

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Introduction

Drawing on standards established by the Nuremberg Code and the Declaration of Helsinki, most countries have issued national guidelines on the ethical conduct of research (Schüklenk, 2000). The establishment of research ethics committees (RECs) has followed the basic principles presented in these international normative documents, which has lead RECs in different countries to take on similar roles and endorse comparable standards. In contrast, such a guiding policy has never existed to frame the evolution of clinical ethics committees (CECs). This less systematic process has led to debates regarding what comprises clinical ethics consultation and how CECs should function (Baker, 2009; Fletcher & Hoffmann, 1994; Scofield, 2008; Singer, Pellegrino, & Siegler, 1990).

Some countries have established national guidelines for CECs, reflecting their local cultural, social, ethical, political and legal contexts. Although these policies may not reflect CECs' practices at an institutional level, they would be expected to mirror national preferences and they are thus critical in shaping the discussion on

how CECs work. Previous studies have identified practice variations in CECs between European countries and hypothesised such differences could be attributed to the ways in which CECs developed locally (Fournier et al., 2009). However, a comparison of CEC development in different countries has not been offered and no study has analysed international guidelines framing the practice of clinical ethics. Therefore, documents from the United States (US), the United Kingdom (UK), France and Canada are analysed in this paper, to examine how CECs developed within diverse countries and how national guidelines may have shaped the growth of clinical ethics locally.

Methods

Documents regarding CEC services in the US, the UK, France and Canada, in French and English, were analysed. We hypothesised that the models for CEC work would be different between these countries and believed this might generate interesting contrasts and comparisons. Eligible data for this analysis was published between 1985, when the American Medical Association published their *Guidelines for Ethics Committees in Health Care Institutions* (AMA, 1985), and September 15th 2011, publication date of the American Society for Bioethics and Humanities' *Core Competencies*,

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2nd edition (ASBH, 2011). Data included all published documents and reports from government sources, national institutions and organisations or legal briefs regarding clinical ethics work, committees or consultation practices. These documents were available on the websites of national bioethics organisations and their bibliographies were cross-referenced to ensure exhaustivity. To inform analysis, a review of the scientific, humanities and bioethics literature was conducted using PubMed, Cinahl, Google Scholar, Web of Science and documents' crossreferences.

For this qualitative content analysis, initial categories, informed by the research question and literature review, were pretested on US and UK documents. Then, 25 categories were developed inductively (Krippendorff, 2006). The results were analysed and coded into main themes (Appendix A). Content analysis was performed by the main researcher; documents were independently reviewed by a second researcher and results compared for validity.

Results

Table 1 offers a summary of the main themes identified in our analysis: roles, approaches, members/requirements, decision-making, and evaluation. Documents referenced are available in Appendix B. Guidelines from different countries focused on distinctive aspects of clinical bioethics. American documents were interested in healthcare ethics consultation, British guidelines focused on CECs, French documents addressed issues in medical ethics and Canadian policies examined the bioethicist's role. Although these terms may express conceptual differences, they nonetheless all pertain to the way ethical issues in healthcare are being practically addressed.

United States

In the US, CECs have grown in numbers since the 1970s, endorsed by court rulings such as *Quinlan* and accreditation bodies (Aulisio & Arnold, 2008; JCAHO, 1996; *Quinlan*, 1976; Singer et al.,

1990). Nonetheless, there is no legal framework regarding the functions of American CECs (Fletcher & Hoffmann, 1994). In 1998, the Society for Health and Human Values and the Society for Bioethics Consultation, now the American Society for Bioethics and Humanities (ASBH), published the *Core Competencies for Healthcare Ethics Consultation* (ASBH report) (ASBH, 1998). Shortly thereafter, the Veteran Health Affairs National Center for Ethics in Health Care (VA) also published influential documents meant to standardise CEC work within their hospitals: the *Guide to Ethics Consultation* (Fox, Berkowitz, Chanko, & Powell, 2006). Resulting from collaboration between the ASBH and the VA, the 2nd edition of the ASBH report was recently published (ASBH, 2011).

In American guidelines, healthcare ethics consultation is defined as:

“A service provided by an individual or group to help patients, families, surrogates, healthcare providers, or other involved parties to address uncertainty or conflict regarding value-laden issues that emerge in healthcare.” (ASBH, 1998, p. 168)

The ASBH reports encourage CEC involvement in issues in patient care, policies regarding patient care and ethics education for the healthcare organisation in which they operate.

The ASBH defines ethics consultation as “the identification, analysis and resolution of ethical issues as they emerge in clinical cases in healthcare institutions” (ASBH, 1998, p. 174). “Ethics facilitation” is presented as the preferred approach to consultation, defined in the 1st report as “identifying and analyzing the nature of the value uncertainty and facilitating the building of consensus” (ASBH, 1998, p. 171). In the 2nd edition, the definition evolved to endorse “a principled ethical resolution” as preferable outcome. As such, American CECs are expected to resolve conflicts to avoid turning to the courts (ASBH, 2011).

In contrast, consultations represent only a portion of the VA's comprehensive *IntegratedEthics* approach, which targets issues within healthcare organisations' systems and institutions' global culture. The VA's CASES method (Clarify, Assemble, Synthesise,

Table 1
Characteristics of CECs in the US, the UK, France and Canada as portrayed by guidelines.

	United States	United Kingdom	France	Canada
Roles	Conflict resolution ASBH: healthcare ethics consultation, amongst others VA: ethics consultation, preventive ethics, ethical leadership	Advice and support on ethical issues in patient cases, professional education, hospital policy	CCNE: medical ethics policy development Institutional groups for ethical discussion, education, research	Bioethicists within healthcare institutions can have many areas of interest and responsibilities None specified
Approaches	“Ethics facilitation” Multidisciplinarity ASBH: conflict resolution through consensus or principled ethical resolution VA: systematic and standardised	“Ethics support” Multidisciplinarity Identify a range of ethically acceptable options Families more or less involved in consultations	No consultations Multidisciplinarity Cultural, educational, and methodological support in decision-making	
Members/requirements	ASBH & VA: <i>Core competencies</i> Competency assessed by VA toolkits Consultations by individuals, teams or committees	UKCEN <i>Core competencies</i> Competency assessed by: 2 references and educational portfolio “Core-plus-options” model	All backgrounds and fields Include ethics' experts: postgraduate training in humanities	“Bioethicists” Masters' or terminal professional degree, some practical experience, capacity to demonstrate <i>Core competencies</i> Role not specified
Decision-making	Strong decision-making authority Turn to courts if no resolution possible	No authority More supportive than directive	All decision-making authority for physicians “Espace éthique” not involved in patient care	
Evaluation	VA toolkits endorsed: Ethics Consultant Proficiency Assessment Toolkit Ethics Consultation Feedback Tool	Encourages evaluation of user satisfaction, educational activities, policy work <i>Core competencies</i> used as terms of reference	None	None feasible as there are no standards for practice

ASBH: American Society for Bioethics and Humanities; VA: Veterans Health Administration; UKCEN: UK Clinical Ethics Network; CCNE: Comité Consultatif National d'Éthique.

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