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Clinical Ethics Committees: an analysis of their role and function

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Dedication

This thesis is dedicated to my precious children, Andrew, Katy, Isobel and Jak.

"The best CEC's that I have known have an awesome multiplicity of skills from legal scholar, psychologist, healer, philosopher/theologian, case manager to friend and confidant. To behold the best is to behold a real professional. The question for us, I believe……… is the why and the how?" (Childs 2009 p238)

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ABSTRACT

Healthcare Clinical Ethics Committees (CECs) are increasing in numbers. Critics argue that they undermine the moral development of the practitioner by not encouraging them to think deeply and for themselves about medical ethics. This could result in abrogation of responsibility for decisions to CECs.

These criticisms arise partly out of a lack of clarity about what should be the most appropriate function of the CEC. Some consider CECs to be a group with a remit to act as an expert on ethical matters, review a clinical case, balance the moral duties of the practitioner against rules or principles, and make a recommendation on action. In America and Canada CECs such as these are often given a mandate by law, and are closely aligned to management and quality assurance functions.

Another view of CECs is that they are a supportive forum for reflection to enable clinicians to consider the ethical implications of a difficult decision; the clinician is then more able to decide on an appropriate action, having holistically reviewed the situation from a range of perspectives, this is a more usual role for European CECs.

This thesis will argue that CECs can offer a useful service to clinicians in the UK by providing a safe environment for reflection. Within this space the CEC can support exploration of solutions to the issues by using a non directive structure to their questioning techniques. Central to this process is the need for the clinician to be present throughout the discussion. Within this reflective space, questioning by the CEC is structured to enable practical planning to occur, after dialogue about

the situation or issue, acknowledging the impact of emotion, and moral and non-moral influences influencing the case. This thesis proposes the use of solution focused techniques and casuistry within the CEC which form the basis of a model developed by the author entitled the ASCS (Ask, Seek, Clarify and Solution) model. Use of the model can provide a framework for structured dialogue which is simple, evaluable and brief. Use of the model within the UK CEC has the potential to increase the skills of the practitioner to tackle ethical issues in practice. Such skills once learnt can be utilised by the team to deal with ethical conflict in the workplace in the future.

Introduction and Background

Intro.1 Difficult ethical challenges facing health care professionals in the UK

Clinical decision making in healthcare practice has become increasingly complex over the last 40 years. A dramatic improvement in available technology and increasing life expectancy has led to extra competition for finite resources between patients and also between healthcare services. Healthcare budgets in the UK have limited resources unable to match demand from the resident population. As the Public Action Support Team (2012) state:

> *"In a national health system, it is likely that the aim is to meet needs rather than wants…….But it is also the case that meeting one need may mean that another is not met and that no-one has discovered a limit to need".*

The healthcare team is required to make difficult ethical decisions about issues such as; allocation of resources, withholding treatments, and consent issues. Often this has to be done speedily and efficiently, in a clinical environment, that is distracting, and sometimes chaotic.

Increasing patient expectations around quality of care and choices for care have added further pressure upon healthcare services, and ultimately upon clinicians attempting to deliver care. Parker et al (2000 p2) identify that the greatest effect medical ethics has had in the last 20 years has been to inform and enable patients. They state:

> *"The paternalistic model of medical care has been consistently attacked and eroded. But such stress on autonomy is itself an aspect of the more general social changes which might be seen as broadly consumerist".*

The health consumer now rightly demands quality of care and support, access to treatment, information tailored to need, and explanation of decision making processes. This has placed greater responsibility than ever on clinicians to consider, discuss, document actions, and demonstrate the fairness of their decision making.

There are also increasing demands for clinicians to defend processes and outcomes of decision making to professional bodies, and through civil and criminal courts. The Nursing and Midwifery Council (NMC) is clear about where responsibility lies with regard to accountability for decisions and actions, for a registered nurse. The NMC (2012 p1) states:

> "Accountability is an integral part of provision to practice, as, in the course of practice, registrants have to make judgements in a wide variety of circumstances. Professional accountability is fundamentally concerned with weighing up the interests of patients and clients in complex situations, whilst using professional knowledge, judgements, and skills to make a decision. This enables registrants to account for any decisions they make".

Doctors also face increasing scrutiny and Johnston (2010 p201) reflects:

> "In 2005, the Royal College of Physicians Working Party report on ethics in practice (RCP working party) noted that in a climate of advances in medical technology and increasing scrutiny of, and challenges to medical decision-making, 'medical practitioners are encountering ethical uncertainties and even dilemmas in their daily practice with increasing frequency'."

Calls for a review of clinical decision making, either healthcare trust review or civil or criminal proceedings, often happen after it is perceived an adverse event has

occurred. Beyleveld et al (2002 p17) identifies examples of such harm, stating that in 1997 three doctors at Bristol Royal Infirmary were charged with incompetence for continuing to operate on children with heart problems, even though they knew death rates were well above the expected average. Other harms cited by Beyleveld (2002) can be seen in the cases of deceased children who had their organs retained without appropriate permissions being obtained. Subsequently these children were buried with organs missing without the knowledge of their loved ones. A more favourable position would be to offer healthcare teams an opportunity to take pro-active steps to avoid harm by challenging unethical practice or by improving holistic decision making in practice, and the CEC can be part of this proactive support to avoid harm which is being asked for by patients and clinicians alike.

Intro.2 Clinicians are asking for support systems to assist their decision making when faced with difficult ethical dilemmas

Clinicians are asking for extra support when considering difficult decision making challenges. Gillon (1997) cites Dr Larcher who identifies that there is dissatisfaction amongst clinical staff about the way decision making dilemmas are handled. Being confident in individual and team judgements can be undermined by the complexity of situations a healthcare professional may face. In the pressured healthcare environment, the most appropriate decision about action, in a rapidly changing complex situation, may become obscured by competing demands between patients, and inconsistent and uncertain outcomes. The combination of the complexity of the issues, numbers of people involved in the decision, and the pressured environment, makes reflection in practice difficult. There may be a number of actions that could be considered appropriate in the circumstances and

the clinical team may need to make judgements about what is in the individual patient's best interests from a range of options, taking into account the patients current or previous statement of preferences. The question arises how is such proactive support offered and can this support be improved upon?

Intro.3 Support available to help clinicians with their ethical dilemmas

Should the UK healthcare team be experiencing difficulties concerning a clinical dilemma, the clinician currently has access to a variety of support and guidance, including, access to individual clinical ethicists often linked to a university, and help through professional guidelines and advice from professional bodies, such as the General Medical Council and the Nursing and Midwifery Council. Legal advice is available from solicitors attached to all NHS Trusts as well as support from chaplaincies and other clinical colleagues who have been identified locally as sources of advice on ethical issues. McLean (2007 p497) states that the recognition of the burdens on healthcare professionals has "generated some interest in the provision of ethics consultation".

One developing area of clinician support is the clinical ethics committee. Clinical ethics committees (CECs) are a group of interested lay and professionals who volunteer to review proactively or reactively ethical issues in practice.

Intro.4 Clinical ethics committees in the UK: structure, prevalence and membership

According to Gillon (2010) in 2010 there were 66 Acute Trust Ethics Committees in the UK. This number has continued to grow. Slowther (2012) states that in 2010 there were 82 committees known to the UK Clinical Ethics Network and in 2011 there were 84. CECs in the UK today are comprised of a diverse membership.

Members are often a mix of professionals, ethics specialists, legal experts, patient and lay representatives. The particular membership of any group appears to be locally decided and dependent on the skills of those who volunteer. The UK Clinical Ethics Network (2012) describes the groups on their website as:

> "Multi-disciplinary groups, including health professionals and lay members that aim to provide support for decision-making on ethical issues arising from the provision of patient care within NHS Trusts and other health care institutions".

Activity varies between CEC groups; some groups appear more confident to offer advice on current cases than others. Many UK groups involve themselves in retrospective case review, as a learning exercise. Larcher (2007 p10) states that such retrospective review is aimed at skilling CEC group members for future cases. Development of guidance on ethical issues, and comment on guidelines for issues such as consent, capacity, and do not resuscitate orders, is work undertaken by CECs in the UK today (UKCEN 2012). The CEC also finds itself involved in education aimed at increasing awareness around medical ethics. The UK Clinical Ethics Network (2010) cites the following balance of activity for CECs:

> "54% frequently contribute to Trust policies and guidelines, 20% frequently interpret national guidelines, 37% frequently provide ethical education within the Trust, 66% frequently provide ethical support to clinicians".

Many in the UK believe the CEC is here to stay. Slowther and Hope (2000 p649-650) express the following view:

> "Clinical ethics committees at the level of NHS trusts, health authorities, and primary care groups are likely to play an important part. Professional bodies

will want such processes to be in place; the courts may consider them a

process; and clinical governance will need to include ethics within its remit".

CECs are not only found in UK healthcare practice, but also in European, North American and Asian healthcare. UK groups do share some similarities with these other groups, but also some important differences. The remit and the scope of CEC responsibilities differ depending on the healthcare system within which the committees work. The differences reflect the cultural attitudes toward ethical dilemmas. Carter (2002 p1) states that within different countries "perspectives on liberty, social justice and the value of life differ significantly" and the differing remit and function of CECs globally reflects this. For the purpose of this thesis recommendation about CEC group structure and function will draw upon experience from committees outside the UK where appropriate, but will focus recommendation primarily on the activity of the UK CECs.

The issue for CECs in the UK and abroad is a lack of agreement about their role, function and benefit. They are more than informal review groups, and not legal review agencies. They occupy a middle ground with potential to do good but also if used improperly to cause harm.

Intro.5 The case of Marion

In my time as a clinician I have experienced membership of an evolving hospital CEC and also experienced informal multidisciplinary case review. Both these forums were used to attempt to resolve difficult ethical issues in practice. Whilst participating in an informal case review process at the hospice where I now work I began to consider; firstly what was it in the processes that helped the team resolve issues and secondly how could the reflection be structured to make the informal

review process more helpful and efficient. If a reflective review process could be structured effectively to facilitate positive change then how could the UK CEC use such a structure to ensure they offer evaluable, effective clinician support as they reflect on ethical issues?

Below I will discuss a patient whose care raised a number of ethical issues, and whose behaviour led to an informal, reflective meeting of the hospice MDT. Her case was the first step in the journey which led to the development of the ASCS model which I propose in this thesis can support reflective practice in UK CECs. The name of the patient in the following case study has been changed to protect her confidentiality.

Marion was admitted to a large inner city hospice for support and pain relief. She had been treated in a major cancer centre where she had been diagnosed with an unstable spinal cord compression. She had been advised she could mobilise as she wanted to, but must at all times wear her hard cervical collar, as she was at risk of sudden permanent paralysis from compression of her cervical spine if she did not. She had been seen many times by the neurological physiotherapist at the cancer centre and had had been given written and verbal information about the potential consequences of not wearing her collar. The staff at the hospice, including myself, worked with Marion to improve her pain relief. Less pain, it was hoped, would mean she felt more confident to mobilise. Marion refused to wear her collar and continued to mobilise and increase her risk of paralysis. She had no impairment of the mind or brain and could understand, retain and believe the information that was given to her. She was able to communicate clearly her decision not to wear her neck collar as advised. Despite all efforts of the staff, Marion continued to make, what the staff considered, an unwise decision, and

some questioned whether all the information about risks had been explained to her, as they found it difficult to understand that she would take such a risky choice if they had. Marion clearly articulated that she was dying and in her last days needed to feel the freedom of time without the collar and needed important time with her partner without the collar on. This unwise decision troubled staff, and they were concerned all had been done to emphasise the risks to Marion. This concern led to negative feelings between the different staff groups. All groups blamed each other for not being able to get Marion to see the 'error of her ways'. The distress turned to anger between each other, as nursing staff felt it was the doctor's responsibility to assert the consequences, and the doctors felt the nurses had the relationship with Marion and should try harder to 'persuade' her. This was having an impact on the relationship of the team with Marion.

There was clearly a need to offer an opportunity for staff to take some time out to reflect upon the issues causing distress in this case, and to find a way of working together to address the situation. van der Dam et al (2012 p264) in their evaluation of care givers moral concerns in two elderly care organisations in the Netherlands identify concerns identified by their research respondents that mirror the hospice teams concerns with regard to Marion:

> *"In a substantial number of cases the source of the moral question lies in the expressed or presumed wish of the resident, manifesting itself in a demand or refusal. These cases reflect, on the one hand, the tension between the societal and institutional emphasis on respect for autonomy, and on the other, the daily practice where caregivers meet the limits of autonomy".*

Intro.6 The experience of an informal review of an ethical issue.

The hospice team was offered a reflective space, out of practice, to discuss and consider the competing obligations, with regard to Marion, which troubled them. The time out for reflection was supported by hospice management and was seen as a valuable way to ensure good team working practice. The subsequent dialogue about the situation allowed individual disciplines within the team to understand more fully the differing perspectives involved in the situation and to recognise that Marion had the autonomy to make her decision, albeit one that was considered by many health care professionals to be unwise. This opportunity for dialogue improved understanding between team members which improved working relationships, and diffused tensions, to enable the team to work effectively with Marion, whilst respecting her wishes.

A reflection on the process.

Reflecting upon the experience, I noted that the meeting was not formally structured, yet yielded a positive outcome for the team. An ad hoc informal review group had formed in response to the situation. I began to consider what it was about this opportunity that enabled the team to communicate about ethical issues and facilitated improved team working. I wondered what were the skills used within the process to stimulate and direct the dialogue. I wondered how this unstructured meeting could be improved upon for future cases.

 In the case of Marion, prior to the meeting, the team members had all questioned and debated each others roles in the situation, independently of each other, in the ward area informally. They also found an outlet for their tensions in practice, by blaming other team members who they identified to be "at fault" for Marion's

unwise behaviour. This had led to distrust and rumour and was undermining good team relationships. This unhelpful team behaviour continued until we were enabled to consider the situation together through the reflective review. It became clear from the informal reflection, carried out away from the ward area, that each profession had important insights to share with each other, and most importantly time was needed for the team to reflect upon Marion's wishes and the wishes of her husband. It became clear that the whole team shared the same goal, Marion's wellbeing. The lack of dialogue between team members, and lack of time for planning a shared approach toward such a difficult situation, prevented us dealing with the situation as effectively as we could have. We needed the opportunity to work together, reflecting on practice, to consider how Marion's wishes could best be respected, whilst considering our professional obligations to minimise harm.

 After reflection, the medical team was faced with the reality that the medical advice in this case, was not being followed by the patient, who had capacity to make the decision, and this was uncomfortable for them, but an appropriate decision for her. Questioning medical autocracy is an increasing feature of UK healthcare, as multi-professional teams no longer support isolated, paternalistic decision making, and patients question medical advice. Dörries (2003 p245) identifies that the growth in the interest in the ethical dimension of healthcare, and the movement away from paternalistic medicine, can sometimes challenge the usual communication structures within healthcare.

Support such as clinical ethics committees have developed to assist with the new communication challenges that arise out of a more democratic approach toward clinical decision making:

> *"This change which is in line with the general trend towards more democratic elements and societal pluralism, takes place slowly and often not without resistance…..Therefore, in the last decades new structures have been developed, such as clinical ethics committees….They challenge the usual way of clinical communication between the professions"* (Dörries 2003 p245).

Although not classed as a formal CEC the group review did enable the hospice team to set goals and plan a shared approach to a difficult ethical situation. The group recognised that although we had differing individual values and views there was a need to find a meaningful compromise to develop a shared goal as a team in order to effectively plan and support our patient. As Reiter-Theil (2000 p199) states it is important to recognise such increasing plurality of values and how these impact upon individualised decision making:

> *"One of the reasons for the increasing ethical awareness in the health sector is the plurality of values. Not only different religious values or contrasting political ideologies, but also a plethora of lifestyles and personal preferences, make it almost impossible to generalise from one individual's wishes to other patients about, for instance, how to handle the doctrine of truth-telling at the bedside, or how to live the last weeks and days at the end of life".*

Reflecting upon the situation, I compared the informal reflective practice setting I had experienced when discussing Marion, with the opportunities for reflection on ethical matters available within healthcare today. Having been a previous CEC member I was interested to find how CEC structures and processes had evolved since my experience as a member many years ago.

My journey was to begin. It was a journey which led me to explore CECs and their functions nationally and internationally, and then consider which appeared to be the most appropriate ways UK CECs can support clinical practice. This review resulted in my development of a CEC model for reflective practice, which I will present and discuss within this thesis.

Prior to making recommendations and describing the model I will analyse the current situation with regard to UK and international CECs. Understanding the history of CEC development is crucial to understanding why CECs in the UK find themselves in such an uncertain and poorly evaluated position.

Chapter 1:

1.1 Clinical Ethics Committees: The objections.

Concerns have been raised by clinicians, philosophers and the committees themselves who question the ability of the CEC to offer useful, guidance on ethical issues to highly pressured medical teams. White (2006 p352) states:

> *"Articles have appeared in peer reviewed literature that reflect what seems to be a tension between those in clinical medicine and formally trained philosophers concerning the ability of each group to provide meaningful guidance in instances of moral conflict and distress regarding patient care (Hoffmann et al, 2000). Clinicians decry the lack of insight by non-clinicians into the complexities of clinical medicine. Philosophers observe the lack of a formal basis for moral judgements".*

Singer et al (2001 p5) highlights a key danger of ethics committees in the USA as being "diffusion of responsibility within the ethics committee". One further critic is the bioethicist Leavitt, who argues that CECs should not be part of modern healthcare practice, stating:

> *"As a philosopher-bioethicist (not a doctor) in a medical school, I deplore efforts by my colleagues to encourage the existence of Clinical Ethics Committees……Instead I think our function should be educational, helping present and future doctors and nurses to think deeply, systematically and for themselves about life, death and their ethics" (Leavitt 2000 p1414).*

So why does Leavitt (2000) reach this conclusion? He cites four reasons to support his argument. The first is, that by having an ethics committee within a hospital culture, ward staff are able to "let others take responsibility for hard

decisions" (Leavitt 2000 p1414). The second reason is that the presence of a committee offers an excuse to clinicians not to engage with ethics literature and not to think deeply for themselves about ethical questions. Thirdly, he is concerned ethics committees may be used to serve the interests of hospital management, and he cites a theoretical example where they may be pushed into adopting liberal do not resuscitate policies which may serve the interests of management, with regard to resource allocation, but may not be in the best interests of patients. Lastly, he raises a concern that ethics committees may be predisposed to push for uniform policies and by doing so they may discourage creative case-by-case thinking, by clinical staff involved in the situation.

In his reflection on the development of American CECs Daar (2001 p4 in Benatar 2001) identifies similar concerns to those of Leavitt expressing a belief that CECs offer the potential for an abrogation of moral decision making by the referring physician, the usurping of moral decision making by ethics consultants, and a diffusion of responsibility within the ethics committee. He states "today it is still difficult to see how these three key dangers can be avoided" (Daar 2001 p4 in Benatar 2001).

These objections appear to rest on the premise that CECs have a model of practice that regards the clinicians who bring issues to them as passive recipients of a recommendation made by the CEC. The clinician is regarded as someone who could choose to abrogate responsibility for a difficult decision to the committee and who may be persuaded by a committee to accept a recommendation on action, even if the clinician did not agree or understand the reasons for the recommendation. Within this model the committee also appears to

be ascribed with a power to influence the clinician into a decision that they may not have taken themselves.

This formal consult and recommendation model is more favoured in healthcare institutions in the USA. In America such CECs are closely aligned to management structures in the organisation. Such recommendations are of concern as US CECs are not regulated and the quality of such legally binding recommendations cannot be assured. Hoffman et al (2008 p63) state:

> "The role and legal status of ethics committees in the United States remains amorphous. Committees, for the most part, remain unregulated and disagreements exist in the field as to whether regulation is appropriate. Despite the lack of homogeneity in committee function and operation and the inconsistent quality in committee performance, a number of state legislatures have given CECs legal authority to make health care decisions for patients lacking health care decision making capacity and/or available surrogates. While threats of malpractice may lead to improvements in ethics committee performance, in a number of jurisdictions ethics committees have been protected by statute from liability. In addition, suits have been rare and there are no published judicial opinions that have articulated standards for ethics committee process".

Motivation for growth of CECs in America was to serve the ends of the organisation, not primarily the patient by reducing the cost of expensive litigation and as a condition of accreditation. As Hoffman et al (2008 p47) state:

> "perhaps the greatest motivation for hospitals to establish ethics committees was the Joint Commission on the Accreditation of Health Care

Organizations' requirement in 1992 that, as a condition of accreditation, hospitals have in place a mechanism to resolve ethical dilemmas in patient care".

The initial development of CECs in America followed recommendations from the New Jersey court in the Karen Ann Quinlan case in 1976, the primary intention being to set up a body able to review clinical decision making. As Pentz (1998 p213-4) describes, the powers and remits of the members of CECs in some states of the USA are more far-reaching than in the UK at present. She discusses the composition of an American CEC, identifying its move from a full committee consultation model to a small team model. This small team comprises a nurse, a doctor and someone from the Professions Allied to Medicine or a lay representative. Each member of this small team takes 'ethics on call', making recommendations on current cases. These cases are then reported to, and evaluated by, the full committee if required. Pentz (1998 p213) describes an example case: "I received a call from a bone marrow transplant physician I knew well……..Would the clinical ethics team review the case of a 45 year old man with progressive low-grade lymphoma, whose medically indicated treatment was a stem cell transplant?". In response to the request the American approach was to consider appointing a member of the group as the patient's advocate, who would argue for the patient, and the committee then voted on whether to carry out the stem cell transplant or not.

Despite the tendency of ethics committees in the USA and Canada to have more far-reaching legal powers, and a different model of support, with greater emphasis on consultation and recommendation, there is still very little evidence to support their efficacy in this role. As Slowther comments "the evidence from the North

American experience of hospital ethics committees (HECs) suggests that they are popular with those who use them but that this group account for only a small percentage of all clinicians in the hospital, usually those who already have an increased awareness of ethical issues" (2002 p4). Slowther continues that, furthermore, "there is little published evidence of the effectiveness, in terms of changing behaviour, of HECs in North America" (p4). Nathoo (2012 p1), discussing the Canadian experience, reflects that the committees "have variously floundered and been rejuvenated over the years, and many have only recently (past 2-3 years) been established and are still finding their proper role and place within the ever changing world of healthcare". Despite this issue with their structure and positioning, the issues addressed by these Canadian CECs are shown to be remarkably similar to those discussed by UK CECs: "withdrawal of life-supporting therapy, patients and residents living at risk, demands for care that are deemed inappropriate by care providers (so-called futility), allocation of scarce health resources, and decision making for minors or non-competent patients" (Nathoo 2012 p1). In a survey of all Canadian hospitals with over 100 beds, the findings also reflect an increase in the number of Clinical Ethics Committees, but a different attitude toward the nature of their development. Gaudine et al (2010 p135) state that:

> "meetings of the CEC have become more regularised and formalised over time. The CECs continue to be predominately advisory in their nature, and by 2008 there was a shift in the priority of the activities of CEC, to meeting ethics education needs and providing counselling and support with less emphasis on advising about policy and procedures".

The Canadian reviewers call for more research into the outcomes of the groups' time-consuming deliberations, not just for the health professionals, but also for the patients and their families. Gaudine et al (2010 p132) make the following point about Canadian CECs that is reflective of the UK situation:

> "Although CECs have had time to become more established throughout Canada and mature in their organisational practices, much still remains to be learnt about Canadian CEC.......Furthermore, an understanding of the effectiveness of CEC remains to be determined.

1.2 The UK and European direction

In the UK and Europe an alternative, reflective approach, without recommendation, model has developed. As Lebeer (2004 p8) states, the European CEC is first and foremost a body for reflection. Reflection on practice allows the clinician to generate ideas about right action based in the experience. As Napier and Fook (2000 p7) state:

> "(A) reflective approach posits that contrary to traditional conceptions, 'theory' is implicit in the way people act, and may or may not be congruent with the more formalised theory that they believe themselves to be acting upon. In a reflective approach theory is induced from practice in more of a bottom up manner. The best way to access this theory is thus through processes of reflection on specific actions, and linking these with unacknowledged assumptions and features of the specific context".

In the UK Larcher et al (1999) identified the functions of the Great Ormond Street CEC as being a reflective and advisory body offering:

"Confidential, multidisciplinary analysis and discussion of cases and topics away from the acute clinical setting, informed contribution to the generation of guidelines for good ethical practice, education of health care professionals in health care ethics".

Although as Hurst et al (2007) state committees need to be culturally sensitive in their activities, as there do appear to be cultural differences in the local perception of ethical issues or the predominant types of ethical issues that emerge, there still needs to be greater agreement about what CECs offer and the skills required to undertake their task effectively. Holm (2010) describes a rise in the number of committees in Norway over the last decade, and comments that individual committee growth and development has occurred, in a way that reflects local interests, rather than following any guidelines that might ensure greater uniformity concerning composition and functioning.

Concerns have been raised by Dörries (2003) with regard to German CECs where development of such groups has been led to a greater extent, by multi-disciplinary team or lay members and because of this Dörries questions whether the CEC recommendation would ever be fully accepted by the medical teams they advise. Dörries (2003 p246) describes the obligation for German doctors to act according to their conscience and "rules of medical ethics and humanity". As many of the members of the CEC groups in Germany are non-medical, and may not even be trained, Dörries raises the professional issue of accepting directives from these lay groups. It could be argued to counter this concern, that diversity may improve the quality of the debate, by bringing in different perspectives and allowing non-medical issues, which may be the more pertinent issues for the patient and carers involved, to be raised.

van Der Dam et al (2011 p 328) state that there can be seen to be 3 different approaches to moral case deliberation (MCD); 1) MCD grounded in care ethics, 2) MCD grounded in principlism and 3) dialogical ethics. Even within Europe models of practice within the CECs vary considerably. Such different approaches to case review have led to confusion within and outside the groups and as Godkin et al (2005 p505) argue one of the fundamental issues that underpin the confusion and distrust of CECs is this lack of clarity about what, exactly, CECs are offering to the health teams. They state:

> "there is not a clear understanding of the nature and scope of clinical ethics services. Sulmasy [2001] defines clinical ethics as 'the systematic, critical, reasoned evaluation and justification of right and wrong, good and evil in clinical practice, and the study of the kinds of persons healthcare professionals ought or ought not to strive to become' .... this theoretical definition provides limited information as to how clinical ethics services are enacted".

As Gillon (2010 p 2946) states:

> "There is a tension between people who see clinical ethics committees as exercising ethical and legal expertise and those who see them more as thoughtful friends facilitating ethical reflection from a variety of backgrounds".

There are other issues that also have the potential to undermine the efficiency and influence of the UK CEC. Slowther (2008) identifies the CECs potential for isolation which could result in a lack of coordination within and between groups. This could leave CECs without a structure, either internally or externally, to enable

them to "share experience, learn from others more expert in the field and contribute to the development of research that will then inform future practice" (Slowther 2008 p40). In response to this concern the Ethox team established the UK Clinical Ethics Network. The network offers support both in terms of education, and an on line information service to keep UK clinical ethics committees talking to and learning from each other.

Another concern about CECs has been raised by Sokol (2005 p741) who identifies that committees are too inflexible to respond to current case situations and clinicians may be reluctant to raise issues for fear of reprisals. He states:

> "About a fifth of NHS acute trusts currently have a clinical ethics committee. These provide a valuable service in drafting hospital policies and helping doctors resolve ethical dilemmas. However, most clinical ethics committees are ill suited to respond to the immediate problems that doctors encounter in their daily work. Committees are not as flexible and approachable as individuals. Many doctors are unlikely to present their ethical concerns to a committee for fear of appearing foolish or ignorant. As junior doctors are notoriously loath to flag their ignorance, summoning the hospital's clinical ethics committee to evaluate a situation runs counter to the prevalent ethos".

This is concerning, as it could be implied by the Sokol (2005) comment that the CEC may be perceived as a group of evaluators, judging the ethical skills of the junior doctors which may diminish their confidence, rather than an independent support group offering an opportunity for reflection and support, to enable the doctor to make the right judgement, and justify the reasoning behind this choice.

1.3 Limitations of using a principlist approach to review cases within a CEC.

Those in support of the benefits of objective external review promote the benefits of exploring an ethical issue or case with an 'objective' eye. Sometimes emotions and relationships within the clinical area will influence judgements, and for those who believe there is an objective truth to be found in ethical situations, the objective and analytical review may be considered a way of gaining clarity about the most appropriate action, especially where emotions, or other subjective influences, appear to be preventing a decision being agreed. The notion of objective review is grounded in the principlist philosophy. The principlist approach accepts this notion of the universalisability of moral norms. Danner-Clouser et al (1990) define principlism as a term used to refer to the practice of using principles to replace both moral theory, and particular moral rules and ideals, when dealing with moral problems in medicine. It is promoted on the UK Clinical Ethics Network website as one of a number of possible methods to be used by CECs when debating ethical issues. Through rational 'objective' deliberation using the principlist approach, the case review process within the CEC, it could be argued, would benefit the practitioner by considering the clinical case 'away from the heat of battle'. The CEC can then recommend suggestions for appropriate action after having weighed up the clinician's obligations against the four principles of respect for autonomy, beneficence, non-maleficence and justice, as advocated by Beauchamp and Childress (2001).

Principlism is a widely favoured approach to moral decision making in medical ethics. As Walker (2008 p229) states:

> *"Principlism aims to provide a framework to help those working in medicine*
>
> *both to identify moral problems and to make decisions about what to do.*

For it to meet this aim, the principles included within it must express values

that all morally serious people share (or ought to share), and there must be

no other values that all morally serious people share (or ought to

share)………Principlism has proved a popular framework for thinking about

medical ethics, and often forms part of the education for those coming into

medicine. It is not intended to be a general moral theory, but rather aims to

provide a framework to help those working in medicine both to identify

moral problems and to make decisions about what to do".

Muirhead (2012 p195) reflects that "the principlist account, first proposed by

Beauchamp and Childress, presently dominates medical ethical theory". To accept

that this framework is an appropriate starting point for CEC deliberations relies on

the acceptance that there can be generality in applied moral reasoning.

Deontological philosophy adheres to the belief that there are universal rules

governing behaviour that need to be adhered to. Therefore if it is wrong to kill, it is

always wrong to kill, whatever the circumstances.

"Question: Why should I not make a false promise to get what I want from

you? Answer. Because I cannot will that it be a law of nature that everyone

who wants something from someone else lies" (Crisp and Slote 1997 p1).

Boyd (2005 p482) reflects upon how healthcare has embraced the four principles

approach:

"We must also be grateful to the philosophers for one particular

deontological approach, which countless health care professionals and

students today have grabbed as an ethical lifebelt-the Four Principles of

Bioethics.....One problem with this framework, however, is that the four

principles as advertised, are each prima facie".

Unfortunately principlism as a formula to structure CEC reviews can be criticised.

Intuitions and actions have found themselves generalised into rules, or common sense notions (principles) of what is right, such as rules on euthanasia, theft and abuse. Sometimes, though, intuitions lead us to feel uncomfortable with rules. This discomfort leads us to want to reflect and consider why. It may be that the rule or principle in question is inappropriate in the particular situation, or that it requires amending as a rule per se.

Whilst acknowledging the importance of principles, arising out of our moral intuitions, the prima facie nature of principles may make them not sufficiently action guiding in complex clinical situations. Once principles begin to compete with each other the clinician still is left to make a moral judgement between them. Even for the CECs who may favour objective review and recommendation, there is the need for the clinician to decide whether the argument proposed, after analysing it against the principles, is one he believes in and agrees with. It would be difficult to comprehend that a CEC would ever wish a clinician to accept their advice and instigate an action he did not judge to be appropriate in the circumstance.

Principlism has been criticised for being too simplistic a formula to apply to the difficult area of healthcare ethics, and for failing to stimulate reflection at a deeper level. Most importantly, concern has been raised about the lack of attention to the moral significance of context within the theory. Dabbagh (2008 p31) states "One way of criticising and showing the inadequacy of this approach is undermining the whole idea of generality in moral reasoning". A morally relevant feature can differ,

depending on the moral context. Therefore, a rule about right action cannot be made generalisable, as it needs to be contextualised. The clinician needs to exert judgement when considering these principles and their prima facie duties.

Considering the issue against more than principles

Those who promote the evaluation of the rightness of an action against rules, duties or principles argue that these are necessary in order to judge whether an act is right or wrong. But, due to the fact that there are competing principles, the clinician needs to develop the ability to consider the situation independently of them also. This will allow the clinician to ascertain which of the competing principles may be right, or wrong, in the circumstances. Clinicians need to develop moral awareness and virtues in order to make appropriate judgements about many influencing factors, including relevant principles. This is not to say that the principles should not be considered, just as the CEC can consider previous cases, guidelines or intuition within their review processes. However, judgement of the act in relation to the principles should only form part of a holistic evaluation of the situation, which encompasses other features such as context, ethnic influences, gender and societal issues. As Muirhead (2012 p196) states "A key philosophical objection to principlism is that it is insufficiently action guiding: even when the facts about a situation are known, the principles alone still cannot identify the right ethical course". Walker (2009 p231) also reflects this view stating "If we take principlism to be an attempt to capture the moral norms that are universalisable, and furthermore to claim that all moral norms are universalisable, then principlists owe us an explanation of why morality is so narrowly constrained". He goes on to argue that the principlists have not supplied such an argument.

Waide (1988 p466) further identifies the limitations of principlism stating:

> "Our attempts to formulate and defend moral principles turn out to be
> attempts to codify judgments which are not based on principles rather like
> writing a set of rules for evaluating drama. Certain principles seem more
> intuitive, more plausible, than others but no principle or conjunction of
> principles seems adequate to capture the essence of morality."

Gillon (2012 p198) responds to the claim by Muirhead (2012) that the four principles are unreflective of how medical decisions are made. He remains supportive of the use of the four principles in medical ethics, but agrees they must be embedded within a wider contextual framework. I would argue that the principles need to be considered within the holistic framework of particularism. Being part of this review of the whole picture, the principles can illuminate, but not dictate, which action is ultimately considered to be appropriate.

It may be that a clash of competing principles has caused the issue to be brought to the CEC in the first place. The benefit that can be gained for the clinician by using the CEC is the opportunity to explore and refine skills of appraisal and judgement in the situation. A CEC which restricts its self to analysis against principles offers a partial service to the issue bringer. Gillon (2012 p198) supports the need for clinicians to have skills to enable them to make judgements about complex medical cases stating:

> "Of course clinicians may not wish, or have time to pursue such analysis
> [the four principles] on particular occasions, which is why it is important for
> them to have ingrained tendencies to follow GMC guidelines, rules and UK

law 'with integrity'...so they should be able to understand and justify the

rationale for any particular ethical stance".

If the CEC members set themselves the task of objectively reviewing the evidence available, so as to establish a consensus recommendation, then they would be acting as a group exploring the issues in the abstract, establishing reasons and justifications for action out of the context. Hare (1978) talks of abstract ethical discussions as being akin to archangels, commenting that the archangel critical thinker does not need intuitive thinking, everything is done by reason in a moment of time (Hare 1978).

This is clearly not the way forward for the CEC in UK professional clinical practice. There is a need for the CEC to be embedded within the culture of the organisation, and to understand the patients' and clinicians needs. Context and non moral features need to be considered as important influences on the appropriateness of a decision.

If the CEC takes on the persona of an archangel, i.e. a body with super-human powers or an ability to present abstract thinking or tackle a problem in an abstract way, somehow able to reach a conclusion beyond that achievable by the practitioner, where will this lead? It may lead to clinicians feeling that their own ethical positions, complex, and influenced by intuition, context, bias and perception are akin to the behaviour of a "prole" (Hare 1978). The clinicians may consider themselves a somehow less morally worthy individual than the "archangel". This position could undermine the clinician's moral confidence. Therefore this model works against the aims of the CEC to improve skills and confidence, at times of decision making difficulties, for health care workers.

Consequentialism, another act or rule-based theory, remains influential and well supported as a framework for considering ethical issues in healthcare. Initially, the theory considered the notion of responsibility but now (as happens in the deontological approaches) considers the distinction between right and wrong. Supporters of consequentialist approaches to ethics believe that the agent is equally responsible for intended and unintended consequences, and also that the act is right if its overall outcome is the best possible. The measure of this outcome differs according to different schools of consequentialist theory, but measures such as 'pleasure' and 'happiness' have been used. Crisp and Slote (2003 p1) state that a consequentialist would ask:

"Why should I not aim solely at my own wellbeing? Because there is no difference between a 'unit' of my own pleasure and that of someone else's".

Morality is again seen as impartial, this time obliging us to produce as much overall wellbeing as possible. Some consequentialist approaches do not deny the importance of intuition, context, or the potential inherent value of an action, but as with deontological theories there is an emphasis on an 'objective review' of the situation. Consequentialist theorists argue that the practitioner can find the right action in a situation, by considering the following options: action A can be seen to be superior to action B, if this can be seen to result in more happiness or other type of good. But, goodness and happiness are difficult concepts to measure or define, even for philosophical theorists how could the inexperienced members of the CEC make this evaluation? Therefore, rule or principle based approaches do not offer CECs a framework which can answer the criticism that CECs encourage abrogation of responsibility or perpetuate the inference that there can be a group of people able to make a 'better' decision than the clinician themselves, which is

de skilling. The reasons for why CECs are unable to make a more reliably robust decision than the clinician will be discussed throughout the rest of the thesis.

1.4 Specific concerns surrounding CEC recommendation on clinical case.

At present, many CECs in the UK are criticised as many encourage current case dilemmas to be brought to the CEC despite the lack of robust processes to monitor case review activity and quality of subsequent recommendations. Slowther (2012) identifies that referrals to UK CECs for case review are increasing. Unfortunately, precise details about the nature of case reviews, reason for referral, and systems used for case analysis, have not been fully evaluated (Slowther 2013, Williamson 2007, 2008). Serious consideration needs to be given to the framework used for questioning by CECs as ad hoc activity between groups does not offer clarity to the clinician about what they should expect and could deter use of the service. If aim and quality of deliberation is not clear, it is very difficult to measure whether the group has provided a quality and efficient service. Above all the CEC does not exist to cause harm, yet at present, CECs cannot guarantee the quality of their review processes and can make no guarantee to the clinician, to this effect.

Other available case review processes in the UK.

There are a number of other frameworks identified for CECs to utilise when reviewing a case, either current or post-hoc. The UK Clinical Ethics Network (UKCEN 2012) cites four influential frameworks that a CEC may use as a basis for structuring their case discussion. These frameworks are the Ethox Approach Framework (UKCEN 2012), the CARE Framework (Schneider and Schnell 2000), the Four Principles Approach (Beauchamp and Childress 2001) and the Four Quadrant Approach (Jonsen, Siegler and Winslade 1981). All the models have differing philosophies underpinning their approach to case review. The four

quadrant approach highlights the importance of considering morally relevant contextual features within the review. The CARE approach asks the clinician or group to explore decisions in similar cases (casuistry). The Ethox flowchart for deliberations clearly describes the making of a recommendation on an action, if appropriate. Although available to CECs, use of a framework is not obligatory for any UK CEC.

Present models can be criticised. At present the clinician is not always obliged to be present during the review process and is not always encouraged within the models available. The patient and their family are even less well represented. Slowther (2013) identified that in a 2010 UK survey of CECs, only 49% of committees accepted referrals from patients or their families. Only 24% included patients and their families in acute case consultation group discussions and 33% reported individual meetings with patient/family for an acute case consultation. These figures reflect that there is work to be done to ensure all UK CECs are confident to invite input from all important team members involved in the situation if required, namely the clinicians and the patient and their family and this will be discussed more fully in chapter 6. The need for the clinician and or patient (if appropriate) to be involved in the discussion is pivotal to the model I have devised that will be discussed later in the thesis.

In European CECs there is also a reluctance to involve the patient. Weidema et al (2011 p221) state that their evaluation into moral case deliberation (MCD) highlighted a reluctance to involve the patient, which may be due to fear, saying:

> "Client participation in MCD is precarious, since it involves reluctance,
> vulnerability and even fear. Yet, this empirical finding is not in itself a
> contra-indication for the normative ideal of client participation in MCD.

Feelings of fear and vulnerability may decrease over time. This indicates

that a pragmatist approach is desirable: If we do not just do it, it will never

be realized."

They continue that reflection upon the experience may increase confidence for

further involvement in the future. I believe this premise holds true for clinician

involvement in the CEC review process also.

The need for the clinician/patient involvement in CEC review

It is my belief that, to increase the chances of the CEC being able to develop the

moral judgement skills of the clinician, the reflection should be undertaken with the

clinician present throughout the review. This clinician focused discussion can

facilitate a greater understanding by the clinician of the issues involved.

Some European CECs are taking a lead in embracing reflective practice within the

CEC. Lebeer (2004 p9) reflects on the Norwegian model for review which has

always favoured a reflective approach and states "the designers of the Norwegian

project considered it crucial to recognise a 'non-expert grounding' for ethics: The

ethical review is based on a non-expert foundation in regard to experience and

virtue". This notion of non-expert is crucial in establishing the CEC as a structured

reflection group, with the aim of facilitating the moral development of the

practitioner.

The CEC, by rejecting the notion of 'authority' or 'recommendation' can

concentrate on offering an opportunity to open up the dialogue with the clinician

during the CEC discussion process about the ethical issue. The CEC and the

clinician can also agree shared and realistic goals and outcome and can ensure all

involved understand the benefits and limitations of the processes used to facilitate

reflection once identified. The clinician and or patient can bring the important current contextual perspective to the debate.

Craft (1995 p1457), reflecting on his experience of working alongside ethics committees, raises concerns about the fact that ethics committees often have no personal knowledge of the individuals requesting treatment, and dismiss the significance of the professionals' opinions. He reflects that this could be because the CEC members feel that the clinicians are "too emotionally involved" (Craft 1995 p1457). It could be argued that being emotionally involved is needed, to ensure decisions are made with empathy and with regard for the patient's subjective experience of the situation. This knowledge will often be pivotal to decisions on a course of action. In healthcare it is the first question that clinicians are obliged to ask. 'What is the patient experiencing and what does/would the patient want?' Craft (1995 p1458) asks the pertinent question "Do we really need ethics committees to decide?"

As previously discussed there is a counter argument which asserts that having a non emotional and more objective opinion on the issues being discussed can be useful to bring 'fresh eyes' to the debate. Being too emotionally involved, it could be argued, may lead to a greater difficulty in making an unwanted or unpleasant decision as emotions may prevent clinicians feeling able to carry out actions that may be appropriate but may be against the wishes of the patient and may cause distress. Acknowledging the importance of taking account of emotion and also the value of taking a more dispassionate view may mean that both perspectives are regarded for their importance in the CEC review process, and support can be offered for the difficult and emotionally distressing choices. Taking into account the value of both subjectivity and objectivity allows for a more rounded view of the

situation, from which a more informed decision can subsequently be made. This fusion of subjective and more distant perspectives can be harnessed to test, question, challenge and support the clinician as they consider potential compromise solutions to the dilemma they face.

1.5 Concerns about recommendation on case review raised by Clinical Ethics Committees themselves.

There is some evidence that CEC groups have perceived discomfort themselves in their involvement in recommending on current clinical cases. This discomfort often surrounds the considered need to recommend an action with partial information and poorly evaluated systems of review. Szeremeta et al (2001) explore the experiences of five UK CECs, with regard to their case reviews. Common themes emerge from the committees with regard to their activities. The themes include, concern over involvement in case consultations, and a lack of formal training for some of the groups.

Wright (2001 pi15, cited in Szeremeta, 2001) discusses the experience of a CEC in a large hospital, when discussing a case of whether it was ethically right to test a high-risk patient for HIV without their consent, and notes that "the complexity and unusual nature of the case had been a serious challenge" (Wright 2001 pi15, cited in Szeremeta 2001). Other important concerns raised were, issues around conflicts of interests among the members of the group, and the fact that the health worker bringing the case had expected an "executive decision" (Wright 2001 pi15, cited in Szeremeta 2001) to be made. Worryingly, Wright comments that "the two meetings [held by the CEC about the case discussed] had come to different conclusions based on two different approaches to the problem (utilitarian and deontological)" (Wright 2010 pi15, cited in Szeremeta 2010 pi9-i17).

In Szeremeta's (2001) review, many of the groups felt happier reviewing guidelines than current cases, but one of the groups made an interesting point that, in their opinion, the most valuable role of the ethics committee could be to emphasise the difficulties inherent in clinical ethical dilemmas, and not just to provide answers. The CEC — although not fully representative of all individuals involved in each case — can represent a diversity of views within the clinical arena, and can develop an empathy and understanding of the difficulties experienced by the clinical teams when trying to balance options whilst taking different perspectives into consideration, by working with the teams and assisting them with their goals rather than seeking to make a recommendation.

The importance of a CEC to act as a supportive role model, to assist the clinician to develop his confidence with regard to moral judgement, cannot be overestimated. This would be a more effective way of supporting clinical teams, than trying to gain acceptance for a recommendation, when the clinician may not understand or agree with the justification for the suggested action.

Tweeddale (2001) cites the risks inherent in imposing a guidance document on the clinician, without their understanding of the documents rationale. He states: "how could we, or should we get acceptance of our document? Excellent though it was, it was based on ethical principles with which most members of our medical staff were unfamiliar. How could it be understood, let alone acted upon, when its premises and foundations were unfamiliar to those to whom it was directed?" (Tweeddale 2001 pi41). Although in the above case Tweeddale is discussing a document, the same issue applies to the CEC recommending an action, where the rationale for such a recommendation is not clear or is felt by the clinician to be inappropriate in the circumstance. In the worst case scenario, the objection raised

by Leavitt (2000) about acceptance of an action that is in the best interests of the organisation, but not of the patient, could be possible under these conditions. If a CEC group coerced or persuaded the clinician that the recommended action was right, without his having thought through the issue for himself, the clinician may accept their judgement, considering the group to be 'experts' in this field, and carry out an action not in the best interests of his patient. Recommending an ultimate action opens the CEC groups up to the criticism that the clinician is being encouraged to abrogate responsibility for the action and to not think deeply about the issues he faces. This situation should surely be one that is consistently avoided and guarded against by the membership of any UK CEC. The CEC can be of some use without a recommendation model therefore such a model should not be pursued.

1.6 The need for a UK model of practice for case review.

UK CECS should not seek to replicate the American model as using a principlist approach to seek recommendation out of context has the potential to cause harm as previously discussed. Therefore UK CECs need to find a model of practice that fits with our own unique healthcare system and answers the criticisms about abrogation of responsibility to the CEC and not the fact that recommendation does not support moral development of the clinician in practice.

If the CEC in the UK focuses on being a peer support group for ethical review, respecting their important function as a reflective practice forum to maintain dialogue with organisational management and the clinician the CEC is in the best position to offer meaningful support.

CECs in the UK can work best as reflective bodies by basing their reviews within the moderate Particularist philosophy and utilising the benefits of casuistry. Particularist approaches offer the CEC a framework to support the clinician in their exploration of the detail of the situation. Through this exploration issues can be clarified. The clinician can then set goals to tackle the issues and can explore possible solutions to the problem in order to choose the most appropriate in the context. Kaebenick (2000 p310) notes the benefit of approaching an ethical issue in this way saying:

> "Dancy (1993)......argues that deliberation over a moral case is analogous to grasping 'the shape of the circumstances' and Nussbaum (1986 p305) holds that '[p]ractical insight is like perceiving, in the sense that it is non-inferential, non-deductive; it is, centrally, the ability to recognize, acknowledge, respond to, pick out certain salient features of this complex situation".

Review of the situation and exploration around possible solutions to the dilemma through dialogue can increase practitioners' awareness of possible options and the skills they already have to tackle the issue that is causing disquiet. The clinician can explore motivations, moral and non moral influences on the situation, precedent cases and the use of the virtues he possesses. The clinician can consider the virtues required such as courage, honesty, truthfulness and kindness and can consider how the skills he has in these areas can be used to assist him with the case in hand. Recognition of the use of such skills builds confidence for the future that he has the ability to tackle situation and has done so in previous situations. The situation may be new but the skills needed to address the challenges are not. Repeated review of ethical issues in this way by the clinician

can help develop habits within the worker that assist him to approach problems in the future in a manner that takes into account differing perspectives involved. The analysis of the case, using this approach, will be rooted in the situation not in the abstract. The complexity and the influence of the environment on the situation are recognised.

In the UK many committees have already identified the importance of their supportive role. Larcher et al (2008) responded to an article criticising anonymous decision making by committee rather than by clinicians and patients as follows:

> *"As members of the clinical ethics service at Great Ormond Street Hospital for Children, we must challenge the picture painted in the article 'Doing the right thing' (24 April). You imply that complex ethical decisions are increasingly taken by 'anonymous committees' rather than clinicians and parents. Clinical ethics committees provide advice, support and consultation, but our role is clearly defined as advisory. To remove the power to make decisions from the clinical team helping a child and their family would be wrong."*

This thesis will discuss over the next chapters the evidence to support that CECs in the UK have a useful role to support clinicians and the organisation. It will then develop the argument to explore why CECs need to be clear about the scope of their influence to enable the clinician and organisation to view the CEC in the most appropriate manner. The next chapter will explore why the appropriate role for the CEC should be as a non expert facilitator to support dialogue about ethical issues. Skills to facilitate dialogue about ethics and to assist with clarification and solution focused resolution will assist teams to manage value conflict. The thesis will

further discuss that value, role and processes conflict are often reasons for a CEC referral.

After discussing these major points the thesis will present a model I have developed which answers the criticisms already levelled at CECs about undermining of clinician autonomy and not stimulating or supporting moral growth.

This model is titled the Ask, Seek, Clarify Solutions model of CEC case review. This is a clinician centred model which keeps the clinician, patient and their family at the heart of the dialogue. Using a particularist philosophy the CEC asks the clinician to tell their story and perception of events. Once differing perspectives have been sought in the seek part of the model the clinician is facilitated, by the use of solution focused questioning, to consider changes that can improve the situation and may lead to solutions and resolution of the dilemma. This does not require any particular ethical stance to be used. The problem talk is kept to a minimum and compromise solutions are actively sought. The CEC, if required, can assist the clinician's considerations by providing information with regard to precedent cases, or what other reasonable clinicians may have done in similar circumstances, using casuistry in the clarification quadrant of the model. The clinician having considered possible solutions will then be enabled to try some of the changes in practice discussed, knowing that the group is available for support. The support is not offered in a directive manner but in a supportive manner to assist the clinician to plan solutions to tackle the problem. As all the four stages of the model are distinct the skills used by the CEC to provide support is evaluable. Such evidence and can be used to support claims by CECs that they are a useful form of ethical support to the clinical team and can assist with identification of

areas for development. Chapter 5 and 6 will discuss the model in great detail and will offer a case example of the use of the model in practice.

In the next chapter I will discuss the perceptions and evidence available to support the argument that CECs are beneficial for the organisation and the clinical team. The influential position of the CEC within the healthcare culture obliges the CEC to use a clear and evaluable model such as the ASCS model to ensure that it can evidence it is offering the most effective service in the most appropriate way.

By choosing a model for reflection that is simple, evaluable and clear the CEC can evidence benefit. The greater the evidence available to support the argument that CECs support the moral development of the practitioner rather than diminish it the greater chance clinicians and organisations will feel confident to use such an important service. Greater integration into the healthcare culture can enable the CEC to become firmly embedded as a useful service to assist in case and ethical issue debate, guideline review and formation, education and influencing a culture of dignity, respect and openness.

Chapter 2 _The Benefits of the existence of Clinical Ethics Committees within a healthcare organisation._

This chapter will discuss the benefit that can be offered to the healthcare organisation by the existence of the CEC within it. By existing within the organisation CECs can positively influence its culture, education and patient care. Therefore there is value to be gained by working with and investing in the CEC to be the best ethics support group that it can be to ensure that this influence is maximised and is a positive one.

2.1 A forum for discussing a range of clinical ethical issues and working with management not for management.

One important role for the CEC in the UK is to be a group engaged in dialogue with organisational management and clinical staff about ethical issues. This dialogue should be undertaken with the support of management but CECs should not be an agent of management. Support by management offers some credibility to the CEC and allocation of time, profile and money by the organisation offers important support for the work of the CEC. Links with management are therefore important for continued development of the groups in the UK. As Dörries (2011 p196) states "a committee, that is not clearly part of the organizational structure of the hospital in which it sits risks being ignored".

This does not mean that the CEC should be complicit with "alibi ethics" (Dörries 2011 p 197). CECs can have a role in promoting the development of an ethical organisation rather than being used by the organisation as a token gesture to tick the right boxes that they "do" ethics to be able to satisfy certain targets without

believing in the value of stimulating the growth of an organisation whose heart-beat is person centred, patient focused, high quality care. Such an organisation is one that pays attention to both individual clinical ethics and organisational ethics. High profile reports such as the Francis Report (2013) have demonstrated what can happen when the ethics of a healthcare organisation are poor.

Beyleveld (2002) cites the following holistic, patient-focused desires which are identified by CECs: to promote respect for the patients' interests, to raise the level of ethical awareness, to form a consensus and attempt to resolve conflicts of thinking through review and support, to raise confidence, resolve conflict and encourage participation on ethical issues, and to demonstrate ethical procedure. CECs in the UK should never be viewed as a vehicle primarily to reduce litigation, although an ethical organisation may well have fewer complaints due to improved communication and person centred care. CECs should not collude with organisational 'image management' without culturally demonstrating commitment to the core values as defined above.

As an ethical extension to the multi-disciplinary team, the group can play their unique part in ensuring high-quality patient care whilst helping the clinician consider safe practice and develop skills of discernment and judgement. The role of the CEC should not be considered as regulatory or supervisory, but should be aimed at achieving patient and clinician-focused goals to achieve high quality care and support. Health trusts need to demonstrate real commitment to the process and not merely pay lip service by investing scant resources into CECs.

As Beyleveld (2002 p22) states:

> "With the current crisis in medical authority deepening by the week (as one admission of failure to obtain consent follows another), it is clear that a

cosmetic response will not suffice. Hence it would be a serious mistake to

establish CECs with a view only to being seen to be done (regardless of

whether ethics actually are done)."

CECs should never be perceived as regulatory, management or punitive bodies.

There appears to be a warning here that if CECs are to retain their focus and

impetus and offer patient and clinician support they must be clear about their role,

function, and affiliation. The extent, to which a CECs decision making is

independent of the actual health care institution, in a formal and informal sense, is

an important issue. As Beyleveld (2002 p18) states:

"If CECs are to become the rule rather than the exception in the U.K., and

particularly if NHS trusts are required to have CECs, then it is important to be

aware of the range of missions that CECs might have. It is one thing for

CECs to be established as a result of the concerns of healthcare workers,

quite another for CECs to be management led. It is one thing to want ethics

to be taken more seriously in clinical practice, quite another to want to restore

public confidence in the integrity of the health service. It is one thing to want

to support clinicians, quite another to want to manage a crisis."

In research carried out by Dauwerse et al (2011) board members of Dutch health

care institutions, ethics support staff, and advocates of Clinical ethics support were

surveyed as to the perceived benefits of having clinical ethics support. Dauwerse

et al (2011 p6) state that the research respondents considered that clinical ethics

support has an important role to play in encouraging a climate which encouraged

reflection on ethical issues. This climate could be fostered by, encouraging the

organisation to pay attention to ethical issues, supporting employees to deal with

moral questions daily, and by facilitating processes by which deliberation on ethical issues could happen as part of daily practice.

The CEC is able to represent the ethical concerns of the practitioners to the managers if required to do so. CECs can facilitate good communication between clinicians and management. Clinicians are influenced by the organisation, and the organisation influenced by clinicians, therefore each group within healthcare has a requirement to understand the needs of others. For example, a greater understanding by clinicians of the organisational resource allocation decisions that need to be made will improve clarity about why such decisions, such as staffing cuts, and alterations to services, need to be undertaken. This awareness does not oblige agreement with the changes. An appreciation of the reasons for decisions, enables those involved to understand goals, facilitates adjustment and adaptation to the changing environment, and offers the clinician an opportunity to raise concerns.

Ethical decision making is a social and collective endeavour and is influenced by the whole organisation as McKie (2004 p116) reflects:

> "*according to Fealy [1995], ……caring is not simply a series of actions but rather a way of acting which is both contextually dependent and value bound'. This social perspective asks us to examine the aspects of ethics which we share together in practice. In addition, we need to consider the impact upon such ethics of the environments and contexts in which we work*".

Many complaints within the health service surround communication breakdowns. CECs can role model and promote effective multi-disciplinary communication.

Good communication yields positive outcomes for the organisation by offering the opportunity for inclusion of a range of insights into boardroom debate which can be considered; such insights will inform and increase the chances that the decisions made are the most the most appropriate in the context. The UK Clinical Ethics Network (2012) identifies the following organisational and individual discussions CEC members have identified they been involved in; Consent, end of life decisions, confidentiality, DNAR orders, advance directives, refusal of treatment, resource allocation, restraint of patients, genetic testing and capacity issues.

The CEC is well positioned to influence, in a meaningful way, the ethical development of the organisation, not just the practitioners within it. In the study by Dauwerse et al (2011 p7) the respondents identified that the clinical ethics support available, which includes CECs, could be used to encourage the fostering of an accountable and transparent organisation stating, "CES [clinical ethics support] can help health care institutions to be an accountable organization by developing and implementing an institutional policy (including core values of the organization). Respondents mention the following sub-goals: (1) Careful decision making; (2) advice about ethical issues and (3) developing policy".

The CEC is also well positioned to offer advice on organisational ethical issues, not just individual cases, and this is a developing area of activity for the CECs in the UK and beyond, and, as with individual case review the benefit of such involvement needs to be evaluated. Silva et al (2008 p320) state that "the role of clinical ethicists in, and perspectives on, organisational ethics has not been well described in the literature". The study by Silva et al (2008) in Canada found the most pressing organisational issues identified by ethicists are "resource allocation, staff moral distress linked to the organisation's moral climate, conflicts of interest,

and clinical issues with an organisational dimension" (Silva et al 2008 p320). The clinical issues identified included budgeting, staff morale in relation to cuts, funding for medication. Encouraging reflective practice around such issues, respecting diversity is a role CECs can champion whether the issues discussed are individual or organisational. The skills I will discuss in relation to the ASCS model are transferrable to all forums discussing ethical issues, as they are skills to enable the CEC and others to hear perspectives and handle value conflict.

Support in times of value conflict is seen by Dubler and Liebman (2004) as a key role for CECs and will be discussed more fully in chapter 4. Effective communication with management, staff and patients is vital to allow this conflict resolution to happen. The ASCS model for CEC reflection that I will propose in chapter 5, using solution focused techniques discussed in chapter 6, offers a framework for managing such value conflicts.

The role of the CEC as part of quality assurance

Another important organisational role for the CEC is in the domain of quality assurance. As McClimans (2012 p141) states "there is emerging agreement that UK CECs have the potential to play an important role in helping Trusts meet regulatory standards" (McClimans 2012 p141). This role is particularly apparent in relation to CEC activity to support the organisation and clinician as they strive to achieve standards set by bodies such as the Care Quality Commission (CQC). Although not directly referring to 'ethics', the standards set by the CQC in the guidance about the compliance document *Essential Standards of Quality and Safety (2010)* asks for assurance about quality in areas which UK clinical ethicists and CECs are actively involved. For example Regulation 17 states:

> *"providers must ensure that service users are allowed to express their views about what is important to them, and that they understand their care or treatment choices as well as their risks and benefits".*

This statement highlights issues pertinent to the dimensions of informed consent, disclosure, understanding and voluntariness. In the Slowther (2012) survey of CEC chairs, there is evidence of activity within the groups that overlaps with areas of interest for the CQC such as, confidentiality and consent and capacity. A consultation document produced by the UK Care Quality Commission (CQC 2009) on their strategy for 2010-2015 reiterates that their work will be "underpinned by the principles of equalities and human rights. This will include a strong focus on the differences in access to services, the safety and effectiveness of care and peoples' rights to be treated with dignity and respect" (CQC 2009). This document, Dörries et al (2011 p200) state, offers an opportunity for CECs to become more firmly embedded within the quality management processes within an organisation. They reflect:

> *"The principles articulated in this statement are fundamentally value laden and therefore, putting them into practice will require significant ethical reflection. CECs can contribute to the development of quality management by facilitation of considered reflection on the values underpinning quality improvement within the institution".*

Ethical governance is vital to healthcare organisations and CECs can demonstrate leadership in this respect by attending to the issue of quality of deliberation within the CECs themselves an issue that has so far been poorly addressed. Through demonstration of firm philosophical foundations, clear terms of reference, and use of effective models for review, CECs can and need to integrate ethical governance

more firmly within their systems of practice. In turn, the evidence gathered about the ethics of the ethics committee can support the calls for further development and investment into CECs, as they will be able to more robustly argue the value of their existence. Governance of, and evaluation of, CECs are areas that need to be addressed as a matter of urgency. Williamson (2007 p6) reflects that the "failure to regard clinical ethics services as potentially important tools within the pursuit of clinical excellence will have a detrimental impact on the development of quality ethics services. This is because the services are unlikely to be standardised or assessed with any rigor if they are not regarded as important". As Slowther (2012) states it may be of some benefit to CECs to be acknowledged for their potential worth. The way to secure recognition for the value of their support is to ensure that the CEC themselves are role modelling transparent processes for high quality governance.

The issue of inflexibility

Clinical Ethics Committees do not need to be rapid response bodies as there are other services to provide this role. CECs can answer the criticism about inflexibility by reasserting the difference between their role and that of the individual clinical ethicist. Clinical ethicists offer flexible support to the clinician in times of difficulty, and are particularly popular in American healthcare organisations.

Sokol (2005 p741) states:

> "*In North America, many hospitals have full time clinical ethicists as well as clinical ethics committees. Although not all from a medical background, most ethicists hold postgraduate degrees in subjects such as moral philosophy, theology, medical ethics, and law, and they are increasingly*

trained specifically in clinical ethics. They can be called on by staff or patients who need help in medico-ethical matters. Some are available 24 hours a day. Although clinical ethicists have no claim to greater virtue than others, their task is to help resolve moral problems by drawing on their knowledge of ethical issues encountered in hospitals, their past resolution, and by using a set of principles for analysing them".

CECs are not clinical ethicists, their value lies is in their diversity and non-expert status, and the value of facilitating shared group discussion. There exists in the UK the misconception that CECs should seek to offer a service that is akin to that offered by the clinical ethicist. The CEC should not attempt to achieve this aim as its value lies in a different sphere. CECs are not as flexible as individual ethicists can be, due to the need to assemble a number of members to review an issue. CECs are not required to be, and should not seek to be, rapid response services. CEC members are part of the committee as a result neither of their in-depth knowledge of 'ethics', nor of their greater ability than those in the clinical team to sort out a complex situation, and therefore should not be called upon to advise in an urgent situation. All trusts in UK healthcare have access to 24-hour legal teams and individual ethics advisors. Such services will be there when needed in times of crisis, and offer a different and complementary form of clinical ethics support. If it is not possible to offer such a service, then it could be argued that other methods of ad hoc ethical support that are more flexible would be more appropriate in situations where access to ethical support is required

The CEC role in conflict resolution

In challenging situations, the promotion of good team work and adequate support can help the process of conflict resolution. Clements et al (2012 p27) discusses

research commissioned by the Canadian Health Services Research Foundation, and other research and evidence on effective team work in healthcare. They cite a definition of effective team work by Oandasan et al (2006):

> *"Teamwork requires an explicit decision by the team members to co-operate in meeting the shared objective. This requires that team members sacrifice their autonomy, allowing their activity to be coordinated by the team, either by decisions by the team leader or through shared decision making. As a result, the responsibilities of professionals working as a team include not only activities they deliver because of their specialised skills or knowledge, but also those resulting from their commitment to monitor the activities performed by their team-mates, including managing the conflicts that may result".*

Being able to reflect and consider ethical issues as a group, debate and find meaningful compromises in situations where there may be justifiable opposing, courses of action, the CEC can develop skills that maximise effective team working, which can be passed on to others within the organisation through case review and education.

This is an important function as promoting and supporting confidence in effective clinical team work, in relation to ethical issues, enables teams to work together more effectively and this will result in better outcomes for the patient.

> *"Members of effective teams have faith in their ability to solve problems, are positive about their activities and trust each other. They can determine areas for improvement and reallocate resources to do so. And of course effective teams are self-evident because they produce high-quality results.*

In healthcare, these include improved patient outcomes and cohesion, and competency or stability for the team itself" (Clements et al 2012 p29).

The role of the CEC in conflict resolution will be discussed in greater length in chapter 4.

Having a CEC team dedicated to looking at the ethical dimension of healthcare is important, and represents a worthwhile and valuable investment for the organisation. All teams within healthcare are interdependent and, through embedding the CEC in modern healthcare, the skills gained by the CEC team will be transferable, through their activity, to others. This team should not be seen as a group of experts sitting outside of practice, and casting judgement upon it, but should be part of the culture, sharing and experiencing ethical challenges and difficulties and collaborating with other teams to find answers. Clements et al (2012 p29) point out that inter-professional — and I would say inter-team — collaboration can yield a range of benefits:

"These include reducing medical errors, improving quality of patient care, addressing workload issues, building cohesion and reducing burnout of healthcare professionals".

Having a supportive culture that empowers the clinician to consider modern-day ethical dilemmas, while respecting his and others' realities, is an important and fundamental part of good clinical practice and team work. Such skills for healthcare workers are developed through a range of means, but particularly through reflection on experience (either current or post hoc).

Although awareness of how legal/professional decisions are, and should be, made is necessary, the 'right' context-specific decision is not always reached through the

rigid application of rules or based on the suggestions of others without due consideration. The CEC can help the clinician to consider an appropriate application of clinical guidelines or professional codes of practice, which are often broad, but not always action guiding, in specific complex situations where there may be competing duties or obligations.

CECs can help bridge the theory practice gap. Peile (2001), when considering ethics advice and education in primary care states that there are indeed gaps between the professional guidelines promoted by the BMA and the GMC, interdisciplinary approaches and the differing philosophical standpoints that can be employed. He sees CECs as groups that can help bridge this gap by conducting multidisciplinary reviews, drawing on collective experience. The advantage of the CEC Peile (2001 p3) identifies here is "looking at the actual dilemmas that arise in the course of Trust business or clinical practice and entering discussion with management and individual clinicians". This role predicates an independent committee that is able to consider different issues from an ethical standpoint, separately from clinical governance or budgetary considerations.

CECs are able to promote the humanistic element of healthcare. The work of Gadamer (1975), and before him Heidegger (1927), highlights the importance of the need to consider the *art* as well as the *science* of knowledge. Science is seen to be lacking when one seeks to interpret the nature of knowledge, and that perception is key to a person's understanding of what he believes to be happening. This perception can be prejudiced by many things, including the culture within which the person lives and works. In healthcare, the culture is predominantly scientific. A rebalancing of this towards the humanitarian aspect of care can be stimulated by having empathic and supportive ethics champions in the

form of the CEC. The diversity of skills within the CEC - from lay members, to chaplaincy, to lawyers, to patients - provides a richness of insight that can be harnessed when considering the ethical direction of a healthcare organisation. The diverse group also reinforces the pluralistic nature of healthcare, and the wide subjective interpretations of the 'truth' of a situation and can help with deepening our understanding of the impact of services not just from a scientific or biological point of view.

Warren (2005 p19) reflects the need to consider how knowledge is interpreted other than by the scientific, stating:

> "scientific knowledge has not just sought to become the predominant method of understanding in its own disciplines, but also has claimed the primacy of its knowledge in the humanities. Scientific method has been applied to philosophy, history, art and psychology for the purposes of discovering the scientific truths within these fields. Gadamer argues that we need to go beyond the narrowed scope of scientific knowledge in the arts and humanities in order to describe human understanding and experience".

Warren (2005 p19) also discusses the value of conversation to further the process of hermeneutical enquiry (seeking understanding) to enable an unclear topic to become clearer through an exploration of different perspectives on the topic stating:

> "Gadamer uses the example of the conversation to explicate the hermeneutical process. A hermeneutic conversation involves two parties coming together for the discussion of a topic. There is a temporal distance

between these two parties, as each has his or her own horizon of

understanding".

The CEC is a vehicle that can provide an opportunity for discussion of diverse perspectives whether these may be philosophical, emotional or practical. Emotion will invariably play a part, as there is often conflict and distress inherent in the situation. Support for the emotional impact of the issue and recognising that a range of contextual, cultural, ethnic and gender issues influences matter, and can positively influence the culture of decision making, can challenge more traditional ethically analytical approaches. This re-balancing is an important role for the CEC. As Vieth (2011 p295) identifies:

"The problem of ethical consultations in the clinical setting should be

reasonable, but it cannot be reduced to reason and philosophical theory

alone. I will argue that emotions are constitutively and discursively relevant

features of the evaluative experience of persons" (2011 p295).

This approach then becomes a cultural role model for empathic practice that considers the impact emotion has on the situation, rather than disregarding or trying to eliminate it. The CECs can inspire others by role modelling this practice. Considering CECs as discourse groups, aimed at revealing the perceptions of those involved about the 'truth' as they see it, provides, according to Levinas (1969) the opportunity for the 'I' to teach and inform the 'other' through conversation. As Warren states, "thus in discourse, the I teaches the other and the other teaches the I" (2005 p23). Through an understanding of differing perspectives, personal ethical growth and individual awareness of the clinician's own moral position and the reasons for it, can take place. Compromise can then be found from a respectful platform of understanding.

2.2 Input into guideline development and review

The CEC can support the clinical teams indirectly through involvement in organisational guideline development. They can do this by offering diverse perspectives on guidelines on ethical issues, being involved in the interpretation of national guidelines, and helping to develop local policies for use by the clinical team. The value added of the CEC is that they can offer this insight having reached a competence in applied ethics and therefore may have a more informed critical eye in conjunction with their own diverse and important perspectives when reviewing the document.

Many clinicians within the organisation may never have accessed, and may never access the CEC directly as it is not compulsory, and does not replace other forms of ethical support. Clinicians are regularly involved in decision making about practical clinical problems involving team-to-team and team-to-client ethical dilemmas. Here, the clinician and the team frequently reach decisions without the involvement of a third-party committee, and it should never be made a requirement to involve such a party. The existence of a CEC will not change this situation nor interfere in day-to-day clinical, in the moment, decision making and nor should it, if those involved in the clinical situation do not request the involvement of the CEC. If the clinician does not find the CEC method of ethical support appropriate — and they may not, especially as the committees in the UK presently exist in a very ad hoc and fragmented way — they will choose not to access the support, and may not be influenced directly by its existence, either through case reviews or education, but they may be influenced indirectly through guideline review.

Guideline formation and review is a generally agreed function of the CEC. Ethox (2004) describes the function of CEC guideline review as consisting of the following: developing local guidelines for use within the trust, drawing on national guidance or professional guidance where available, providing ethical input on the guidelines produced by other committees or clinical groups within the trust, and commenting on and clarifying national policies and guidelines. This is perhaps the least contentious element of the work of the CEC but represents an agreement that consultation on guideline is a good thing. As Doyal (2001 p47) states:

> *"without appropriate expertise, discussion and debate, such policies are more likely to be ineffective and to reflect arbitrary rather than public interests. Therefore it is hardly surprising that nationally agreed ethicolegal principles concerning the duties of clinical care have all been formulated by committees".*

CECs can help interpret national policy around ethics, and present it in a manner that is useable and applicable for the busy practitioner. Busy healthcare professionals may not have the time to consider and interpret the key points in large, unwieldy national guideline documents. Thus, a group trained in and committed to exploring and commenting on such documents could form a bridge between theory and practice by providing concise summaries. Feedback from the dissemination of such information could then be integrated into local documents/guidelines, which could lead to more appropriate local policies being developed. Doyal (2001 p47) identifies key areas in which CECs are involved in policy formation and interpretation stating that "by far the most important has been, and will continue to be, problems concerning the non-provision or withdrawal of life-sustaining treatment". He goes on to say that:

"the second most likely issue to demand pro-active CEC attention concerns the boundaries of obtaining informed consent to clinical treatment. Within the United Kingdom, the law offers scant guidance for good clinical practice in obtaining consent. It is still common for medical lawyers to state that there is no such thing in law as the doctrine of informed consent and that the standard of disclosure of information commanded by common law is very weak indeed".

Over the last few years, the input into guideline development undertaken by CECs have been developed and diversified. Interestingly, the two examples of inputs into policy on the Clinical Ethics Network (2010) website cite the activity of the Newcastle Clinical Ethics Advisory Group and their work on advance refusal of treatment, and the Sheffield Teaching Hospitals Clinical Ethics Group's development of a document regarding the Police Reform Act, and how to deal with requests for blood samples from patients unable to give consent. Some other examples include guidance on the presence of relatives during CPR attempts, blood transfusion for Jehovah's Witnesses, the clinical alert policy, and clinical confidentiality and the media (Ethox 2004). Such guideline formation can be seen to complement the educative role of the groups, as it can enlighten subsequent teaching, and insights from educational discussions can then be used to enlighten subsequent case reviews. Educational events will also enable the relevant guidelines to be promoted and distributed and the underpinning rationale for the guideline to be discussed.

The committees must respect the advisory nature of their role and the fact that they are there to support, not recommend action to the clinical teams. One area that they must be aware of is the requirement not to formulate guidelines for

particular patients. It is essential that CECs do not exceed their terms of reference as bodies that advise on, but not formulate, clinical policy about specific patients. This should remain the responsibility of the clinicians. Those who have been concerned about the creation and operation of CECs have been most concerned about their potential for clinical interference, and concern is valid. Clinical relationships with patients are highly individual in character, and depend for their success on a strong bond of trust and as Doyal states "If patients come to believe that 'strangers at the bedside' are making key decisions then this bond may be undermined" (Doyal 2001 p48).

Concerns have been raised about the limitations of CECs with regard to healthcare policy development. One concern surrounds the need to consider the applicability and implementation needs of any guidelines that CECs are promoting, and formulating, and the influence they may hold as a group to ensure that policies are accepted into the healthcare culture. In this regard, Doyal (2001 p49) states:

> *"the CEC may formulate local ethicolegal policies but it will not have the capacity or authority to disseminate them. The extent to which the institution does do this will signal to staff its commitment to the work of the committee".*

Ultimately, real-time decision making rests with those clinicians directly involved in the incident, and accountability in practice stresses the need for the clinician to be able to justify their own actions both within a court of law and morally to their patients, themselves, and their professional body, as they have ultimate control to interpret the guidelines. Throughout the clinical training for doctors, nurses and allied health professionals this obligation is stressed and professional regulatory bodies exist to call clinicians to account for their actions. The case and education

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activity of the CECs can help develop that moral judgement and ensure all three areas of influence impact upon, and support one another.

2.3 *Empirical evidence to support the inclusion of CECs in the healthcare culture.*

Contrary to the argument that the CEC, by its very existence, may diminish clinicians' moral growth by encouraging abrogation of responsibility and diffusion of responsibility within the CEC, there is a growing body of empirical evidence to suggest that clinicians have perceived benefit from being able to access CECs in the UK and internationally, which has increased their confidence in their decision making.

Kalager et al (2011 p119) summarise the reasons why clinicians have brought cases to a CEC in Norway. The reasons are; to have a broader discussion of the case, to clarify the ethical challenges, to get an "external perspective", to be better equipped to deal with cases, to get advice on the decision, to gain support for one's own decision, to clarify the values at risk, to improve cooperation, to share responsibility, because the case involved conflict, to create agreement, to learn more about ethics, because the case was deadlocked. Kalager et al (2011 p119) also reflect that in the previously identified areas the clinicians perceive some benefit from CEC consultation. Debate within the Norwegian CEC follows a reflective consultation model. The authors state "The committee has no powers of decision but is intended to function as a form of support in decision making and as a forum fro clinicians and other affected parties in the discussion of concrete ethical problems whether prospective or retrospective" (Kalager et al 2011 p118).

Dörries (2003 p254) also reflected the clinician's perceived benefit of taking the case to a CEC:

> "Even today there are reports that the mere existence of a Clinical Ethics Committee leads to more communication among professionals and to discussions about ethical conflicts in a better atmosphere".

Discussing the evaluation of satisfaction with work undertaken by a Clinical Ethics Advisory Committee (CEAG) in New Zealand, Dare (2012 p7) identified that, in a group of 18:

> "respondents were overwhelmingly positive: 100 per cent said they would recommend the CEAG to colleagues and 94 per cent thought the opinion was provided within the expected time. 65 per cent thought the opinion helped with clinical decision making. (Interestingly, these statistics suggest that even those who didn't find the opinion useful in clinical decision-making would recommend the committee to colleagues!)"

Despite enthusiasm for the concept of a service such as a CEC there is still uncertainty about how best to structure the group's activities to best meet the needs of clinicians, particularly in relation to case review, and avoid any erroneous belief that the clinician could choose to delegate or abrogate responsibility for the ultimate decision. Slowther (2012 p210) identifies a "scarcity of good quality empirical evidence about the functioning of CECs".

Some work is being done to review the activity and benefits of the CEC in the UK. Frith (2009) explored the use of clinical ethics committees in infertility clinics and although she concluded that there needs to be more research in this area, she states that "the case for the utility of CECs is a strong one and more infertility units

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could benefit from their use" (Frith 2009 p93). More evaluative work needs to be undertaken to determine what it is in the encounter that is beneficial. This will to enable CECs to strengthen the most effective part of their service. Initial indications point toward the benefit of the encounter being the discussion not the outcome.

As Kalager et al (2011 p121) state:

> "The survey indicates that healthcare professionals who have made use of ethics committees in individual cases found this useful. At a time when more and more is possible in the field of medicine, new ethical challenges will emerge. The ethics committees can make a positive contribution in such cases by ensuring that all involved parties are heard, and by shedding light on all aspects of the case – thus promoting ethically acceptable solutions".

Moeller et al (2012) reviewed the outcomes of 100 consultations by the Summa Health System's Medical Ethics Committee. This committee aimed at providing an educational, educative and supportive resource to patients, their families, and the service providers. Part way through the evaluation study a Palliative Care Consultation Service (PCCS) was introduced with the aim of providing a supportive bedside service in times of crisis and also advice about symptom control. The aim was to offer support and to promote open lines of communication rather than recommendation on action. The results of the study demonstrated that in areas such as the 'family opposing withdrawing life sustaining treatment' and issues of 'capacity' referrals dramatically decreased with the introduction of the PCCS service. The data does not clearly offer a reason for this but the decrease in numbers of certain referrals to the ethics committee may indicate that a number of

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these referrals are stimulated by communication difficulties, and value conflict that can be adequately resolved by a supportive confident empathic clinician at the bedside.

If the CEC increases its role as a reflective practice forum evaluations of CEC activity in the future may demonstrate that CEC support and facilitation is more beneficial to the clinician than formal analysis, and recommendation of action. This evaluation of the benefit of a reflective forum urgently needs to be undertaken in greater amounts than it is at present. This evaluation would add weight to the argument that CECs need to develop their skills to stimulate high quality reflection on practice. Moeller et al (2012) identifies that the exponential growth of the bedside support service may offer some indication that benefit to the patient and team to facilitate resolution of difficult clinical ethical issues is to be found in a confident, supportive clinician. This may in turn lead to confidence in identifying and addressing more ethical issues that have previously been unrecognised. This growth of new issues to discuss is exemplified by the increase in cases brought to the PCCS. Moeller et al (2012 p110) states:

> "The decline in the number of EC consult requests after initiation of the PCCS for issues surrounding withdrawal of life sustaining treatment deserves comment…… Given the mission and work of the PCCS some of the cases regarding withdrawal of life sustaining treatment may have shifted from the EC to the PCCS and contributed to this decline. More remarkable is the volume of such cases identified through the PCCS database growing to several hundred per year by the time the service had matured (Radwany et al 2009)".

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This comment raises the question about whether, through reflective practice and support, the CEC can encourage good supportive communication that respects diversity and differing values. This may in turn lead to far more identification of need and resolution of issues more quickly at the bedside by the more ethically confident clinician.

There is no doubt that further research needs to be undertaken into whether the presence of a supportive ethics committee enhances or diminishes the confidence of the practitioners within an organisation and how the former can best be achieved. With the existing evidence, and in the light of the emerging evidence that clinicians themselves are asking for CECs to offer support for their practice, the argument for the further development of CECs is strengthened. Further evidence about the CECs deliberations, and about which approach would maximise the potential of such support, is urgently required. A few evaluative studies on the committees themselves do exist, but they focus on the process of the deliberations, usually whilst they are seeking to make a recommendation, rather than on the benefits of the groups per se within the healthcare culture and how they can be part of, and foster ethically aware and respectful teams. From the research undertaken so far, elements thought to improve the likelihood of success for a CEC are (1) the allocation of a budget, something very few UK ethics committees have, which may allow the committees to purchase appropriate and high-quality training for themselves, and (2) the number of meetings, with committees often finding it difficult to hold them regularly. Rues and Weaver (1989 cited in Scheirton 1992 p344) found that a multidisciplinary approach generated success. They state that "such a multidisciplinary committee adds credibility to

educational endeavours increases the number of requests for case reviews and promotes the acceptance of hospital policies or guidelines".

Therefore it can be seen that CECs can be seen to be an important part of modern day health care culture. They can stimulate and demonstrate respectful discourse. CECs can role model and inspire clinicians and organisational leads and demonstrate that effective discourse can happen among clinicians but also between management and clinicians. This can lead to clarification and resolution of ethical issues and a greater understanding of each other's competing obligations. In order to maximise their benefit they need to attend to their structure and function, so that the clinician and organisation know where CECs can help. The next part of the thesis will look at how CECs can structure their activity to ensure those using the service get a clear message about their role and they are operating at their most effective.

Chapter 3 _Clarification of the role of the CEC._

This chapter will explore how the CEC can develop and demonstrate clearer aims and objectives for their activity, which can support the growth of the areas discussed in the previous chapters in which they are useful, and increase awareness about which activity should be avoided. Once clear aims for the UK CEC are established the CEC is able to concentrate on the appropriate structure for activity particularly current case review. The following prerequisites are vital to enable an effective case review function to be developed.

3.1 A clear vision and message about being a reflective forum

If the CEC wishes to promote itself as a "forum in which health professionals can raise ethical problems, check their own judgements and intuitions, while benefiting from open discussion with other clinicians and appropriate outsiders" (Dare 2010 p7), they will need to ensure that the clinician and the organisation see their role in the same way. The term 'committee' could be misinterpreted by practitioners as a group who are going to solve the problem, leading to a different expectation of the CEC remit than the CEC has of itself. Traditionally other types of committees have been devised to review evidence or information and to reach a conclusion about the presented 'facts'. The traditional notion of the committee is identified as an:

> *"individual or a group, appointed by an agency, authority, or larger*
>
> *assembly, to whom a matter is referred, or is committed for attention,*
>
> *investigation, analysis, or resolution" (Business Dictionary 2012).*

The clinician may be looking to take the case or issue to the CEC for a quick answer to a difficult problem. It would not seem unreasonable that the clinician

should look for this. Within health service culture there is a precedent that difficult clinical problems are escalated by more junior staff to more senior for a 'decision'. The demands of the clinical arena generate demand for quick, practical solutions from patient, client and clinicians. The healthcare culture also generally accepts the legitimacy of referral of difficult cases to 'consultants' who are expected to have developed greater expertise and may be able to direct the case more appropriately. The referrer will in turn expect an answer to be borne out of this consultant expertise.

In referring to the CEC, particularly with regard to contemporaneous cases, there may be an expectation by clinicians that ethical deliberation will be carried out by those sufficiently trained in ethical analysis and that the 'right' ethical answer will be offered. Here the expertise assumed to be embodied within the CEC is an expertise that somehow the CEC has the skills to make a 'better' decision. This assumption rests upon two premises. First there is the assumption that an interest in ethics, or theoretical knowledge of ethical theories, makes the CEC able to make a better decision in clinical practice than the clinician. Secondly there is the assumption that this decision carries with it a claim to greater moral authority than the clinician could claim and therefore the clinician can defer the responsibility for that decision to the CEC.

Before we explore these two premises it could be argued that whatever the skills of the CEC the clinician should always retain responsibility for their own actions and justifications of such actions. Siegler (1986) has argued that the notion of abdication of responsibility by the clinician may be in itself unethical, as the physician is responsible morally and legally for decisions around patient care, and should not abrogate that responsibility to others. Blake (1992) questions whether

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any single group of medical professionals can claim sole ethical authority.
Decision making in practice is a community endeavour and the notion of expert in
ethics or morals with moral authority, whoever that may be, should be rejected, as
the CEC can neither claim moral expertise which is greater than the clinician, nor
the moral authority to have any recommendation made by them implemented over
and above the wishes of the clinical team.

Example from practice

A recent case experienced in my clinical practice highlights the problems inherent
in accepting the traditional referral to experts' model in relation to moral issues.
Certain details have been changed to protect patient confidentiality.

When lecturing at a large university I was approached for support by a group of
distressed chemotherapy nurses as I was their mentor in practice. They had been
caring for an elderly lady with dementia who had been recently diagnosed with
lymphoma. She had fluctuating capacity, but in their opinion, did not have the
capacity to consent to chemotherapy treatment or at least to understand how to
comply with the aftercare required which would maintain her health during the
treatment. The nurses were concerned that if she were administered the
chemotherapy she would be unable to comply with the instructions needed to help
her avoid infection and that she may not tolerate supportive measures such as
blood transfusions. The nurses were administering the chemotherapy (although
the Doctors prescribed it) and they felt they would be administering something that
would potentially hasten her death from an associated infection. The medical team
did not agree and prescribed the medication, and the nurses felt obliged to
administer. Unfortunately the anticipated problem happened and the lady died of a
septic neutropaenia one week after the chemotherapy, having not reported

symptoms that would have led to medical interventions that had a high chance of saving her life, due to her confusion. The nurses were frightened that this situation might happen again. They felt their concerns were unheard by the medical team, and they felt a tremendous guilt for having administered the chemotherapy injection. If a best interests meeting had taken place there would hopefully have been an opportunity to discuss the nurses concerns, and hopefully a compromise decision about care reached to the satisfaction of all team members and in the best interests of the patient. The medical team in this case, it could be argued, took a paternalistic and narrow minded approach to the situation, not considering the non-medical influences on the situation. Their objective view of the ability of the lady to consent was not wrong, but was rendered inappropriate due to other contextual issues. Neither the CEC nor any one clinician has the claim to authority to make the decision without consulting and considering the perspectives of others. The CEC may objectively have agreed with the judgement of the medics, if they had not been aware of the other issues influencing the situation. Rather than taking the medical issue out of context, a CEC structured to support team discussion, from a non expert position, could facilitate all the perspectives to be considered and avoid the risk of supporting a clearly wrong judgement.

The CEC being seen to be 'expert in ethics' making decisions where those referring think the situation is too complex, could be seen to be akin to a narrow minded paternalistic medical team who believe they have the answers and the jurisdiction to pressurise others to behave in a manner that those being pressurised did not agree with or understand. The resulting decision would undermine team relationships and trust and may be catastrophically wrong for the patient. The CEC should approach decisions in a different way and ensure all,

from management to worker, to patient and carer, understand why this needs to be the case.

3.2 Maximising the benefit of non-expert status.

Rejecting this 'expert' role does not reject the benefit of the group. It offers the group more scope to concentrate on what they can offer which is unique, supportive and enabling. The CEC occupies an important role within the organisation. They are generally neither academically qualified in law or bioethics (although the group may contain members who are, such as bioethicists).The CEC are a group of interested advocates, who wish to support peers, and further the cause of ethical fairness and justice within the organisation. In the next part of the chapter I will explore in more detail the benefits to be gained by acknowledging and embracing their non-expert status. I will also explore the benefit to the clinician of recognising and embracing such a group of ethically aware peers, who have no moral authority to recommend or impose an action and who need not do so to be of some use.

Why moral expertise cannot be claimed by the CEC

Expert performance has been defined as the possession of a high level of knowledge and skills in a limited area. Ericsson et al (1996) identifies that the highest levels of human performance in different domains can only be attained after around ten years of extended, daily, deliberate practice activities. This professional idea of expertise or expert performance is often what is assumed to exist, or felt should exist, by some clinicians within CECs in healthcare. Clinicians will be familiar with a cultural tradition in healthcare of referral to those with greater knowledge in complex medical cases; for example, the GP referring a lady with a breast lump to the specialist breast surgeon.

Although the notion of clinical practical expertise may be more straightforward to define the notion of moral expertise is not easy to define. McGrath (2006 p97) considers the complex task of identifying those with genuine moral expertise. She states*:*

> *"In general, identifying those with genuine expertise in some domain will be most straightforward when we have some kind of independent check, one not itself subject to significant controversy, by which we can tell who is (and who is not) getting things right".*

Members of CECs can not claim to have achieved expert status through passing such an independent check. There is no such moral measure available. They also, on the whole, cannot guarantee a greater theoretical knowledge on philosophy and ethics than a well informed clinician. They may also have very little experience in debate and argumentation (unless they have a separate role outside of the CEC such as bioethicist or trust lawyer). Therefore members of the CEC could be seen as no more than enthusiastic novices when it comes to ethical review.

Referral to an 'experts' culture in healthcare can lead to de-skilling. It can promote a misconception amongst workers that experts would be more able to find an answer to their problems, and that the clinician is not such an expert, as he/she is struggling with the question and is unsure of the answer. It is important for the CEC group to consider that each individual is their own moral agent, with the capacity to develop skills and confidence in moral judgement. As such, every individual can reach their own moral view on a situation, and reach a decision on a course of action, even in the case of complex events. If the clinician is educated to understand that the CEC group is no more expert than he would seek to be, it could give the clinician confidence that, with support, he could make the most

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appropriate decision. This equality of perspectives would empower the clinician to accept or reject the insights offered, during the reflective process of review of a clinical case. The CEC may have some procedural expertise around how to translate ethical views into the action needed in the clinical environment. Indeed, that is their worth: to help with clarifying the perspectives in the situation, and encourage action. It could be enlightening and empowering for the clinical team to realise that everyone accepts there is no 'correct' ethical answer to every problem. The essence of an ethical dilemma is that there may be a number of courses of action available, each with justification. Context defines the rightness of an action, and the clinician is the expert in judging their own case, according to these contextual issues. The CEC should be offering a forum by which the clinician can develop his skills to become a more confident moral judge. John Rawls (1951) identified the notion of a competent judge and added that the judgement gained in stature when the judge believes strongly that the judgement is correct and is one that other judges would conclude is correct in similar circumstances.

If we agree that all clinicians can develop their skills in relation to moral judgement the question must be how can this be supported and facilitated by the CEC and how clinicians can be taught to deal with prejudice and bias. De Marco (1997) raises the question about how the judge makes these decisions, and how he controls his own prejudices. The CEC is one mechanism by which the clinician can test such prejudices, can explore views of other competent judges and can grow in moral confidence. De Marco (1997) raised the concern about bias and how this can be minimised to ensure decisions are not based on flawed premises. I would propose that it is a more effective way to consider bias will be a feature of moral decision making, it is important to accept imperfection, prejudice and bias and

promote discussion about it, rather than denying its existence. No model or approach to moral thinking can confidently offer an answer to how to reliably identify bias, and offers an answer about how to exclude or remove it from the analysis about right and wrong. A decision is more likely to be right, if it is an action that many clinicians would consider appropriate in the circumstance, as they are unlikely to have the same prejudices which may influence one clinician. Therefore comparing cases containing similar features is a mechanism by which flawed premises can be highlighted, as suggested actions would not fit with what others agree as reasonable. Jonsen (1981) is cited by De Marco (1997) as acknowledging that an action can be just within a setting that may be morally imperfect, and many of the problems that arise may be because of the unjust nature of the institutions in which the problems arise.

The notion of moral expertise, and whether it is present or not within the committees, has been identified as a concern by Gillon (2010 p2946) who comments:

> *"Critics of clinical ethics committees have expressed concerns about their legitimacy; expertise; appropriate function and purpose; and lack of appropriate governance, regulation and due process."*

With regard to this, there is a need for a greater clarity and understanding of what the CECs can, or should hope to achieve, and that they should not seek to be expert bodies, but should offer support that embraces the benefits of their diversity and non-expert status with regard to morals. This does not encourage any inference that they as a group could reach a decision that was more ethically skilled than the clinician. The CEC can concentrate on offering skills to, facilitate and support moral reflections of the clinician, to enable them to make decisions for

themselves, and justify judgement. There are many groups within health services that have legitimate and useful supportive functions, who seek to have performative expertise in their supervisory and support role. This is the area in which CECs should be striving to achieve excellence, and demonstrate high quality facilitation of reflection on practice. There is a wealth of literature supporting the use of clinical supervision, reflective practice and peer support. CECs can gain legitimacy as supportive groups, aimed at furthering the cause of improving deliberation on medical ethics. Frameworks can be put in place to monitor activity of CEC support processes, questioning techniques, mandatory education, and the experience of the clinician (these processes will be discussed at length in chapter 5 and 6).

The criticisms of CECs reflect the constant tensions that underpin their work. If they are seen to make recommendations that are too fixed and binding (as experts) clinicians may want or feel compelled to delegate responsibility or dismiss the recommendations completely. Neither of these positions is useful to support the moral growth of the physician. Alternatively if CECs do not offer sufficient guidance they risk being seen as ineffective. The need to encourage the clinician to make ethical judgements, justify how the decision was reached, and engage in a dialogue to assist with, clarification of the perspectives involved, is the important role of the CEC, and must start from the premise that they are not experts in ethics, which is an advantage to their role, but have developed an expertise in deliberation to enable resolution of issues. It is probably easier for such a diverse group to claim non-expert status than the clinical ethicist, as they can claim no expertise in philosophical theory, and therefore it is easier to promote throughout the CEC review process, that the responsibility for the action remains with the

clinician. Alongside these decisions comes responsibility. CECs are responsible for any advice they give and its influence on the decision, and clinicians have a responsibility to consider their judgement based on the support and information offered. Accepting responsibility for outcomes is often easier when control over the process has been perceived by those involved, and this is why the clinician must always remain central to the process, and take responsibility for their decision making. Clarity over the status of the decision, and who holds responsibility, must be discussed with the clinician, prior to any CEC meeting happening. As McLean (2007 p497) states:

> *"As support for clinical ethics committees in the UK grows, care must be taken to define their function, membership and method of working and status of their decisions".*

The CEC can exist to promote dialogue and challenge inconsistencies, offer a voice for the underrepresented and promote clinical responsibility. The clinician is required to consider any advice from whatever source, carefully against their moral conscience, in the real-time context of the situation. Interestingly, Racine (2008 p64), in his review of HEC members, comments on the very diverse perspectives contained within the committees he studied:

> *"HEC members tend to have a multi-dimensional perspective on clinical ethics: different defining aspects of clinical ethics co-exist and are not mutually exclusive. For example, some members define clinical ethics in a contextual manner (mainly female respondents) without excluding the importance of ethical principles......aspects found in different moral theories such as narrative, context, principles, relationships and ethical principles all allow them to grasp moral problems and identify moral solutions".*

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3.3 Interest in or knowledge of ethics does not make a claim for moral authority in decision making about clinical cases stronger.

If a clinician defers a decision to a CEC, hoping for a more expert answer, he may consider that the CEC embodies characteristics that enable them to make a more appropriate choice on an ethical issue, assuming an expertise that if it exists is very difficult to define, and may not in many cases exist. In the clinical area, the assumption of expertise, may lead to referral and deferral of a decision, as the implied expertise is often accompanied by an assumption of authority.

As Rasmussen (2011 p649) states:

> "Expertise makes claims to authority plausible: Unless there is a special area of knowledge, or set of skills, over which some but not all may claim mastery, there is no reason to deem some but not all authorities".

If CEC members cannot claim that they have the ability to get the decision 'right' more reliably than the clinician, by having no measure by which to prove, this, then the aim of the group should not be to seek this end.

Neither, can the group claim to hold perspectives that can be seen to be representative of the clinical teams, and the patients and their families, due to the diverse nature of individuals in society. We live in a highly diverse and multi-cultural society in which decisions are made in the context of, cultural, religious, professional, societal norms and rules. Each individual is subject to their own unique set of influences which will impact upon the decisions they make in life.

A small number of persons cannot confidently act as moral experts, able to identify what constitutes morally right action for another.

As Rasmussen (2011 p654) states:

> "From within a pluralistic society, the idea that a single person, or even small team of people, can adequately serve as moral experts for all moral perspectives seems ludicrous".

There will be expertise in the group that can be drawn upon to illuminate, clarify, challenge and confirm issues and perspectives however.

Moral authority and the clinical ethicist

It is easier to defend the position that CEC volunteers, with varying experience and knowledge of ethical theory, cannot claim greater moral expertise than the clinician. The clinical ethicist, who is often part of the CEC, may find this assumption more difficult to argue against due to their title and assumed high level of knowledge in ethics. Clinicians will see the clinical ethicist as an expert in his field, an expert in argumentation and debating, and akin to the senior medical consultant, they even share the same title. This notion of authority linked to theoretical knowledge should be refuted by the ethicist in his role in the CEC. They should also reject the notion of moral authority through such ascribed expertise.

Bioethicists are acknowledged for their theoretical expertise and this has been recognised as linked to authority at times. As Scofield (2008 p95) states:

> "bioethics has come to be recognised as an authoritative field. Indeed, many would argue that the field has come of age. Increasingly, bioethicists are sought after for their expertise".

In the case of the CEC, such expertise cannot be seen as conferring moral authority, particularly in the ethicist's role as a CEC member. I have already mentioned that no member of the team can make claim to moral authority in a

difficult clinical case, except maybe the person with capacity making the decision. There are other reasons why moral authority by the CEC member, even if a trained ethicist, cannot be claimed. In an objective sense, an action may seem rational and reasonable. When the non-moral features of the case are considered such as culture, beliefs, religion, the clinician may make a different choice. This different choice may not at first seem to be the most rationally or objectively apparent, but taking into account the previously mentioned, cultural, social, religious needs, becomes the right one by nature of those influences.

The case of the Jehovah's Witness family refusing blood products that could save the life of their child is an example.

This rejection of moral authority within the CEC does not mean that there is no benefit to case or issue review by such an interested group. A 'fresh pair of eyes' from a non-medical perspective, a willingness to question, challenge, compare cases and assist the clinician as they ensure all perspectives are heard within the case. Varying levels of expertise should be recognised and utilised to assist the clinician and the team. Moral authority is not an attribute that the CEC should seek to embody. Assumptions on moral authority should be dispelled at the outset and throughout any consultation for the reasons identified.

The confusion around the notion of 'ethical expertise' and how this translates into moral authority is reflected in the statement by Bishop et al (2010 p75) who state:

> "Clinical Ethicists, according to Engelhardt, claim normative expertise in matters moral and at the same time deny moral authority in actual cases. This equivocation is fed by and contributes to the confused expectations for clinical ethics consultation".

CECs can support the clinician with their consideration of a judgement on action, not by exercising their morally expert status and assuming moral authority for the decision, but by demonstrating by harnessing dialogue and assisting the clinician to translate this into action. Practice of ethical review through active and post-hoc cases assists the CEC to develop procedural skills, knowledge and attributes which can be taught to the clinicians using the group. This procedural and ethical competence is on a par with competence any reasonable clinician should and could seek to achieve, and which is enhanced by practice using the model in a variety of contexts. Members of Clinical Ethics Committees can demonstrate a reflective model within CEC debates that allows the dialogue about issues that arise, considering we all have a common-sense morality. The notion of common-sense morality is defined as "the set of moral maxims of which ordinary people have knowledge and of which they make use in their quotidian lives" (Archard 2011 p123). These maxims may be difficult to interpret at times, and people may require support to consider them, but they are maxims everyone has access to, and make judgements upon.

Performative expertise

The skill that the CEC membership can therefore develop, which places them in a unique position to offer support, is in the area of performative expertise. The CEC by the nature of being a group brought together by a common cause, to further the future of clinical ethics, can develop skills that support and enable themselves and other team members/clinicians to develop their own moral competence in decision making and moral judgement. Skills they can develop useful to assist them in this endeavour are; group facilitation, conflict management, demonstration of empathy, communication skills, and all the skills which allow them to provide the right

environment, for case discussion to happen and for learning to occur, which will inform the clinician and build his moral confidence. Weinstein (1993) discusses the difference between epistemic (cognitive) and performative (act) expertise, here the expertise to be pursued by the CEC should be that of performative expertise through the ASCS model, that I will discuss later, to enable them to assist the clinician with their issue/case concern by using an appropriate structured questioning and facilitation technique to enable the clinician to make the decision for themselves.

The benefit of being non-expert in ethics is that there is no obligation on the part of the CEC to provide a recommendation on action, and there is no obligation on the part of the clinician to accept such a recommendation, in fact this would undermine the goal of the CEC working for the previously mentioned reasons. Even if an expert in morals or ethics were to be found who could argue clearly the rationale for his very plausible and logical solution to a dilemma (and I have identified that we have no way of measuring who is such a person), this still should not oblige the clinician to accept the judgement, as the most appropriate one, as Archard (2011 p120) states "acknowledged experts can and frequently do differ in their judgments".

3.4 The value of the clinical ethicist to a CEC.

Steinkamp et al (2008 p174) proposes that clinical ethical 'expertise' "involves thorough knowledge of moral propositions and ethical theories, and the skills to use this knowledge in a professional way". This level of skill can be useful to the CEC in the form of the clinical ethicist. Clinical ethicists can be a useful and important support to the CEC. The ethicist can bring their valuable knowledge to

inform, supervise and support the CEC membership, as they develop their confidence working together on case review. Casarett et al (1998 p6) state:

> *"the consultant is conceptualized as either a technical expert or a mediator. On one hand are those who contend that the ethicist is a specialist who possesses expertise in moral theory…..At the other end of the spectrum, arrayed in ranks that appear to be growing, are those who propose a more modest model for the ethics consultant, one that draws on models of mediation, hermeneutics or psychotherapy".*

Within the CEC the ethicist can offer both valuable aspects of support, both expertise and coaching, without seeking moral authority over decisions in the cases that are discussed.

Casarett (1998 p6) Identifies an important parallel between one perceived role of the clinical ethicist and the CEC. Describing the ethicist's role as one that can:

> *"facilitate communication, to clarify the moral positions of others, and to arrange a safe moral space within which differences can be aired, understood and resolved. On this view the ethics consultant's role would consist, not so much of problem solving as of interpretation, communication and consensus building".*

Reflection and evaluation as to the effectiveness of the clinical ethicist in this role to support the CEC will strengthen the argument for a clinical ethicist to be an integral part of a CEC. This will be for appropriate reasons, not for wrongly assumed moral authority, but in the capacity of CEC supporter, educator, facilitator and advisor.

The expertise of a clinical ethicist is often harnessed within UK CECs. The ethicist's role in the CEC, although desirable, is not a requirement for all CEC groups. Williamson (2008 p10) identifies a lack of clinical ethicists within CECs at present, stating that various empirical studies examining the constitution of CECs in both the US and UK have found a low percentage of committee members to be ethics specialists. She also indicates that these studies have found relatively low levels of ethics training, amongst members with a different subject specialism.

Therefore, far from being ethics specialists, some members of these groups may be beginners or novices in terms of their knowledge of ethics, philosophical positions or argumentation. The clinical ethicists can play a valuable role in developing the CEC members from novices to competent.

3.5 Collaboration between experts and non-experts in ethics.

In addition to the benefits gained from the group not being ascribed expert status in ethics, but seeking competence in their advisory function, and excellence in their supportive function, there could be another advantage to combining skills of the non-expert CEC group members, with theoretically expert clinical ethicists (something CECs often seek). Communication between ethicists and non-ethicists within such groups will help to inform clinical ethicists, about the culture in which they are working, and the views that may be prevalent among non-ethicist clinicians and CEC members. Then, when clinical ethicists are asked to provide advice outside committees, their advice may more effectively bridge the theory-practice gap, as a result of their having gained a better understanding of the clinical context through being part of the deliberations within the CEC. As a group representative of the diversity of the healthcare team, the CEC should comprise morally competent members who "focus on the internalised faculty of judgement,

based on the expertise of healthcare providers in their professional field, and with the profession's internal morality" (Steinkamp 2008 p187). That is they are all speaking the same language of the healthcare organisation and have a shared understanding of the culture in which they work.

As long as CECs consider their role to be supportive and non-advisory, they are in an excellent position to facilitate moral development of the clinical teams. The best compromise, as already stated, would be for everyone to learn from each other by reflection on case or guideline, be that performative or epistemological learning, in order to reach a balance that provides the growth and development of all involved, in the process of review.

Knowing the difficulty of knowing what is the 'truth 'and supporting the healthcare team with that difficulty

The unique contribution of the CEC is to explore with the clinician, and patient as appropriate, the difficult situation they face. The range of perspectives within the group, whilst not seeking to be reflective of all, can challenge the clinician's perception of the 'truth' and increase awareness as to its subjective nature, and that making judgement about morality in a complex situation is not adequately guided by one moral framework, for all of those involved. As Richardson (2011 p2) asks "Are there any true general principles of morality, and if so what are they? At this level utilitarianism competes with Kantianism, for instance, and both compete with anti-theorists of various stripes, who recognise only particular truths about morality." Within healthcare as within life, we are constantly called upon to consider one action against another, using moral reasoning. The benefit that can be offered by the CEC health care user is to offer the opportunity for those with

concerns to consider what appears reasonable against a range of subjective views on a difficult situation.

All of the members of the CEC, and those involved in the clinical case itself, will have different realities, influenced by a myriad of issues, including education, race, culture, ethnicity and experience. This diversity enables pertinent questions to be asked, which can improve clarity and result in the choice of an appropriate course of action. As Widdershoven (2007 p49) states "People interpret their situation from a specific perspective or background of practical expectations. This horizon of meaning structures understanding. It is normally taken for granted. Yet one's perspective can be put into question, if it is being confronted by other perspectives". This process of "hermeneutic understanding" (Widdershoven 2007 p49), results in a dialogue between perspectives and consideration of a "fusion of horizons" (Widdershoven 2007 p49).

The ability to weigh up different insights, and decide which is most suitable in practice, appears to be a necessary skill/habit that should be encouraged for all clinicians. By practicing it through review, in a safe forum such as a CEC, which is set up as a supportive reflective practice group, clinicians are encouraged to develop this skill of judgement confidently and appropriately. Clinicians can be offered appropriate support to consider ethical issues from a range of perspectives, acknowledging that consensus agreement by all, on right action, is not always achievable, due to the pluralistic nature of healthcare and wider society. As Powers (2005 p305) reflects, we are obliged to appreciate "the wide range of reasonable disagreement that will remain past the point of extended reflection and discussion".

CEC members can practice and refine the previously mentioned skills themselves through post hoc review. The first role of the CEC is to reinforce to the clinician that his struggle with a complex situation, is representative of how it should be, (because he is wrestling with competing obligations). The clinician's concern indicates ethical awareness and a desire to find the right path. This demonstrates that he is aware of competing obligations and is in a position that demands a judgement to be made on these competing issues, which is extremely difficult, and the CEC exists to offer some guidance on how to undertake this assessment even if it is not to recommend an action.

The forum can benefit the clinician by challenging and highlighting inconsistencies within the scenario being considered. CECs should approach the review, using a model that takes into account the particulars of a situation, but also acknowledges that in healthcare, clinicians' work within the confines of legal and professional rules and principles, which shape their perceptions of an ethical dilemma. This approach acknowledges the pluralistic (diversity of values) nature of healthcare. Pellegrino (2005), whilst identifying the growing movement towards pluralistic approaches to applied ethics, and the growth of thinking in healthcare that "absolutes are now judged to be out of date" (p471) nevertheless Pellegrino (2005) outlines some principles enshrined in our cultural norms, that can still be seen as guides to our personal and professional moral conduct. He describes the premise that all healthcare workers and CECs ascribe to, namely aiming to do good and not evil. He states that the:

> *"'patient', by definition is a person who is suffering in some degree and in*
> *some way. He is in an altered existential state – anxious, dependent,*
> *vulnerable and impeded in the pursuit of his daily life. He becomes a patient*

formally when he decides he needs professional help. In that state the

physician asks how he can help. The patient understands this as a promise

of the possession of skill and knowledge and a promise that they will be

used in the patient's best interests" (p74).

Within the professional practice of the clinician should be embodied absolutes such as 'do not kill' and 'act for the good of the patient'. The professional also has responsibilities to maximise choice, keep promises, and preserve dignity. Although these obligations can be explored by the CEC in relation a case, it has no more expertise to make judgements and recommend on these issues, than the clinician themselves. The CEC members may, however, be obliged to challenge actions that may not appear to be in the best interests of the patient in a given situation, and to support an exploration of why this may be the case.

The CEC, rather than promoting themselves as experts in ethics, a role they do not need to fulfil, should promote themselves as catalysts and facilitators for ethical review, a task in which they could achieve performative expertise if supported by the organisation and trained appropriately to do so. This CEC activity is directly aimed at supporting the clinician to cope with the difficult situation, and its emotional and practical repercussions. Steinkamp et al (2008 p185) argues that "the main goal of clinical ethics is to improve the quality of patient care by identifying, analysing and attempting to resolve the ethical problems that arise in practice". They add "Referring to Dreyfus and Dreyfus, it could be shown that moral competence, prior to ethical reflection, plays a significant role when moral problems are to be approached." But ethical competence within the CEC should represent the level of knowledge that may be sought by any clinician, in clinical practice.

The model promoted by Dreyfus and Dreyfus (1980) explores the concept of coping with skill acquisition, and this appears to be what clinicians are aspiring to do in the clinical environment, when wrestling with ethical issues. They are attempting to cope with the stresses of balancing interests, and reaching a solution to a problem, in an often restricted period of time. As Dreyfus and Dreyfus (1980 p8) state "Competence comes only after considerable experience actually coping with real situations" which are seen as "no longer context free".

Appropriate promotion of the role of CEC, to reflect that CECs were established to support clinicians in coping with difficult decisions, will remove any incorrect assumption on the part of the clinician, that the group can prescribe an action that must be adhered to, because of its 'expert' status. Then, CEC will be able to focus on supporting practitioners, to enable clinicians to make sense of complex clinical situations, and so reach their own decisions. According to Weinstein's (1993) idea of expertise, this could be seen as performative expertise, which is described as the ability to perform a task well.

3.6 Clarity about the legal standing of CEC activity.

CECs have responsibility for the advice they give and for ensuring the quality of their processes of deliberation. Although CEC recommendations or advice in the UK cannot be seen as legally enforceable, and for previously mentioned reasons should not be, the processes and outcomes of CEC deliberations do have legal importance and will have ramifications for members of the CEC the clinician and the patient. CECs in the UK are neither benign groups without any organisational influence, nor juries that can make legally binding recommendations. As Somerville (2004 p180-181) explains CECs can be held accountable for their actions or advice if they fail to act as "reasonably competent" committees. It is thus

important for CECs to consider their role, and purpose and be able to justify their actions accordingly. If their role were to facilitate effective thinking around ethics, as an ethically and procedurally competent diverse group, then the legal expectations of their activities would reflect the expectations of that role. As Somerville (2004 p180) argues "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". Therefore, CECs have a responsibility to ensure that procedures for membership, representation, review processes and group education are robust, and that the influence they exert is as far as possible, grounded in good ethical practice in the groups themselves.

A binding legal recommendation is not required in order for a CEC to have a positive influence. In fact, it may serve to jeopardise the positive moral influence that the CEC members would hope to have on the clinician, through role modelling and support. The legal aspect of a situation is often intrinsically linked to, but separate from, the moral and ethical issues. Although a lawyer is not an obligatory requirement on the CEC committee, as with theoretical moral expertise in the form of a clinical ethicist, the skills a lawyer can bring to the group may be useful. Hendrick (2001 pi50) states:

> "for some commentators law and legal expertise is very welcome, enriching and enhancing ethical analysis, particularly when applied to such legal concepts as informed consent, best interests and advance directives. The explicitly analogical nature of law and its clear articulation of distinctions among cases can likewise improve ethical analysis and study".

Many CECs whilst recognising their role within the law do welcome lawyers to be involved or linked with the CEC as they recognise the inter relationship and that there may be a need to clarify some legal questions that arise in the case or issue discussions. The CEC, of which I became a member, valued the support of the trust lawyer and found his clarification on matters of statutory aspects that influenced the cases very valuable and enlightening.

Example from practice

In palliative care, there are rules underpinning professional responsibility, specifying practitioners' legal obligations with regard to euthanasia. In an objective sense, it can be seen that, if asked a question concerning euthanasia the CEC can give advice (after relevant consultation) on the general legal and professional position, such as the criminality of the healthcare professionals taking another's life as primary intent. This is information that is clearly within the public domain, and accessible. The following is a description of a recent case in the clinical area. It highlights the delicate balance between legal and moral ethical issues, and the grey areas of practice.

A man being cared for at the hospice was gravely ill. His daughter was extremely distressed at the situation, and also with the problems the specialist team were experiencing whilst attempting to control his complicated pain. Despite all attempts to offer pain relief, the patient was often distraught, and sometimes described his feelings of hopelessness and wanting to be out of his misery. His daughter was constantly at his side, and was witnessing her father's pain. This resulted in her clearly expressing a wish to have him home so she could "end his suffering". On questioning, her views did not alter and, despite the seriousness of her statement being made clear to her, she repeated her distress and the statement. This matter

was clearly of great concern to all involved and third-party advice was sought. A plan was put in place after discussions with the police and social workers, amongst others. The ethics committee was also able to advise about potential strategies, that could be adopted in the light of the threats. In an objective sense, would sending the man home be an act of negligence in the light of the conversations with the daughter? How much weight should be placed on the daughter's distress? Should an already-distraught daughter be subjected to police processes, given that death threats are not acceptable according to the law? The questions raised by this case were numerous. All of the above mentioned ethical considerations had to be judged against and within the constraints of the law. Despite the compassion for the man's daughter, if she clearly repeated her desires, despite having been made aware of the potential consequences, a decision would need to be made about whether to involve the legal system. The professionals facing such a complex dilemma could not simply rely on moral maxims and rules to guide them. They had to be considered as part of the larger, more complex picture, against other competing legal rules and professional responsibilities.

As law can influence morals, so feelings about the appropriateness of a law can stimulate a call for its change as it may be wrong, outdated or misguided. It may be that, through deliberation and review, the CEC becomes aware of legal rules that require challenge or modification. Society is an organic and evolving entity and, through the work the CEC is involved in, it may become aware of discrimination, unfairness and the need to challenge trust policy and even legal rules. There are examples of agreed legal rules prohibiting activities that appear to

be right, such as a "law against criticising the government" or a "law that requires racial segregation" (Nagel 2004 p190 in Sommers et al 2004).

In the case of issues that cannot be resolved except in a legal sense, recourse to the law may be the only option that can be considered, or advised by the CEC. Recourse to statute will sometimes help resolve issues. Appropriate referrals for legal advice or review, will depend upon the group being educated and insightful enough to identify when a legal issue is paramount and needs to be addressed.

Are the CEC members at present educated to appropriately identify legal issues and ensure that appropriate advice or intervention is sought?

Pedersen et al (2009) found that a number of CECs he observed failed to recognise that, in some cases, legal issues were a problem:

> *"In most of the committees, some members asked what kind of actions would be lawful.………However this kind of question was often not answered or was sometimes answered erroneously. Although only one of the participating committee members present in this study was a jurist, only three committees mentioned that they would have considered seeking legal advice" (p150).*

In conjunction with this, the legal standing of the groups is made difficult and ambiguous by their ad hoc and voluntary nature. As Hendrick (2001 pi50) states:

> *"the vulnerability of committee members to legal action is difficult to assess with any certainty. This is because the CECs that have been set up in the UK are, if the American model is followed, likely to vary significantly in terms of their functions, procedures, composition, structures and authority".*

Training to assist with clarification of salient issues, including legal ones will assist with this and should be a prerequisite for any CEC member engaging in case review activity, and a clearer role and purpose will address both these issues. Lawyers linked to CECs can also play an important role.

Hendrick (2001) identifies two key roles that may be undertaken by lawyers, within and associated with the CEC. The first role suggested is that they use their skills and training to clarify the salient legal issues to be discussed by the CECs. This can be done through education, starting by educating committee members about the law "dispelling common legal myths and explaining what the law allows" (Hendrick 2001 p i50). The lawyer could then "contribute to seminars, lectures and other forums designed to educate hospital employees about legal and ethical aspects of treatment and so forth" (Hendrick 2001 pi50). Secondly, the ability of lawyers to scrutinise and question guidelines and documentation for review is promoted by Hendrick as another important function. The identified strengths of the lawyer may be best used in a more formal, structured case review but sometimes the deliberations of cases are more a process of debate and consultation, and here their role can be seen as clarifying the legal repercussions of different actions considered. In terms of possible areas of legal input, it does appear important that the members of CECs receive education about the legal aspects of cases. Education should offer CEC members the opportunity to improve their skills and enable them to more confidently clarify the legal issues of a case. This in turn will enable them to involve experts when it is appropriate and to understand more fully the role of those experts. This said, too rigid a framework or reliance on structure, rule or edict will inhibit the value of less-structured 'case discussion' that allows everyone in the group to express an opinion without feeling

hindered by their lack of knowledge, standing, power or ability to present a critical, legal argument.

3.7 How would a CEC recommendation be seen in the UK courts?

Hendrick (2001) identifies the confusion and different approaches among different courts in the USA towards CECs. Some have taken into account the deliberations of the committees, especially if they have documentation and can identify the processes used to back up their decisions. Other courts have rejected their findings. Despite this Hendrick (2001) reflects:

> *"Nevertheless in view of the UK courts' traditional deference to the medical profession, it is unlikely that they would seriously challenge a CEC's decision—unless of course, it failed to comply with a responsible body of medical opinion" (Hendrick 2001 pi50-53).*

It is only a matter of time until a CEC is asked to account in a court of law for its deliberations and recommendations. As Hendrick continues:

> *"it would almost certainly be a negligence claim, in which it would be alleged that there was a failure to exercise due care in giving advice or making a recommendation and the patient suffering injury as a result" (2001 pi50-i53).*

Therefore, just as it has already been argued that the CEC members need to gain grounding in the key issues pertinent to ethical review, they should also receive education and support to enable them to reach a level of competency, to identify legally relevant issues to enable them to refer for appropriate advice as required. As the evidence from Pedersen et al (2009) shows, it cannot be assumed that

deliberations will attend to the relevant legal aspects. Access to training and support will increase the chance that the legal issues are identified.

Concern over the perceived weight of the outcomes of their deliberations, and confusion over the binding nature (or not) of their recommendations, is closely related to the CECs influence and whether it is seen as a tool for imposing the agenda of management or trust. If CECs are to survive as credible bodies, they have much to do to improve their position. To live up to the claims made about them and the task they have set themselves, there needs to be a greater clarity and homogeneity of purpose. At present, there are a number of significant ethical concerns regarding the existence of such groups. This is an important issue, not only morally, with respect to the responsibility they hold over people's lives, but also legally, as by their nature they are ascribed with legal responsibility. Such groups cannot be dismissed as mere talking shops. Campbell (2001 p480) argues for the potential benefit of deliberations by CEC in assisting with court decisions, stating:

> "In the same way that clinical practice guidelines help courts discern whether professional conduct was reasonable and consistent with accepted practices, so may ethics codes guide their assessment of moral underpinnings of professional choices and behaviour. More specifically, they illuminate principles that are valued in a community and a society and thereby help courts decide whether medical decisions and conduct uphold and promote these moral underpinnings".

In the American system, the avoidance of litigation and legal action underpins CECs reason for existence. As Fleetwood et al (1994 p320) states "Institutional Ethics Committees in health care facilities have been hailed as a good way to

resolve complex ethical issues in patient care while avoiding the costly, often adversarial, legal system". In the USA, some individuals who acted upon CEC recommendations have been indemnified, as they were following the recommendations of a body ascribed with the power to reach such conclusions. Fleetwood (1994) argued that such immunity in the USA would enable doctors to implement difficult treatment decisions, after consulting with an ethics committee, without having to worry about future legal repercussions. The status of the CEC is different in the UK, however. Here, Gillon (1997) suggests that many see CECs as a "chorus in a Greek tragedy" rather than a body with legal influence:

> *"The chorus offers advice and history and support for the*
>
> *protagonist....establishes a moral resonance for the hero's fate" (p204).*

Campbell (2001 p476), a Canadian lawyer, calls such deliberation and guidance "soft law", categorising it with non-regulatory and non-legislative sources that advise on action. Other sources include "ethics policy statements, and codes and guidelines from professional or quasi-governmental bodies". Although she was writing from a Canadian law background, I believe that many of her comments are relevant to UK committees as, through their existence, remit and scope of activity; they have a position of power, influence and responsibility and are accountable in law. Based on Campbell's definition, the CEC could certainly be considered an instrument of "soft law". The deliberations of such committees would be seen by many as weighty in a legal context. Some argue that such "soft law" recommendations should be shown deference by the courts, given judges do not usually have sufficient expertise in the field on which the group is deliberating, or the subsequent standards that emanate from it "and thus are not fit to substitute their own view for professional opinion" (Campbell 2001 p476).

In the UK, the supportive nature of the groups should be stressed, and the ultimate autonomy of the clinician-patient relationship held paramount. It is nevertheless the case that, if the dilemma became a legal dispute, then the CECs recorded deliberations, and its recommendations made on the basis of these, would be held as part of the record of events, and the clinician's actions would be measured against them.

Therefore, it can be seen that the role of the CEC is not straightforward with regard to ethical or legal expertise. Promoting the non-expert nature of the group may help their aims of facilitation of reflection on practice. This does not lead the group to dismiss their legal and ethical responsibilities, to the clinician, patient and society. As with every healthcare body, the CEC deliberation processes and advice offered should be subject to review and appraisal, and this may be through the legal system if required. This should oblige the CECs to consider their processes, and justification of their actions as a group. It should ensure that they address their processes of review, to ensure that they do offer support that is aimed at developing the moral confidence of the practitioner, is about not promoting themselves as experts, and does not accept abrogation of the clinicians responsibility for the decision. The CEC needs to accept responsibility for their own training, advice offered and methods used to offer support. In the UK, as will be discussed in later chapters, this should be done by accepting each member requires a prerequisite training in ethical awareness and communication skills. This training will aim to maximise the CECs ability to, recognise ethical and legal issues, offer empathic support, facilitate reflective practice effectively, and support teams to manage conflict. It also makes it imperative that after over 20 years of committee development the training and activity of CECs needs to be

comprehensively and formally evaluated nationally as to their ability to do this and if improvements need to be made they should be nationally driven. Just as CECs exist to support clinicians to explore the complexity of their actions and justify their behaviour CECs must take the lead and do the same.

The thesis so far has considered, the general benefits of having a CEC within the organisation, the important messages the CEC has to promote, which ensure that they are best positioned to maximise the benefits they can offer, and also their non-expert status, which places them in a good position to support the clinical teams in practice. The next chapter will explore the role that they can play supporting the teams in context particularly with regard to conflict management.

<u>Chapter 4</u> Context matters CECs can support decision making in context.

4.1 The CEC role is to support good practice in context.

This chapter will explore the benefits offered by the CEC to the clinician to assist them to manage ethical issues in their work context.

CECs should not seek to recommend an action out of context, as this would not develop the moral confidence of the practitioner, would risk missing important contextual elements that influence the decision, and could lead to the perception that clinicians could abrogate responsibility for a difficult decision.

The CEC offers a valuable safe space for the clinician to explore their obligations, consider others' alternative interpretations of the situation and weigh up options to address dilemmas. Solutions identified during the course of the reflection, facilitated by the CEC can then be applied by the clinician within the clinical arena. Confidence gained by experience of such a process can improve skills of judgement and team working which can then be used in future situations by the practitioner.

The nature of the changing environment undermines the confidence that the CEC could have in the decision being appropriate. The clinical environment is complex and situations are rapidly changing, this does not support decision making out of context as the changing context could invalidate a decision moments after it has been made.

As Hartrick-Doane et al (2009 p237-238) reflect that one element very noticeable in their research on ethical inquiry in nursing practice was the constantly changing pace of events, which led to the need for adaptations to the original premises.

They state:

> *"the pace, number and nature of the changes on nurses' ethical practice*
> *was in itself a significant finding. It was challenging to 'fix' something (in a*
> *problem solving sense) because nothing was fixed (people, contexts,*
> *decisions, actions were ever changing). For example, during our time on*
> *the unit, there were several changes in senior administrative posts,*
> *including a change of CEO and a change of Chief Nursing officers in fairly*
> *short order. Similarly there were budget cuts, changes in bed utilization*
> *policies, staffing ratios, and so forth".*

Within complex healthcare situations there is ambiguity, and events may not be as they first seem. This is described by Schon (1983) as the "swampy lowlands of practice". Often there is a need for clinicians to take time out of practice to consider and clarify what is actually going on. This is described as reflection on practice rather than reflection in practice. CECs offer an opportunity to reflect on practice in the workplace. There tend to be issues which stimulate requests for CEC involvement. DuVal et al (2001 pi24) state:

> *"One hundred and ninety of the 344 responding physicians...reported*
> *requesting ethics consultations for ethical dilemmas related to end-of-life*
> *decision making, patient autonomy issues and conflict".*

The CEC has a role to support teams to manage conflict in practice. But this role must be to assist them to develop their own skills to manage the inevitable value conflict that arises out of having a diverse workforce and patient group. Differing cultural, faith, professional and social influences will undoubtedly lead to

disagreement from time to time. How effectively respectfully and assertively the team manages these will influence their performance and outcomes.

4.2 Why promoting effective teamwork to manage ethical conflict is an important endeavour.

As McGrath et al (2006) point out, in contemporary healthcare practice the multi-disciplinary team (MDT) is seen as being at the heart of good quality patient-focused care. Due to its complex nature the notion of the effective team is difficult to define. As Mickan et al (2000 p201) state "Effective healthcare teams often elude consistent definition because of the complexity of teamwork". This complexity especially in situations where values are at odds can lead to conflict. Edelstein (2009 p342) identifies conflict in the following way:

> "in the context of bioethics, conflict emerges when patients, surrogates or clinicians perceive that their goals are being thwarted by the incompatible goals of others. These 'others' may be individuals, such as family member or clinician, or they may be systems that are at play in healthcare.........Because of the multitude of actors that necessarily have a stake in healthcare decisions and the inevitability that their interests will not always align, conflict is inherent in ethics consultation".

The complexity of the situation can mean misunderstandings can occur simultaneously, on a number of levels, and to different people within the situation. The culture of healthcare is ethnically diverse with a:

> "wide disparity of knowledge, power and control experienced by the various players. While most conflicts involve some disparity between parties, it is

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unusual for this to be as markedly institutionalised, as is in the case in

healthcare" (Marshall 2006 p6).

Marshall (2006 p1) identifies conflict as an inevitable factor in nurses' daily professional lives. Ethnic diversities, gender inequalities, issues that involve the challenging of strongly held personal or religious values, have been identified by Marshall (2006) as reasons why the cultural mix of a healthcare institution should be fertile ground for ethical tension, debate and conflict to be part of everyday life. According to Edelstein et al (2009 p343) conflict explored in an ethics consultation is likely to revolve around three key areas. These are substantive needs (the issues in dispute), procedural needs (which may centre on the need for justice and fairness to facilitate resolution of the conflict), and psychological needs (the need to be heard and understood).

Empirical evidence is also emerging that concerns brought to the CEC often surround conflict. In a recent study of 400 doctors from Norway, Switzerland, the UK and Italy by Hurst et al (2007 p54) doctors identified the following issues as the ones they experienced most often with their patients: uncertain or impaired decision-making capacity (94.8%), disagreement among caregivers (81.2%) and limitation of treatment at the end of life (79.3%).

The Thomas Killman Instrument (Killman 2012) identifies five ways individuals may respond to conflict. These are avoidance, being competitive, accommodating, compromise and collaboration. Working together to manage value conflict can improve outcomes for patients. As Marshall (2006 p5) states:

"In most situations the best outcomes will be achieved if the parties involved

in the problem work together towards a resolution in a collaborative way.

The types of processes that work well can be generally described as interest-based approaches. Using an interest-based approach means that the parties who are in conflict focus on the interests or needs that lie beneath the conflict, rather than focusing on the positions that they may be taking."

Conflict leads to negative emotions that can hinder effective working practices.

As Molewijk et al (2011 p258) identify emotions play an important part in moral life. Often referral to the CEC has been stimulated by the emotional impact of disagreement within the team. Such emotions as in the case of Marion, discussed in the introductory chapter, can lead to communication breakdowns between team members and family. DeRenzo et al (2006 p320) reflect that communication breakdowns and conflict do trigger referrals to the CEC stating:

"*the consults show that there are significant communication breakdowns between clinicians and patients, and/or family members, and that these communication problems have direct negative effects on the therapeutic relationship. That is, by the time a formal ethics committee consultation is called, there is more conflict than can be managed at the level of treating clinician(s) patient and where relevant, family, but, to our minds, conflict could have been avoided".*

Conflict undermines the stated objective of healthcare teams, which is to provide patient focused care. As Ramsay (2002 p138) states "conflicts can have an adverse effect on productivity, morale, and patient care. They may result in high employee turnover and certainly limit staff contributions and impede efficiency". In addition to the previously stated effects, Marshall (2006 p7) identifies that recent

American research into "patient safety and medical error indicated that positive working relationships within healthcare teams have a significant effect on safety and efficacy of the care we give to patients". Marshall (2006 p7) continues that communication, collaboration and respect among the health care team members, is a vital component that contributes to the provision of safe, quality care to patients.

The CEC can have an important place in assisting the clinician with this conflict, not by making a recommendation out of practice but by assisting the team to work through the issue causing the impasse using skills to encourage reflection on practice. Effective use of reflection on practice within the CEC can challenge prejudice and bias, can stimulate holistic review of the ethical dilemma and can promote creative thinking about solutions for individual clinicians and teams. Demonstrating the power of effective reflection within the CEC can challenge of the traditional notion that underpins medical practice that application of rules and principles to provide an objective answer is the only way to solve issues. As White et al (2006 p78) state such reflection "challenges the view of practice as the achievement of fixed, unambiguous ends using rule governed thinking ". A well-structured CEC which uses a model of reflective practice has the potential to benefit the clinician in a number of ways. Such ways will be outlined below.

How the CEC can offer the clinician effective support to manage conflict?

The CEC can provide a safe forum where dialogue about the clinician's beliefs can begin, recognising that the clinician will eventually have to make his own decisions in context. This is fundamental, as context specific issues which may be non moral and moral will shape the rightness or wrongness of the decision being made. Charalambous (2008 p640) cites Wiklund et al who states "Nursing tends to view

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the person as one who is constantly interacting with the environment, interpreting impressions and ascribing personal meaning to his or her experiences". Watts (2007 p69) identifies that dialogue is a central tool to the discovery of the perceptions of the stakeholders in the situation stating "first there is the live action of talking - relevant here is the identity and personality of speaker and listener, their relationship and the circumstances of the nature of the interaction".

Through facilitated reflection on practice participants can gain a greater understanding of the case or issue. The problems once discussed may not be as intractable as they first appear due to the inability of the team to see a way through the conflict. De Renzo et al (2006 p319) recognise this fact when considering referrals to their HEC. They reflect that:

> "the majority of consults are about issues that we believe the clinicians should have become skilled, by now, in handling themselves. In analysing this growth in demand for ethics consultations, our records demonstrate that the majority of consults are called because communication-based conflicts have arisen in the care of our patients who have terminal and/or end stage conditions".

Agich (2011) identifies that we should clarify issues not by listening to the 'facts' of the case but by attending to the relationships involved in the situation and the feelings around those relationships.

Agich (2011 p276) reflects upon a case he experienced that could have been approached either analytically or empathically which would have yielded a different outcome which involved family conflict over the application of a DNR order for a parent stating:

> "*So often, ethics cases are regarded as matters of ethical analysis and argumentation. The analytical goal is to identify the issue involved in the case and the procedure for resolution is to provide arguments and reasons for following the ethically permitted or required approach. In this case, the issue was analytically simple. Since two of the three children concurred with the DNR order, the ethics consultant could have simply authoritatively informed them of the law and that the physician was authorized to write a DNR order given the agreement of the two children…However, it had the significant disadvantage of inflaming emotional wounds among the family members and it would have provided a powerful negative example for the critical care team…that sensitivity to the emotional needs of a family in distress is less ethically important than reaching a justified result.*"

Sometimes the need to minimise distress overrides the need to adhere to a rule.

The CEC using an appropriate structure can enable clinicians' and their teams to reflect upon not only rules but emotions and values and find strategies for managing the situation balancing all the different moral and non moral issues. Attempting to find consensus, focusing on the purely analytical moral arguments, and seeking to persuade another to a point of view will fail as a strategy to find satisfactory resolution to an ethical conflict. Seeking consensus on values assumes that we all have the same basic views and assumptions, and therefore

agreement can be found. Within a pluralist society, values and assumptions reflect differing approaches to the world, and are different. As Wildes (1993 p506) states:

> "the history of moral philosophy is filled with different conceptions of moral reason and different rankings of moral values. Moral controversies occur precisely because men and women do not share basic values and assumptions".

The role of the CEC is to support the identification of causes of value conflict. They can assist exploration of such conflict in order to find solutions, and facilitate the clinician to find strategies for managing such disagreements, with a view to de-escalation, resolution of the tension and compromise. Alongside this CECs should and can offer emotional support to team members and this should include families if required and CECs should expect that this emotional support will be also one of their key roles. Vieth (2011 p295) argues that ethical evaluations of a situation may include a strong emotional dimension, and cannot be discussed by recourse to objectivity and reason:

> "Ethical consultations should include emotions. Emotions like shame and guilt are complex and learned reactions of persons, which form one basis of ethical reflection. I argue that ethical consultation can rely neither on a strict theory or method nor in a philosophical theory that is external to the situational triggers of consultations in the clinical setting".

Another role the CEC can play is one of 'devil's advocate' Rangel (2009). Because of the relationship developed between the CEC and the clinician, the clinician may wish to share concerns about standards of professional practice. Concerns may be workplace disagreements but sometimes these disagreements will raise

concerns about poor practice, abuse, or other issues that need to be challenged, or may need referral to an agency outside the group. This referral could be a daunting prospect for the clinician. The CEC using their shared wisdom can present counter arguments to challenge inconsistencies, and can raise the issue of further action that may need to be taken, morally, professionally and legally, and clarify the clinician's obligations in this respect.

A member of staff may be concerned about an element of their team's decision making, and feel they have a professional and moral responsibility to explore, and even challenge some issues. Fostering an environment where staff feel empowered to question is an important role for the CEC. Challenge in itself can be a healthy way of questioning, and can alert teams to aspects of the situation they may have missed, or areas that need development or change.

Occasionally, aggression may be aired within CEC discussions, and the supportive group will need to have considered, in advance, how such a situation will be handled, and de-escalated. If this aggression is being experienced by the individual within their workplace, then strategies to manage this may be shared and explored within the safe forum of the CEC. If questioning of a decision raises anxieties or disagreements within the decision-making team, conflict may lead to the triggering of abuse. As Ramsay (2001) identifies, conflict can range from a minor disagreement to violence and abuse can take many forms, some of which the perpetrator may not even think of as abuse:

> *"The hostile environment may be the result of abusive behaviour by other employees, supervisors or physicians. The abuse may take the form of a demeaning attitude, ridicule, off colour jokes, sexual harassment, or even physical violence" Ramsay (2001 p138).*

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Such behaviour can lead to subjugation of junior staff, a culture of repressed emotions and ideas, and a feeling that challenge is prohibited. This is particularly an issue within healthcare professions, as it has been identified that medical personnel may be lacking in "emotional intelligence", despite their high levels of academic achievement. Fernandez et al (2013 p241) state:

> *"Recent work from the Center for Creative leadership....reports that the healthcare sectors top priority for leadership development is improving the ability to lead employees and work in teams (CCL 2010)".*

However, this skill, along with self-awareness was rated lowest of the skills actually demonstrated by healthcare leaders (CCL 2010). Emotional intelligence allows the practitioner to consider the impact of their behaviour on others, and modify and adapt to take account of the needs of the team. Often use of emotional intelligence will enable a difficult decision to be overcome, and for change to happen, because emotionally intelligent practitioners are respectful, are able to accept comment and criticism, and can be flexible. The CEC can have an important role in supporting staff struggling to address abuse, or who are unable to challenge another member of staff, about their practice.

As a supervisory and supportive group, promoting dialogue CEC members can effectively act as mediators facilitating good teamwork and communication through clarification and strategy planning. The opportunity to consider a range of perceptions, allows the clinician to gain a greater understanding of his own position. The clinician can be assisted to reflect upon why, intuitively, this circumstance feels uncomfortable for him. This could be because the context may be making certain principles conflict, such as autonomy and justice, and may be challenging principles the clinician considered to be absolute. The skilled CEC as

facilitator for reflection may be needed, as conflict and emotion may make reflection and clarification difficult to achieve without support and guidance. There may be vested interests in maintaining a certain position in relation to a decision, and a need to stay in control for some of the team, or simply fear about being seen to be "wrong". These issues will all hinter the process of action planning and at times may require challenge and facilitation of expression of emotion or beliefs which can be offered by the skilled CEC.

A recent healthcare example where the CEC may have been some assistance is in the case of the mother in Ireland who was carrying a severely disabled child with deformities not viable with life. The mother's life was at risk as she was in organ failure due to the pressure of carrying the child. The medical team resisted abortion as they held a strong cultural and religious belief in the sanctity of all life and wrongness of abortion. Without removal of the child from the woman she would die what should they do? The team needed to find some compromise in relation to their competing obligations to the mother and child. The skilled CEC could be of assistance to allow expression of belief and emotion in this difficult case and support open debate about possible solutions in a safe and judgement free environment. Increased awareness through case review by the clinician contributes to their development of moral maturity, by enabling them to see that even in the most difficult cases a resolution can be found and by offering them a framework by which they can consider future cases when duties conflict. There is also acknowledgement that this is difficult and it is not a failure but strength of the team that they find themselves grappling with such difficult issues, as they are aware that they need to balance a range of differing perspectives to reach a compromise solution.

Gracia (2003 p230) identifies that ethical deliberation is not an easy task, adding:

> "Some professionals make decisions quickly, as a reflex reaction, and do not go through the long patient evaluation processes. This is often justified by appealing to the so-called "good clinical eye", others think they have good moral instinct…These professionals think they already know the answer, and there is no need for deliberation. This is usually due to fear or a lack of confidence as regards the deliberation process. For this reason, practicing deliberation may be said to be a sign of psychological maturity".

In Chapter 5 and 6, I propose a new model of reflection to be used within the CEC to structure reflective practice to enable a process of reflection to occur that assists the clinician to address the ethical and practical issues raised. I have named this the ASCS model. Using this model the CEC can demonstrate performative proficiency with regard to issue identification and an effective, facilitative, solution focused, reflective questioning technique. In the CEC, reflection needs to be offered using a structured model, not in an ad hoc way, with the clinician present, to maximise benefit for the clinician bringing the issue. As Gracia (2003 p230) states:

> "The deliberation process requires careful listening (anxiety prevents a person from listening to another, precisely because they are afraid of what the other might say), an effort to understand the situation at hand, analysis of the values involved, rational argument of the possible courses of action and of the most appropriate one, non-directive advice and help even if the chosen option by he or she who has the right and duty to make this choice does not coincide with that which the professional considers to be the correct one, or else referral to another professional".

None of this can be achieved without having the clinician as the central point of the review process. The supportive role of the CEC cannot be achieved without the CEC building a relationship with the person bringing the case.

Moral discourse within CECs is happening. Weidema et al (2012) discuss the use of moral case deliberation in ethical discourse in healthcare within the context of the Netherlands. This moral discourse is used to offer an opportunity for structured reflection on current issues, with a facilitator for support who may or may not be an ethicist. According to Weidema et al (2012), the popularity of moral discourse within groups is increasing within Dutch healthcare institutions. Weidema et al (2012 p1) explains that this is because they give clinicians the opportunity to "(1) deal with moral questions, (2) improve reflection skills, interdisciplinary cooperation and decision making, and (3) develop policy".

Groups per se are seen as an asset when discussing issues around ethics and decision making. Rangel (2009 p208) identifies some of the perceived benefits of groups:

> "Groups are often assumed to be superior to individuals as decision-making entities. In particular, groups are often seen as able to represent a larger and more diverse set of perspectives, constituencies and backgrounds. Thus they are viewed as more fair by providing a voice for a greater segment of the population affected by the outcome".

This view is echoed by Lunenburg (2010 p1) who states:

> "What advantages do groups have over individuals in making decisions? Some advantages of group decision making include the following: greater sum total of knowledge, greater number of approaches to the problem,

greater number of alternatives, increased acceptance of a decision, and

better comprehension of a problem and decision (Gunnarsson, 2010;

Proctor, 2011).

Rangel warns this is not always seen to be the case, and decision making by an individual alone can be perceived as superior in defined particular circumstances, but generally the evidence supports that group discussion can offer a range of insights to help enhance and clarify issues emerging in practice. Slowther et al (2004 p14) identify the following perceived strengths of a CEC: it is easily recognised as part of the institutional structure and therefore has more influence with both clinicians and managers; the multi-disciplinary membership provides different perspectives; group thinking promotes wide discussion; they are relatively easy to set up. This diversity of non-expert membership offers a service that is different to individual formal clinical ethics advice, and brings debate over ethical dilemmas back into the heart of practice.

 Dörries also identifies this (2011 p202):

> *"The development of CECs has shown that attention paid to conflicts of*
>
> *values can be something other than an academic activity; that it is both*
>
> *possible and useful to extend the discussion of such questions to health*
>
> *professionals other than doctors and that moral deliberation has a place in*
>
> *the hospital alongside scientific debate."*

This diversity should be welcomed, and CECs should positively encourage a range of members from lay, academic and medical backgrounds, amongst others. Rangel (2009), based on a review of the literature about decision making in ethics committees, argues that there needs to be diverse membership, and the groups

should not just be made up of clinicians. She states, "other disciplines such as social workers, chaplains, patient advocates, administrators, philosophers and theologians, should be more regularly represented" (2009 p221) on CECs than they are presently.

There has been evaluation of reflection on ethical issues with the clinician in a group setting. van der Dam et al (2011) describe a form of reflective case review as moral case deliberation (MCD). They evaluated a model of moral case deliberation by clinicians within two Dutch nursing homes. van der Dam (2011 p328) describe the process below:

> "In MCD health care professionals sit down together to systematically reflect on one of the moral questions from their practice. These questions can be case-specific (e.g. 'what should we consider as the morally right thing to do in this specific situation or how should we do it rightly?') or more philosophical or conceptual (e.g. 'what is respect? or 'what does understanding mean?'). MCD can have several goals: a) to reflect on the case and improve the quality of care within that case, b) to reflect on what it means to be a good professional and to enhance professionals' moral competencies and c) to reflect upon institutional and organizational issues and to improve the moral quality of care at that level".

van der Dam et al (2011 p328) describe the benefit of dialogue as:

> "emphasizing the interrelatedness and dialogical nature of human beings and necessity of intersubjective reflection; moral judgements arise out of dialogue among open minded people in practice.

Inspired by Gadamer, dialogue is understood as an ongoing, social learning process in which participants develop new, and richer understandings of their practice, what Gadamer called a 'fusion of horizons'. The outcome of a dialogue cannot be predicted and cannot be reduced to prior positions. It requires openness and engagement to acknowledge the limits of one's own perspective and to change in interactions"

In the van der Dam et al (2011 p332-3) study of the use of reflection within nursing home groups the following benefits were identified; greater awareness of the moral issues of others, more informal communication about moral issues, and enriched moral enquiry.

There are identified limitations of MCD though. van der Dam identified these as; problems experienced due to differing levels of moral competence, a favouring of issues to discuss that were appealing to the group, a sense of distance from practice, and a sense of concern about how to facilitate solutions with the rest of the team.

The ASCS model addresses the previously identified concerns that unstructured reflection alone may still leave the clinician unsure about how to address team issues that are raised. The van der Dam et al (2011 p337) study identifies that:

"Participants of both the ethics rounds and the MCD groups shared experiences of 'frustration with a lack of solutions' and 'resignation to non change' in the sense of a gap with the rest of the team and the lack of time for reflection in current daily practice. This means that intersubjective ethical platforms may create expectations regarding improvements in their daily work and quality of care".

van der Dam et al (2011) identify that it is important to point out to the team the nature of the difficulty of moral dilemmas, and that they cannot always be resolved, to the satisfaction of all. Within the Dutch nursing homes MCD was set up using a dialogical method. The dialogical method underpins my proposed ASCS model of reflection, but adds a clearly laid out problem focused structure to the dialogue which is different to MCD. The ASCS model, discussed in the next two chapters, offers a framework by which team can debate cases or issues which may be causing value conflict, and also offers a framework which equips the CEC with appropriate skills, to facilitate the formulation of solutions and compromises by the clinician. This method is evaluable and it is hoped when used will yield some evidence to address the concern raised that reflection may be useful to release ethical tensions but limited as a model to provide solutions or actions as this model is action focused. Active involvement in decision making either with the support of the CEC, or using skills refined by working with and being taught by an effective CEC, can improve decision making through practice. Michie (2002 p5) cited research that identified the following improvements for those actively involved in decision making and problem solving:

> *"Those taught skills to mobilise support at work and to participate in problem solving and decision making reported more supportive feedback, feeling more able to cope, and better work team functioning and climate. Among those most at risk of leaving, those undergoing the training reported reduced depression. Staff facing organisational change who were taught skills of stress management, how to participate in, and control, their work showed a decrease of stress hormone levels. Staff taught verbal and non-*

verbal communication and empathy skills demonstrated reduced staff

resignations and sick leave".

As identified earlier the CEC does not have sole responsibility for managing conflict within a healthcare case brought before it. It is important, however, that the CEC is sufficiently aware of the behaviours that may arise out of, or contribute to, conflict. Such behaviours may be motivated by differing emotions or rationales, but will often have a negative impact on the team's ability to address the dilemma, by inhibiting open and constructive discussion among members of the team. As Ramsay points out, within any healthcare group, the:

> *"dysfunctional physician presents an insidious cost to any practice or health*
>
> *care organisation. He or she increases the stress in the work environment*
>
> *and the accompanying loss of efficiency. In a stressful workplace…morale*
>
> *and team spirit suffer…communication is poor, and staff withholds*
>
> *information because of fear of an outburst. The information withheld may be*
>
> *vital for patient wellbeing".*

An opportunity to reflect on practice, with the support of the CEC, may offer insights into issues previously unrecognised. An example of this can be seen in relation to communication skills awareness. Having been involved with communication skills training for many years, many clinicians are unaware of the impact of their non-verbal behaviours on others. Their non-verbal responses, although very influential, are often unconscious. A gentle raising of awareness, and a safe environment in which to discuss the impact on the receiver, can offer the clinician the opportunity to re-consider their behaviour. This cannot guarantee change, but it can at least begin the process to be more likely to allow change to

happen. Without such awareness, there is no possibility of this process ever starting.

Within the CEC there is a vital opportunity to raise awareness of conflict behaviour and explore solutions for change. This can only be done if the CEC recognises the impact on the issue being debated of such behaviours going unchallenged. Fostering clear and assertive communication within the CEC can also minimise the risk of further conflict being generated as diverse views are discussed. Clear terms of reference must be available to all involved with a CEC. As Ramsay (2001 p139) argues "To prevent conflicts a professional code of conduct should be established, not only in the hospital but also [as] part of group practice policies." It is important that linked to terms of reference for any CEC they demonstrate adherence to identified prerequisite training. Such prerequisite training will be discussed more fully in the next chapters.

McGrath et al (2006 p233) cite Irvine et al (2004), who recommends that teams can be encouraged to be more effective if they see ethics as a shared endeavour, where teams are "conceptualizing ethics as a shared social practice…a dialogic approach to ethical decision making that places greater emphasis on open deliberation and the articulation, negotiation, exploration and generation of new ethical perspectives in the here and now of clinical practice." McGrath et al (2001 p250) emphasise that multi-professional clinical ethics support in healthcare (such as the CEC) can encourage this approach:

> *"indications are that the integration of ongoing health professional education in ethics and multidisciplinary clinical ethics services for health professionals at the hospital will assist with the multidisciplinary management of ethical issues".*

Gibson (1994) identified that healthcare professionals often had difficulty confronting dispute and conflict, but received little training or support for this. The CEC can develop skills that enable them to be effective mediators of issues within context. She identifies that mediation is typically organised through a number of stages, these are "Intake, Contracting, Information gathering, Issue identification, Issue resolution, Reaching agreement, Implementation and Review" (Gibson 1994 p58). The model for CEC activity that will be discussed over the next two chapters, addresses the issues brought to the CEC in a manner that is akin to the processes utilised within conflict mediation. As Gibson (1994) reflects, conflict to a mediator is seen as natural and inevitable. It is something neither to be avoided nor feared. She notes that CECs are well placed to develop the skills of an effective mediator and can offer effective support in this area stating:

> *"Effective ethics facilitators, like trained mediators, have well developed*
> *skills in the areas of investigation, empathy, managing the interaction,*
> *strategic direction, invention, persuasion and presentation, and substantive*
> *knowledge" (Gibson 1994 p60).*

The CEC, with appropriate training, is well placed to support identification of value conflict, facilitate strategies to aid resolution of the difficulty and signpost to appropriate support. Considering strategies to manage their own conflict, through the post-hoc review process, will enable the CEC to practice strategies and techniques to resolve value conflict within their own discussions. This helps them to have skills to draw upon should a situation of conflict arise within a current case review with a clinician.

Being a useful support in the sphere of conflict management is not only useful service to the clinician, but is vitally important for the credibility of the CEC as it will

increase the confidence of the organisation in the usefulness of the CEC. Edelstein et al (2009 p345) state "where clinical ethics consultants are unhelpful or even destructive, the credibility of the hospitals ethics committee will be degraded and the potential for any members to be seen within the hospital as wise counselors is diminished".

McLean (2007 p498) questions whether CECs are vehicles for dispute resolution, and cites Annas (1976) who reflects that "dispute resolution requires attention to due process, resulting in the committee becoming a mini court…and both its procedures and the substantive rules it applies are likely (and appropriately) to be much more legal in nature than ethical". Practical moral concerns and disputes can be resolved without recourse to pseudo-legal review within the CEC but the CEC members require a structure that enables them to address the issues competently.

Exploration or discussion of beliefs, especially if they do not readily concur with the 'norm', can be a threatening and painful process for the individual in question. Scheirton (1992 p348) makes an interesting reflection that members of lesser rank "will often be less likely to speak or voice a contrary opinion or less apt to have their comment given serious consideration" as they may fear ridicule, retribution or reprisal. CECs must promote an atmosphere that encourages sharing of diverse beliefs (which is the value of the group), promotes open debate, and manage any disagreements that will be a healthy consequence of such debate. As Gillon (1997 p204) concludes:

> "*Clinical Ethics Committees are obliged to confront all the ambivalence and uncertainty that made the decision difficult in the first place - that would be their value. Just as the openness and flexibility are key to shared*

deliberations to develop constructive dialogue, the group may require

further training in debating skills, mediation, conflict management and

recognition of different ethical approaches".

From my clinical experience clinicians are more likely share their concerns if they feel they will be dealt with sensitively and what they say will be taken in confidence. Ethical issues in clinical practice are often related to concerns about another professional's behaviour, and can raise issues around 'whistle blowing'. These issues are unlikely to be brought to the CEC unless the clinician believes that their views will be treated with respect, kindness and fairness. Danis et al (2008) explored whether fears of retaliation from other staff members would deter clinicians from taking clinical issues to the CEC. Interestingly, although retaliation was feared and experienced by clinicians bringing cases to the CEC, it did not deter them from using the CEC service. This may have been because the need for support was great or, as the authors remark, because "ethics consultation offers a sanctioned and safe venue in the healthcare workplace for raising ethical questions…The value of ethics committees and consultants serving to level the playing field and provide a forum for discussion has certainly been endorsed" (p33).

Building clinicians' confidence in their own ability to make appropriate judgements regarding moral dilemmas has also been directly linked to improvements in practice. Lindh et al (2009 p1883) cite two different studies that showed how nurses experienced increased moral strength to represent the needs of their patients in practice, as their self-esteem improved. Lindh identified a study by Fagerberg (2004) that found nurses' self-esteem to be a crucial aspect in the quality of care they offered. She found that nurses with low self-esteem had

difficulty standing up for their patients. In Canada, Doane et al (2004) found that hierarchical relationships, with a resulting sense of powerlessness, constrained nurses from acting in the way they desired. Using an appropriate model, CECs could, through reflection, foster a "driving force" in clinicians via "an interdisciplinary approach" that would "allow shared meanings to be created and working environments [to] be understood as supportive moral spaces" (Lindh et al 2009 p1888). This could yield positive outcomes for the moral development of clinical teams. In the next two chapters I will discuss the model that I propose can enable the CEC members to offer and demonstrate they offer an effective support service to enable clinicians in practice to tackle effectively ethical issues or improve team working practices around difficult ethical cases.

Chapter 5 *A new model for structuring CEC review*

5.1 Why is there a need for a new approach to deliberation within CECs?

Concerns have been raised about whether the skills within UK CECs are sufficiently developed for them to be able to offer clarification on complex issues and therefore offer any support to clinicians. Pedersen et al (2009 p147) identified that "empirical research observing what is happening" during clinical ethics review was "scarce" and set about looking at the processes occurring within CEC case consultations. Researchers observed practices within nine CECs in Norway. They observed committees exploring a 'paper case', carried out semi-structured group interviews, and analysed the data qualitatively. The results reflected the identified concerns that there is still confusion, lack of clarity and uncertainty within the deliberation processes, and one of these uncertainties was the clarification of the key concepts of the situation. The researchers concluded that there appeared to be value in the multi-disciplinary debate, but also very much recommended the need for targeted training, transparent processes and adequate group composition, and noted that important aspects of clinical ethics deliberation were sometimes neglected. Also, the issues of how to involve patients and how to document decisions caused many of the committees' problems. Interestingly, the groups did appear to have a better process of deliberation when they used simple tools for clarification, such as a blackboard and a deliberation procedure:

> *"The use of a well-known, plain, simple deliberation procedure and a blackboard seemed to make the deliberations more encompassing, explicit, transparent and systematic. On the other hand if structuring was too rigid, it seemed to hamper the dialogue – for example, the possibility of clarifying arguments and disagreement." (Pedersen 2009 p148).*

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Having a framework available can help CECs to structure their review processes, but it does not ensure they are used appropriately or used at all. Despite seven of the nine committees in Pedersen's research identifying some framework for review was available two of these seven "hardly used the procedure" (Pedersen 2009 p148). Therefore, access to such a framework does not seem to address the issue fully. It appears that the benefits for a CEC of using a framework need to be recognised by the CEC and the organisation, and this needs to be accepted as good standard practice.

Bliton et al (1999 p75) identify the nature of the ethics consultant's task below:

> "clinical ethics consultation has two major characteristics. First, its activities are persistently guided by this question for the consultant, 'what do I need to know?' in order (a) to figure out why a clinical ethics consultation was requested? and (b) to get clear about 'what's going on?' Second, clinical ethics consultants seek to identify and discuss, by persistently helping to elicit from the primary participants (patient, family, physicians, nurses and so on) what they themselves find troubling and in need of resolution, and therefore what aftermaths they can live with in the light of what is most worthwhile to, and for, them".

These are the questions to be answered also by the CEC. What do I need to know and what is going on? Skills are then needed to enable the CEC to be able to facilitate discussion with the clinician around these issues. Through discussion, options for action are generated and explored and can be considered by the clinician or clinical team. There is a need, says Rangel (2009), for "devil's advocacy" and "dialectical enquiry" to consider the alternatives in a complex situation. The following part of this chapter considers how this may be achieved

within the CEC using the proposed ASCS approach. The ASCS model combines

ethical reflection through casuistry and also solution focused questioning to

encourage clinicians to tackle their own ethical issues based on the knowledge

gained. In the following chapter I will demonstrate how the ASCS model of review

can offer this opportunity.

5.2 The ASCS model for CEC review in the UK.

At the outset of the thesis I began with the case of Marion. With my team, I

experienced the benefit of reflecting on practice together, and the value of

considering a range of perspectives on a difficult situation, which had a range of

ethical concerns within it. Marion's case raised issues around informed consent,

inter team working, conflict, professional responsibility, information giving and

respect for autonomy. After having felt the benefit of taking time out of practice to

consider such issues, and the benefit to the team of good, supportive

communication, I began to consider how this reflection was being carried out

within the clinical ethics committees that are emerging in UK, Europe and beyond,

as I consider them to have the potential to be evaluated as safe reflective spaces

in which to debate, discuss and analyse difficult ethical cases and issues. Having

researched the evidence available about CECs and their functioning I considered

how I could combine the good communication skills evidence base used,

particularly in palliative care, with the philosophical approaches underpinning CEC

review at present, such as particularism and principlism. I found myself neither

satisfied with the principlist approach to CEC review nor happy that the space

should be used for unstructured reflection. I needed to consider how I could

develop an approach that combined the benefits of a safe moral space for

deliberation with a structure for questioning that would guide and structure those within the CEC and the clinicians whilst they considered the questions in hand.

This new framework would then address a number of concerns identified below.

The first concern would be the need to provide a framework for reflection within the CEC which provides an atmosphere, where the busy clinician or other member of the team, feels able to share their concern on an ethically challenging case or issue, in a supportive environment. The next concern would be to provide a framework for a simple but effective questioning technique that could be utilised by the volunteer CEC members, to assist the clinician in making a judgement. Thirdly the processes utilised within the model could be evaluated as to their effectiveness. Evaluation of activity within CECs is difficult due to the nature of the task. As I will discuss in Chapter 6 this model makes the task of evaluation easier as there is a structure to measure the CEC questioning, processes and manner of support by. This structure can be measured and evaluated alongside the satisfaction of the clinician experiencing the CEC.

Through my research I have not been made aware of a model that approaches CEC review in the manner I am suggesting. As a communication skills trainer of many years, and an experienced Macmillan nurse and teacher, I drew strongly upon my communication skills training, particularly the (Maguire 2013) enhanced communication skills model that is promoted and widely used in my speciality for eliciting concerns for those with cancer and palliative care needs. The model then incorporates the use of casuistry and the solution-focused simple and brief questioning technique to pose questions in a non-directive but facilitative way. Such use of the solution-focused questioning techniques ensures movement through the reflective process and offers a good opportunity for the clinician to

leave the CEC consult with a focus for action to assist him with his day to day work.

The model I have developed is titled the

ASK

SEEK

CLARIFY

SOLUTIONS

Model for reflection within a UK CEC

Although known by a simple acronym, the model is underpinned by a strong evidence base, with regard to, both its philosophical approach and the choice of reflective questioning technique to be used. I feel its strength lies in its simplicity of use but also it's potential to refine, clarify and improve practice.

The model encompasses the key issues that have previously been discussed in this thesis. It offers a way to clarify what CECs are about and what they are doing, it acknowledges the moral and legal obligations of CECs to the employer and the clinician, it takes seriously the legal responsibility of offering support within the CEC as robustly and efficiently as possible, and it recognises that ultimately it is the clinician that decides on ethical issues in partnership with the patient/client and the team.

In the next portion of the chapter I will explain the philosophical underpinnings of the ASCS model. The model is grounded in a particularist philosophy but it utilises a solution- focused questioning technique to help it achieve its goals. Both of these will be discussed.

5.3 Philosophical rationale for the model.

Dialogue about the case is vital and intuitions are regarded as an important starting point.

Decision making in healthcare begins with the particulars. Rules, principles or precedent are important to explore in relation to the situation but these elements cannot be considered until the group has an understanding of what is the concern from the clinician's perspective.

Intuitions are regarded as the beginning of the process of reflection, leading to judgement and decision making. Exploring intuitions can be undertaken by facilitating exploration of the ethical issue through dialogue. A CEC should be a group with its foundations in dialogical ethics, so as to aid understanding. Through the open dialogue, experience, beliefs, contextual issues and relationships are all revealed. Once revealed, the perceived truth of the situation will become clearer. Once clarified, the options for action can be explored. Gadamer (1975 p263) describes the method that seeks to clarify the conditions in which understanding takes place as hermeneutics. Effective dialogue is needed for that understanding to be developed within the CEC. As Widdershoven (2009 p236) states:

> *"Hermeneutic ethics regards experience as the concrete source of moral wisdom. In order to gain a good understanding of moral issues, concrete detailed experiences and perspectives need to be exchanged. Within hermeneutic ethics dialogue is seen as a vehicle for moral learning."*

The underpinning rationale for approaching dialogue about ethics using a dialogical model (the ASCS model takes a dialogical approach) is a rationale that recognises that understanding is an active and productive endeavour. Through

active attention to the dialogical process much can be understood by the CEC. Issues that can be illuminated are varied but include moral and non moral issues that influence the appropriateness of the resulting action, the clinical context and history of the situation, perspectives of the stakeholders in the situation, similar situations experienced by the clinician and strategies used to manage such situations.

Porz et al (2011 p355) cite the influential work of Margaret Urban Walker and her book 'Moral Understandings'. Porz et al (2011 p356) state that Walker describes morality as:

> *"thoroughly interpersonal, collaborative and expressed in the assigning, accepting and/or deflecting of responsibilities. This makes ethics socially embedded; there is no such thing as a pure (idealistic) core of ethical theory or independent moral reality".*

As Porz et al (2011 p356) go on to say, acknowledging the above, moral identities need to be constructed by the use of narrative and humans are essentially storytelling agents who are "*not* independent, *not* asocial, *not* timeless, and *not* space free".

Unstructured dialogue will not use the limited time the CEC has to best advantage. Using a clearly defined structure to questioning, supporting the expression of perspectives, enables the CEC to gently direct the dialogue and facilitate movement through the issue toward solutions. Rather than ruminating in the problem, this can be achieved through application of the ASCS model within the CEC, which offers a moderate particularist approach to the discussion of cases, combined with structured reflective practice. The theory, discussed later in this

chapter tells us that guided solution focused dialogue can yield good outcomes in terms of changing behaviours and dealing with difficult situations. The solution focused theory within the model enable the CEC to harness the dialogue and help the clinician move forward with the issue. As Malpas (2009 p14) states "Theory and application do not occur, then, in separation from one another, but are part of a single hermeneutical 'practice'."

The A or asking section of the model;

Intuitions as a starting point

The model acknowledges that dialogue with the issue bringer begins by offering a safe space for the person to reflect upon the situation or issue causing concern. This is a starting point only as intuitions need to be checked. Sometimes an instinct can be inappropriate or an intuition can be based on a false or misguided premise. Working in healthcare, the practitioner is constantly bombarded by a range of decisions to be made. Sometimes these decisions need to be made immediately in the case of an emergency situation, sometimes they are part of forward planning for the patient. They are often undertaken collaboratively working with other team members, the patient and their family. Working on intuition can have its advantages in urgent or emergency situations. As Patricia Benner (1984) states in her work on how people move from novice to expert, experienced clinicians have often been involved in similar situations before, and can intuitively recognise the features and react rapidly, as they already know what is appropriate in such situations. After critical events, healthcare organisations may offer an opportunity for critical event analysis and supervision. For example, the clinicians involved may be able to reflect upon a difficult clinical situation, where the urgent circumstances prevented a balanced and considered review at the time. Such

opportunities to reflect on behaviour increase the clinicians' confidence that they intuitively 'know' what the right action is. This should further improve their chances of acting appropriately in similar situations in the future.

Take, for example, the case of a patient who falls. An experienced nurse will have been in a similar situation before; knows the theory about appropriate personal and professional behaviour, and responsibilities to the patient and those around. The nurse also knows not to try to catch or save the falling patient, but to ensure safety and security, support the probably distressed person, and summon appropriate help. A more inexperienced nurse, who may not have had the benefit of such hindsight, may 'instinctively' reach out to catch the person, risking harm to her and them. The nurse may have the best of intentions, but actually causes further harm, with what is a rash decision in the circumstances.

Intuitive reactions to situations are part of the way we make moral judgements. In any dilemma, based upon a complex set of social, psychological and emotional issues, we will find ourselves responding immediately. This is a good starting point for decision making. Benner (1984) and other authors, have highlighted the importance of intuition. Intuition is described as immediate knowledge without reason, sometimes shaped by prior experience. Lamond et al (2000 p412) cites various descriptions of the concept of intuition stating:

> *"Various definitions have been given, including: 'understanding without rationale' (Benner &Tanner, 1987, p.23); 'a perception of possibilities, meanings, and relationships by way of insight' (Gerrity, 1987, p.63); 'knowledge of fact or truth as a whole; immediate possession of knowledge; and knowledge independent of the linear reasoning process' (Rew & Barron, 1987, p. 60); 'immediate knowledge of something without the*

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conscious use of reason' (Schrader & Fischer, 1987, p. 47); 'process

whereby the nurse knows something about the patient that cannot be

verbalized, that is verbalized with difficulty or for which the source of

knowledge cannot be determined' (Young, 1987, p.52)".

In society, many areas of decision making involve group exploration of shared insights and wisdom. Bhutta (in Benatar 2001 p2) states:

"I am frequently struck by the relative ease and collective wisdom with

which many communal and 'underdeveloped' societies handle ethical

dilemmas. Often in a manner that is worth emulating by others, a sharing of

burden among extended closely knit families and communities with faith

providing the important binding force".

Discourse in a supportive environment stimulates this ethical review process to begin. Interestingly, Hartrick-Doane et al (2009 p233) found more inherent ethical knowledge within a group of nurses they studied than the nurses themselves actually recognised.

When given a supportive opportunity, the nurses were found to engage in spontaneous ethical discourse:

"During a series of focus groups, nurses told several stories of difficulties

they faced in trying to act 'ethically'. At the same time, the nurses described

the challenges in acting ethically, and they presented themselves as lacking

ethical knowledge…the ethical knowledge was the domain of the ethicists".

Yet Hartrick-Doane et al (2009 p233) describe witnessing a spontaneous analysis of the ethical situations brought before them. The nurses were identifying issues, even if they were not labelling the review as such in formal language.

The benefit of accessing reflective practice in the form of the CEC from the clinician's perspective is twofold. Firstly, an opportunity to air the issues may not be available in the busy clinical environment, and those seeking guidance from a CEC are able discuss the situation, and be facilitated to explore the skills they have in relation to the situation. After considering realistic goals toward changing the situation the clinician can be supported to look at best ways of applying the skills.

Secondly the members of the committee, through their shared learning as a CEC and their experience of exploring post hoc legal and moral cases, are in an informed position to clarify issues, or suggest who may be able to do so, and support the clinician as they consider choices of action. Through use of good communication skills, empathy and sharing their knowledge of precedent cases the CEC can provide the environment and information that will be useful to the clinician reviewing the difficult situation. The CEC, although not existing to advise on action, have experiences and wisdoms that also may be useful to illuminate issues and these should be acknowledged. These shared wisdoms can in turn enrich the debate by allowing it to be viewed from a variety of perspectives "certainly wisdom and insight and diversity all serve to enrich the debate around issues" (Bhutta in Benatar 2001 p2). As Ohnsorge et al (2011 p361) state, the way we as clinicians approach ethical problems in practice depends upon the epistemological and anthropological premises from which we start, and these are unique to each one of us. Our outlook will depend upon influences such as heritage, race, sex, cultural influences and experiences. The diversity of wisdom to be gained in group discussion can raise the clinician's awareness of any blind

spots or prejudices. Increased awareness will contribute toward a more informed judgement on behalf of the clinician.

Deliberation within the CEC using the ASCS model should therefore initially be a matter of reviewing the members' spontaneous moral judgments, which (McMahan 2012 p2) describes as the starting point for moral inquiry. This spontaneous reflection is not a result of conscious analysis but intuition. As McMahan (2012 p2) states:

> *"What are moral intuitions? As I will understand the term, a moral intuition is a moral judgement, typically about a particular problem, a particular act, or a particular agent, though possibly also about a moral rule or principle that is not the result of inferential reasoning".*

Some would argue that this spontaneous and compelling intuition could have normative authority in itself. As Woodward et al 2007 p181 states:

> "*Some writers (Singer, Unger) argue that intuitions about general principles are more trustworthy or deserve to be taken more seriously than those concerning particular cases, because the latter are more likely to be subject to various biases"*

But intuitions require exploration as the bias may be inherent within the person or based on flawed beliefs or information. It can also be argued that intuitions are unchangeable, although this can be disputed, as there is evidence that people's initial assumptions can be modified or even changed completely in the light of reasoned reflection, or new information to enlighten the clinician's perspective. In practice I have been aware of times when my initial intuition has changed in the light of new information.

Within CEC meetings, a case or question will undoubtedly give rise to an intuitive or spontaneous 'gut response' in all present. The individual describes a set of circumstances, and there will be emotional and practical initial responses to it. It is unlikely that the individual involved will amend their behaviour on the basis of shared insights alone, and unlikely that these insights, as diverse and interesting as they are, would be wholly relative to the situation. Such an intuitive response can only act as a first marker, to the position on the issue an individual may hold.

Intuitions can be chaotic and inconsistent, not only between individuals but also within individuals. Because of their inconsistency they have been criticised in relation to their importance to moral decision making. Singer (1974 p516) proposes that intuitions are not a sound starting point for moral judgements as they may arise out of "warped views of sex and bodily functions", or past history now out dated and not applicable to more modern society. Rather than dismissing the importance of such intuitions the CEC can consider them as a beginning to their exploration. McMahan (2012 p3) promotes this role, stating that some philosophers would "concede that intuitions may be reasonably reliable guides to action in most circumstances-since morality must ensure people are equipped with dispositions to believe and act in certain ways in situations in which deliberation and reflection are not possible".

In the A quadrant of the model the CEC are actively exploring with the issue bringer their intuitions. Here the CEC are curious about the situation. The dialogue begins by simply asking the question of the person accessing the CEC, what is going on according to your interpretation?

Active listening is involved here, and one of the prerequisite requirements of being part of the CEC, using this model, is to be skilled at listening and hearing, without

assumption or interruption. This skilled listener does not need to be an expert in ethics or an ethicist. In some Dutch ethical reflective groups the participants themselves are being taught skills which stimulate and facilitate the reflection. Weidema et al (2012 p1) identify that when enacting moral case deliberation (MCD) rather than being led by a 'facilitator', such as a clinical ethicist, 'local co-coordinators' should be developing their skills to enable effective deliberation in practice. Initially MCD was led by an ethicist but training courses in MCD have evaluated that clinicians can develop confidence in facilitating reflection. As Plantinga et al (2012) state:

"Until recently moral case deliberation (MCD) sessions have mostly been facilitated by external experts, mainly professional ethicists. We have developed a train the facilitator programme for healthcare professionals aimed at providing them with the competencies needed for being an MCD facilitator".

Such training has been evaluated favourably. Plantinga et al (2012 p634) discuss the findings of their research which explores the benefit of training 120 health care professionals to facilitate a moral case discussion. They state:

"After finishing the train the facilitator programme most participants feel they have developed sufficient competencies to be able to act as a facilitator for MCD in practice".

To enable the CEC group to enact moral case deliberation utilising the ASCS framework the group need to have considered and addressed their training needs in relation to communication skills. All in the group take equal responsibility for being an active and supportive questioner, regardless of role or status outside the

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group. Therefore all CEC members who are using the ASCS approach to CEC review as mentioned earlier will be obliged to have accessed nationally recognised communication skills training, such as a two day enhanced communication skills workshop which has been developed by the Maguire Communication skills Training Unit Manchester. The communication team is described as:

> *"an internationally recognised unit dedicated to improving patient experience by developing and teaching communication skills. The unit was established in August 2005 by the Cancer Research UK funded Psychological medicine Group, led by Professor Peter Maguire which was at the forefront of communication skills research and training for over 2 decades".*

Such a communication skills workshop aims to increase the CECs member's skills in eliciting concerns. Education and feedback about the individual's strengths and weaknesses with regard to communication via an interactive education programme, is crucial to building self-awareness, and should also be a pre-requisite course for any new member of a CEC. Often in challenging times empathy and emotional intelligence allow sensitive support to be offered in the face of conflict and distress. Being able to handle sensitively emotions aroused by the difficult situation is an important skill to be developed by all CECs:

> *"Emotional intelligence has been recognised as a necessity not only to be a successful leader but also to be successful in life. A high mental intelligence quotient revolves around a narrow band of linguistic and mathematical skills, whereas emotional intelligence involves self-awareness, management of emotions, empathy, people skills and emotion"* (Ramsay 2001 p139).

The environment in which the dialogue is to take place needs to be addressed by the CEC to ensure that the guest to the CEC (person bringing the issue) is at their ease and any intimidating barriers are broken down, use of tables, etc are discouraged. Any note taking is agreed before hand and its reasons and the nature of the way the information is to be used will be discussed.

The S or seeking perspectives section of the model

The CEC and the clinician together will begin the search for meanings in the situation. These meanings are reflected upon, and the key 'facts' of the case, as perceived, are clarified and summarised through the dialogue. This enables the CEC to check that what they perceive they have heard is the correct interpretation. As Abma et al (2009) state the "dialogical process and attitude itself is already a first important step in dealing with problematic situations". Through the S phase seeking out of perspectives involved in the case/issue is carried out. These perspectives can then be further explored using a solution-focused approach to questioning (as outlined in chapter 6). Questions that seek to clarify perspective can be phrased in a non-directive way to enable the person considering the dilemma to reach his own conclusions. Examples of such non directive questions are: what made you consider this to be so; why did this appear so; what happened in this situation; how did you perceive this affected you or others in this case?

 Acknowledging issues and gaining more detail about the situation is not carried out in an interrogative way but in a supportive way in a safe environment. Here the skills learnt by the CEC within the communication skills training can be refined and improved by practice. This is considered as social learning or learning together through experience and experiencing, this is a learning model that health care professionals are used to.

Abma (2009, p231) identifies the benefits of such a learning experience:

> *"Social learning refers to learning as a social and collective process (not solely a cognitive act of the individual). This type of learning focuses not on theoretical knowledge ('know that'), associated with reason and rationality, but on practical knowledge ('know how'), associated with intuition and feeling. Practical learning results in 'local' (contextual and experiential knowledge. This is a relevant source of knowledge because it is located within specific contexts. This is often referred to as the principle of indexicality: the context of the situation is the index for the use of general rules and principles. Nussbaum talks about the 'living conversation'".*

From my years of experience as a Macmillan nurse, being invited as a guest in the homes of those with advanced cancer, and having to hear their stories in order to offer support, I am confident that it is possible to clarify and gather detail even on difficult and emotional matters in a supportive manner, and then assist those facing difficulty to consider what can be changed to improve the situation.

Another important benefit to be gained within the s (seek) element of the model, is that the CEC is obliged to seek out the perspectives of the patient or client or any others who have an impact on this situation. Hearing about the voice the patient and their family's perspective is vital. At present as previously mentioned, the way many CECs are structured does not give a space for the introduction of the voice of the patient and their family. The use of the ASCS model ensures such a space is provided for discussion about the patient and families wishes, even if the family does not want to attend.

As Aulisio et al (2008 p3) identify:

> "complex value-laden clinical decision making goes on in a clinical context
> that reflects the broader pluralistic societal setting and must respect the
> moral and political rights of individuals to live according to their (sometimes
> very different) values…neither patients, families, and surrogates, nor health
> professionals themselves have to check their personal moral values at the
> door of the hospital when entering. Instead, each retains a moral and
> political right to live by his or her own values, a right that must be respected
> in health care as in other settings".

Despite there being a clear need to respect and consider seriously the patient perspective their perspective is not given the weight it deserves in many case deliberations. As Weidema et al (2011 p207) state, "cases often affect clients, however their inclusion in MCD is not common. Client participation often raises questions concerning conditions for equal collaboration and good dialogue. Despite these questions, there is little empirical research regarding client participation in clinical ethics support and MCD in particular. Having this client focus built into the ASCS model offers a structure by which the CEC are required to demonstrate the questions asked, and steps taken to elicit the client's perspective and invite the client to the dialogue if appropriate. The reasons why this is important are discussed in more detail, later in the thesis.

The C or clarification section of the model

Clarification and discussion about reasonable choices of action in the circumstances are considered. Clarification is done by exploring what rules,

principles and previous cases and precedent can offer to inform the current situation.

Issues are considered against what appear to be reasonable responses to the key facts in the situation, to enable consideration of and planning for alternatives. The clarification element of review should recognise the value of both the particulars of the case and principles that guide our common sense morality. They are both important to consider when evaluating what behaviour appears most reasonable in the circumstances, as intuitions are guided by both principles and particulars such as gender, context, sexuality, history, culture, and ethnicity, as well as moral influences.

Why the ASCS model is underpinned by the concept of particularism.

The following part of this chapter will outline why a particularist approach, which respects and understands the place of broader principles, but accepts that rules and principles cannot be sufficiently action guiding in difficult clinical circumstances, underpins the ASCS model.

Andler (2003 p362) describes ethical particularism as "the general view that moral conduct, evaluation, decision making, cannot rely on principles, or perhaps cannot rely on principles alone". Particularism is seen as a method by which CECs can embrace the pluralistic, complex and context-specific nature of healthcare and bioethics, and offer a richer view than by recourse to principles alone. Callahan (2000 p40-41) states that the criticisms of the principlist approach have increased, especially by those who are drawn to virtue theory, feminism, casuistry and multiculturalism. Particularism seeks to redress the concern that context, particularity and cultural differences are equally as relevant to the clinical situation,

as rules or principles derived from universalism. The focus is on understanding the 'why' inherent in a situation. The focus of review centres on developing the discernment of the practitioner, in order to make appropriate judgements rather than seeking rules to apply to give us the formula for right action. The holistic review of the situation will therefore justify the right action. Therefore using the ASCS model obliges the CEC to holistically review the situation together with the clinician, identifying intuitions, clarifying them, considering not against rules, but using the particulars to consider what may be a just action. In this context, one situation may lead to the justification of an act that is completely unjustified in another. It is the features of that situation that guide the decision on action.

Casuistry can then be helpful to enable the clinician and the CEC to reflect upon what action may have been seen as appropriate, in similar circumstances. Many UK CECs have used casuistry as a useful tool in case debates, to facilitate their review, and compare actions in one case against actions taken in others. The question could be asked 'What would the reasonable clinician do in this situation?' "Casuists argue that specific cases inform moral principles, not vice versa. Thus, the best starting point for ethical decision making is examining particular cases and the respective decisions made about these cases" (Carter 2002 p2).

Casuistry's benefits have been promoted as an opportunity for building up useful experience, and an opportunity to compare the application of the factors in similar cases. Ethox identified the benefits of using casuistry within a CEC as follows:

> *"This may be particularly useful in a discussion of best interests of a patient. If it was in patient A's best interests to receive treatment, why and how does this differ from an assessment of patient B's best interests in the same circumstances?"(Ethox 2004 section C p4).*

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The casuistry approach is not a modern phenomenon. The history of the approach dates back to ancient Rome and Greece. It takes into account, not only the action, but the context. Aristotle argued that, rather than adopt universal principles, there was need to consider every situation and its unique features. In modern day medical ethics, casuistry is an attempt to address the tensions between theoretical philosophy and practical clinical ethical concerns. As Townsley (2003 p3) remarks "the case based approach of casuistry lends itself to the pluralistic context in which most medical decisions are made". Townsley highlights the complex medico-ethical position of the clinician, in needing to balance doctor, patient, family, economic, and legal issues. These often include the balancing of quality-of-life issues against the public good. Finding precedent cases with similar issues, offers the CEC a vehicle to focus deliberation. Through the process of review, a best decision based on the available evidence can be considered.

As Townsley (2003 p3) states:

> *"Casuists attempt to classify the event in question, drawing upon paradigms, frequently following analogical reasoning, identifying which presumptions are relevant to the event, commenting on the case's circumstances and how these might affect our overall judgment of the event in question, and often reflecting on the opinions of prior authorities as these might influence our moral assessment of the case in hand".*

Casuistry can be seen as an approach that attempts to marry theory and practice. Therefore, the philosophical rationale for the ASCS model is rooted in the particulars of the experience and considered against the experiences of others in similar cases. The CEC and the clinician consider the case against the invariant core virtues such as justice and kindness, and consider the options for action

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against what the reasonable clinician would or has chosen to do, in these or similar circumstances. The intuitions that form the basis of the model are influenced by rules and other contextual influences, so rules and principles are regarded as important, but only as part of the holistic process of review. Finally options for action are presented.

The dialogue is structured into the four elements that comprise the ASCS model. Ask for the story, seek out meaning, clarify the issues using casuistry as a tool and acknowledge conflict and emotion, and support the issue bringer to set a realistic goal to work toward their solution.

In the next chapter I will outline in more detail how the CEC can use reflective questioning techniques to structure their dialogue within the model, and offer brief, efficient and cost effective support to the clinician. It is important to structure and monitor activity within the dialogue as the CEC hold a position of trust and have a duty of care to attend to the emotional and psychological safety of all involved.

There is a need for the CEC to minimise any risks of psychological and emotional harm to individuals involved and risks to themselves that may be experienced through the process of the review. Issues are rarely without an emotional dimension, less so complex ethical challenges. Such emotions can trigger both positive and negative psychological responses. In this reflective practice scenario, the clinician/team can be seen as the learner and the CEC the facilitators and they have the responsibility for safety as they are aware of the reflective processes to which the group has agreed. As Finlay (2008 p12) states, "What is clear is that both learners *and* educators require support to help them manage the ethical challenges that may arise during reflective practice". The ASCS structure offers a mechanism by which such support can be optimised by the CEC/ facilitator and for

the clinician/learner. The solution focused model offers a way the CEC can provide well-structured reflection and minimises the use of judgemental or leading questions which may influence inappropriately the decisions to be made by the issue bringer. This lessens the risk of harm that can arise out of a poorly structured reflection, where certain the person bringing the case could feel coerced, unsupported, victimised and judged. Poorly structured reflection leading to such negative feelings will not enhance the clinician's sense of moral confidence. At worst it may re-enforce prejudice and lead to a loss of worth. Quinn (2000) discusses the potential use of reflective models and how, if used badly, they can result in the perception of devaluing of practitioners work. Brookfield (1990 p178) states:

> "Questioning the assumptions on which we act and exploring alternative ideas are not only difficult but also psychologically explosive…..[it] is like laying down charges of psychological dynamite".

Therefore a model for high quality reflective practice, with training to support such, will enable the CEC to be confident about their boundaries, and understand their role and limitations. Sometimes the reflection may raise organisational issues, and the CEC has an obligation to the clinicians to use their position within the culture to work against poor organisational practices and lobby at times for change to occur. I have chosen within this thesis the solution focused model as a reflective model of questioning and action planning. The solution focused framework complements the four stages of review. It can be used as a way of focusing, exploring and finding best fit solutions for the issues brought.

As Finlay (2008 p7) states:

> *"Intersubjective reflection makes the practitioner focus on the relational context, on the emergent, negotiated nature of practice encounters. With mutual collaboration, a participatory, dialogical approach to reflective practice is sought – what Ghaye (2000) calls a 'reflective conversation'".*

This should be the goal of reflective practice within the CEC. As I will discuss in chapter 7, the ability of the CEC to perform reflective practice well can be measured through, personal reflection, peer review, documentation of the process and clinician feedback. Building up an evidence base for usefulness in practice is imperative, as there is very little evidence about how CECs structure the reflective practice at present, and whether it is effective. The more evidence gathered the more momentum builds to demand adequate organisational support for CECs to enable them to offer a vital service to clinicians and patients alike.

CECs have a duty of care to use a model for review that maximises benefits for the clinician, and ultimately the patient. CECs are influential bodies in law, and particularly in America their recommendations and manner of getting to these recommendations have been questioned. There have been cases in the USA where CECs were found negligent, as they failed in their duty of care toward the patient and the clinician. It has been successfully argued that a CEC made a recommendation leading to an action, which caused undue harm to the patient. This may be because they failed to consider all the issues in the case and did not seek out the patient perspective. Thus, not only the patient and the clinician could be harmed by an inappropriate decision, influenced by the CEC, but also the CEC members themselves could be vulnerable to litigation for making a decision that is wrong in these circumstances.

CECs face the difficulty of finding an approach that offers meaningful support, and guidance, not in an abstract sense, but in a sense that will affect the lives of all involved. Adopting a consistent approach to current case review has proved difficult for the CECs in the UK and internationally. As McNamee et al (2011 p366) state:

> *"The embarrassing lack of an agreed proper method puts ethicists, especially moral philosophers, in an awkward position when it comes to addressing concrete and pressing problems in applied ethics. Few people would expect ethicists to actually solve these problems".*

S: *Solutions*

Using a goal orientated approach to ethics review, combined with a solution focused questioning technique (Discussed in detail in chapter 6), the clinician is enabled to focus on the issues, the potential solutions, and be able to justify the chosen action. Appropriate training in ethical theory, solution focused questioning techniques and organisational support for the CEC is important to enable the ASCS model to be enacted effectively. Such courses that need to be attended by members, will be counted in a small number of days, and are a worthwhile investment, to ensure a minimum standard of performance from the CECs. This education is vital for quality assurance purposes, as reflective practice if not offered in a skilled manner can cause harm to the practitioner.

The medium of reflective practice is not benign, and used badly in a high impact situation can increase distress. Finlay (2008) identifies the "dark side" of reflective practice. She states:

"There are cultural and personal risks involved, and not everyone ends up feeling empowered (Brookfield 1994, 1995). Moreover, busy, over-stretched professionals are likely to find reflective practice taxing and difficult. Bland, mechanical, routinized and unthinking ways of doing reflective practice are too often the result".

The solution focused model as discussed in chapter 6 shapes the manner of CEC reflection in a simple and supportive framework. The ASCS model relies upon both its philosophical approach and the use of effective solution focused reflective questioning. In the next chapter I will discuss the solution focused reflective questioning technique in more depth.

Chapter 6 **The use of solution focused questioning to support the clinician to make real change in practice.**

This chapter will explore the benefits for the CEC of using a solution-focused reflective model within the ASCS framework to stimulate discourse on ethics with a focus on recognising strengths and visioning solutions. The chapter will demonstrate that the solution focused-model is appropriate to enable and encourage moral growth of the practitioner by using structured dialogue to challenge, question and explore perceptions and moral judgements with the outcome of achievable solutions to be considered. This is aimed at increasing the issue bringers moral awareness and confidence. The solution focused model then promotes thinking about solutions to the dilemma in a group for the clinician to consider when planning action. Furthermore, the approach increases awareness of the patient perspective in complex cases, and can encourage the clinician to consider the best interests of the patient.

6.2 The solution-focused approach to questioning.

The solution-focused approach is a support and supervisory model of reflection that, if used within the context of the CEC, can facilitate reflection and clarification of issues through dialogue. Such reflective practice supports the moral growth of the practitioner by facilitating understanding, which can then be used in any ethical situation that the clinician experiences in the future. This focus on reflection places an emphasis, not on ethical theorising or ethical models, but on dispute resolution, through a focus on exploring shared insights and formulating a plan of action. This focus is different in emphasis from some of the most commonly used approaches in UK ethics committee consultations at present. Many of the current models of review involve considering principles and duties against what appears reasonable,

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as discussed in Chapter 6 and focus on the problem rather than the solution. As Agich (2011 p270) states:

> *"The skills identified and discussed in the ethics consultation literature are primarily cognitive in nature, involving knowledge of ethical concepts, principles, and theories or analytical, communicative and interpretive skills necessary to apply the ethical frameworks to the concrete circumstances of the individual cases".*

Rudd (2002), discussing the CEC approach to case consultation used in Bath in the UK, identifies this analytical approach as the committee's preferred model, stating:

> *"The case referrals are the most challenging and difficult aspect of the work of the committee. For this reason, we would normally consult our ethicist as well as other members following a referral. We would hope to use a logical analytic approach to these [referrals]" (p494).*

Rather than an analytical approach to ethical deliberation, focusing on problems, solution-focused reflection is a dialogical approach to deliberation to assist in decision making. Through the dialogue potential solutions to the issue are considered and resources to achieve the solution are identified, whilst respecting the importance of context. As Widdershoven (2009 p237) states:

> *"A dialogical approach emphasizes that ethics is concrete and contextual. A dialogue is an interaction between people involved in real problems. This distinguishes a dialogue from a theoretical debate. A dialogical approach to ethics implies a crucial role for experience and learning. A dialogue*

presupposes that the participants already have some interest in, and insight and knowledge through, an exchange of perspectives."

The solution-focused approach aims to equip the CEC with skills that, through dialogue, can engage the clinician in a conversation about ethics. Through this conversation, the group enables the clinician to deepen their knowledge, explore perspectives on the situation and consider solutions. As Janisse (2004 p98) states:

"A narrative approach can be a useful ethics tool in the initial descriptive construction of the case and subsequently in normative reflection. Dr Rubin [2002] notes: 'Narrative methods can sharpen out attunement to issues of how the narrative of a case or ethical dilemma are constructed, whose voices are given authority, which plot lines are considered relevant, and which possible resolutions are given consideration. The virtue of using a narrative approach is that it forces us to expose our assumptions and biases, to confront them, and to bring competing allegiances into dialogue with one another'."

For nursing and many other healthcare disciplines, reflection underpins much of the training undertaken in pre- and post-registration courses. The space and safety of the CEC gives the practitioner an opportunity to reflect upon their practice. This process is not simply a vehicle to gather facts that will then be analysed; it is an active process in itself.

Leppa et al (2004 p195) describe reflective practice as an opportunity to "identify weaknesses, build on strengths and develop best practice". She continues:

"Within ethics teaching reflection has become central to understanding the nature of ethical dilemmas and how they impact on those involved.......Rolfe (2002) has outlined a paradigm for reflective practice in nursing education that calls for nursing educators to be 'less concerned with disseminating knowledge than with facilitating the [clinical] practitioner to explore her (sic) own practice through reflection-on-action'." (p196)

The solution-focused approach has been described as "simple but profound" (Fowler 2007 p1). The philosophy is built upon the assumption that the individual has the answers to the dilemma within himself. This "spacious simplicity" (Waskett 2012 p1) evolves out of mutual respect between those involved in the conversation. It is becoming widely used in the health service in a range of team, client-focused and supervisory relationships and will therefore be known to many health service employees, especially those from the areas of social work, health management and health education.

Solution-focused approaches can be and are being used in a number of settings, for client-focused work and teamwork. Solution-focused methods are appropriate within difficult and complex situations. The key trainers in solution-focused approaches in the UK (BRIEF 2012) identify a number of areas in which such a philosophy has been used: supervision and consultation; solution-focused child protection; solutions in education; solutions with children and adolescents; solutions in mental health; solutions with drug and alcohol users; solutions in challenging situations; solutions in housing management; and building cooperation with reluctant clients.

Solution-focused therapy was developed in the mid-1980s, as a therapeutic technique by de Shazer and Insoo Kim Berg. It is underpinned by the humanistic

and behaviourist philosophy, which emphasises concentrating on the relationship in order to promote growth and development, and constructing a solution rather than solving a problem. Problems sometimes seem insurmountable and we can become embedded in problem focused rumination. Solution focused work seeks to harness the resources of the individual to find solutions not just explore at length the problem without an outcome. It was initially aimed at client-focused work, but is increasingly used in relation to team and personal development within the health services. Two essential components of the intervention, as described by Gingerich et al (2000) are "the miracle question, which asks the client to pretend that a miracle has happened and imagine a solution to the problem…[and] the scaling question which asks the client to rate how things are today". There are over 32 published research studies on the application of this approach, including Beyebach et al (1996, 2000), Burr (1993), deShazer (1985, 1991), Macdonald (1994, 1997) and Nelson (2001). BRIEF (2012) reports that the outcomes of such interventions are perceived as successful "in 65-83% of cases". There are no research studies looking at the solution-focused approach within CEC case reviews. The approach has been used and researched in challenging situations where conflict plays a substantial role in the discussion. Issues where the approach has been used relate to serious mental health problems, criminal behaviour and domestic violence. The approach appears to have contributed to learning that has shaped behaviour, and this learning has endured for years after very short interventions (e.g. less than four meetings). BRIEF (2012) do also offer an effective intervention, described as coaching that occurs within a single meeting, making the format applicable to the single CEC review. The techniques used within the CEC should not be seen as "therapy" but as a harnessing of the

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concepts of solution- focused work which are: (1) focusing on desired solutions rather than unsolvable value conflicts, (2) the CEC using a structure to their questions that increase awareness of the resources within and around the clinician to help, and (3) support for the clinician in times of difficulty. Please see Appendix 2 for examples of some of the techniques as outlined by Iveson (2002 p150).

Gingerich et al (2000 p477) review the research on the solution focused approach and conclude, "In less than two decades, solution focused brief therapy (SFBT) has grown from a little known and unconventional therapeutic approach to one that is now widely used in the United States and increasingly in other countries". They continue, "it is short term and therefore relatively inexpensive". Acknowledging that an empirical evidence base was necessary to support these benefits, Gingerich et al (2000) conducted a comprehensive review of the available research into the outcomes of the intervention. They note that empirical studies are few and involve varying methodologies and quality. Although the benefits of the approach could be identified, they express concerns about the methods used in many of the studies they reviewed. In some smaller studies they found that it was difficult to determine the benefits of the approach due to a number of other influencing variables. They did identify a well-constructed study by Cockburn, Thomas and Cockburn (1997) on psychosocial adjustment, and the impact of the therapy on return-to-work rates for patients with orthopaedic injuries. Gingerich et al (2000 p 483) state, "Although the sample size was small (25 treatment subjects, 23 control subjects), it was sufficient to demonstrate that the SFBT group was significantly improved as compared with the standard treatment group". A number of other studies into the solution-focused approach also show benefits, but have not been reviewed in relation to the rigor of their research methods. One interesting work was

Sundmann's (1997) study into the staff development of nine social workers who received basic training in solution-focused ideas. Those who had received the training made more positive statements, and showed more goal focus after six months. Learning the principles of this approach through a short education period (two days), could help the CEC to incorporate the solution focused strategies they could use to stimulate reflective deliberations with the clinician. It could then be evaluated whether this structure actually improves the effectiveness of the support offered by the CEC. Such evaluation is pivotal for CEC future development.

Within the CEC review, the group and the clinician (s) and patient if appropriate work together. Solution focused questions seek to understand the values inherent within the situation. Once understood the CEC can offer to the clinician, patient or whoever is bringing the case a supportive environment in which the issue bringer can identify strategies to help move the issue forward using simple goal-setting techniques. Fowler (2007 p2) states that applying the solution-focused model in practice for clinical supervision, is based on:

> "the idea that a warm, genuine and trusting relationship used to help a person focus on achievable, positive outcomes is an extremely powerful way to help people move forward".

Not being constrained by the need to justify action by considering it against a traditional ethics model offers freedom for the CEC to simply 'hear' the issue. Leppa (2004 p200) discusses the use of a joint education programme with reflection to explore ethical cases, and identifies the benefits of not being tied to reflection through the lens of a single theoretical philosophical model. She states, "Getting away from our constructed pedagogical goals of highlighting specific ethical principles allowed students' own experiences and dilemmas to guide their

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ethics learning. This is an example of the 'authentic problems' that engage students in exploring multiple perspectives and solutions". The solution-focused model adds to this opportunity, by enabling the discussion to be focused and structured, so as to facilitate resolution.

The focus of reflection within solution focused work is to set goals, and identify how the person will know they are achieving such goals, within a short timeframe. This supports the individual's need to work within the time constraints of practice. The approach does this by finding a shared goal and working towards it, instead of focusing on conflicts that cannot be resolved. Dissecting relative ethical positions in a theoretical way is not necessary, as the focus is on a solution being reached by the person themselves, and not on a solution suggested by the CEC. Triantafillou (1997 p309) states:

> *"A fundamental assumption of solution-focused supervision is that 'recognising capabilities is more important than accentuating the intractable deficits, experiences and beliefs' (Thomas 1996 p14)."*

There is an educative element to this model, as the clinician may need to be alerted to any gaps in his knowledge, so that he can find a solution. Through prior learning and the confidence gained from post hoc review, using the model within the group the members can confidently question areas in the dialogue that appear to be blind spots or prejudices. This activity is in line with the stated overall goal for clinical ethicists as identified by the Canadian Task Force of the Bioethics Society and cited by Bishop et al (2010 p76) who states: "the overall goal of the ethicist is to provide leadership and resources to promote ethical decision-making".

6.2 How can solution-focused questioning help?

Within this section of the chapter I will discuss how solution focused questioning can assist the CEC using the ASCS approach to succeed in their task to support and assist the clinician with the case or issue brought to the group.

Clarification of the issues.

The concern is identified by the clinician, (A asking the clinician to begin the story). The group then acts as a curious enquirer, to encourage the clinician to reflect upon the dilemma. There are a number of techniques that team members could utilise within their questioning (S seeking out perspectives including the patient's). The group questions and explores the situation in a way that helps the person with the issue to identify answers from their own personal perspective. This questioning style could be learned by the CEC members via a short training course (2 days), and confidence in the questioning technique could be improved through retrospective case reviews conducted by the CEC.

The group then questions and explores the dilemma using the solution-focused approach. The focus here is to avoid leading or putting answers or suggestions into the mouth of the clinician, but instead facilitate effective reflection. Clarification of the issues in the case is made easier through the use of reflective questioning. Examples of questioning styles include the following:

So what did it take to do that?

What helped you achieve that?

How do you do that?

What did you learn about yourself doing that?

How did you get through that difficulty?

Curious enquirers within the CEC need to become more confident in phrasing questions that are non-directive, and purely about the clinician and his/her responses and actions in a given situation. By focusing the questions in this way, the group minimises the risk of introducing their own subjective thoughts, and of leading the clinician towards a decision by covert persuasion. This can then all aid reaching decisions about possible (S) solutions.

Triantafillou (1997 pp321-2) when discussing elements of solution-focused supervision identifies the following fundamental elements that underpin the review process - establishing an atmosphere of competence, search for client based solutions, and feedback and follow up. Through education and practice, the group would become familiar with the questioning techniques used in the solution-focused model, such as scaling questions, exception-seeking questions, questions about coping, and looking at surrounding day-to-day clinical activities where problems do not exist, in order to place the issue into perspective (Appendix 2).

Fundamental to the success of the CEC case deliberations, is the ability to offer supportive and empathic communication. The dialogue between the case bringer and the CEC must acknowledge that situations including conflicts are shaped by interpretation and context, which in turn shape and alter contexts so that the situation is a constantly fluid and moving one.

As Ragan et al (2008 p17) state:

> *"All forms of human communication can be seen fundamentally as stories, as interpretations of aspects of the world occurring in time and shaped by history, culture, and character (Fisher 1989). Illness, like narrative, occurs*

within context at the same time that it reshapes context, within relationships at the same time that it reshapes them, and within a persons' life at the same time that it reshapes that life".

By acknowledging and welcoming this and not trying to ignore or filter out this important element of the ethical concern, the CEC can offer the clinician the best opportunity to make a judgement based on their own philosophy and shaped by the context. The supportive questioning and reflection facilitated by this approach, offers the best chance of yielding a practical and appropriate answer to the situation from practice and within practice, and will stimulate the moral growth of those involved, especially the practitioner by providing them with skills and confidence to utilise in the workplace and apply within their own teams. As Cusveller (2012 p440) states "ethics education needs to be more practical" and "many of the competencies needed to participate in an ethics committee are, to an important degree, a continuation (and intensification) of the competencies needed to participate in a team of nurses delivering daily patient care in the first place". This can be applied not only to nurses but to all members of the healthcare team, across the spectrum of disciplines. This approach can be seen to have foundations in the teachings of Habermas. Fisher (1989 p92, cited in Ragan et al 2008 p18) asserts:

"Habermas posits persons as arguers; I see them, including arguers, as storytellers......His [Habermas's] concept of the end of communication is understanding; my concept of the end of communication is practical wisdom and humane action".

Key elements of the approach are reflected by the philosophy of "petite ethique" identified by Ricoeur (Potvin 2010). Potvin describes a client-focused philosophy

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with an underpinning ethic of action, where the aim is a good life with and for others, in an institution that is just. She summarises the aim of the clinician in bringing the case to the ethics consultation, and the aim of the response from the clinical ethics group as follows:

> *"The laudable intention of these professionals is to somehow, and according to the very difficult human and institutional circumstances of the clinical setting, provide means for a better life with and for the patient/family. In responding to a request for an ethics consultation, the health care team not only provides a means to act in the best interests of their patient, but also provides a means to act in a responsible manner towards their colleagues' best interests (e.g., by providing an opportunity to share their concerns)" (Potvin 2010 p316).*

The ethic of 'I-You-It' reflects the clinician's aim in bringing the issue to the CEC: 'I want to make the right choices and I am capable of making the right choices.' The motivation is to support the 'you', both the patient and, from the CEC perspective, everyone involved in the situation. The CEC sits well into the framework of 'it', in that Potvin describes the role of the organisation as that of a 'neutral mediator', a phrase that accurately describes what the CEC would be, if it were to use the ASCS model and solution-focused questioning.

Potvin (2010 p317) reflects the imbalance of power inherent in the relationship between the professional and the patient:

> *"The asymmetrical relationship between the expert professional and the vulnerable patient/family is a place of potential abuse. This relationship therefore necessitates mediation, often in the form of rules or norms that*

make possible a fair collaboration between the patient/family and health

professionals. The duty not to abandon the patient, the obligation of

confidentiality, and expectations regarding patient's participation in their

care planning are some examples of these imperatives."

Even if we accept a plurality of ethical views within the situation, there are cultural

norms and healthcare rules against which these differing views can be considered,

and thus reasonable options for action can be identified.

Some of the potential benefits for the clinician ascribed to considering issues using

a reflective, solution-focused approach, include the following: reflection on practice

versus reflection in practice and the exploration of the benefits of an action; the

opportunity to stand back from the situation; being able to look at others'

viewpoints; finding out new legal and empirical details; testing out options;

becoming more aware of the support available; and ethical self-awareness. This

can contribute towards building confidence in relation to clinical ethical matters,

can facilitate good practice and can help to avoid conflict, both between clinician

and patient and between clinician and clinician. Using the approach within the

CEC offers an opportunity for the CEC and the clinician bringing the case to

consider the power the latter holds within the clinical situation and how they can

use that power skillfully and with respect. Through an environment of trust, an

ethic underpinned by trust is built.

Wiggins et al (2005) also discuss the asymmetry of the patient's dependence and

the physician's power, and clearly articulate the latter as follows:

"Because the patient is ill or injured and cannot heal him- or herself, he or

she has become dependent on the knowledge, skills and sympathy of

health care professionals. Therefore, health care professionals have a

power, the power to help, on which the patient has become dependent. This

renders the patient vulnerable to misuses of such power…..The issue of

trust goes beyond simply trusting the physician's medical expertise; it also

involves trusting the moral character of the human being wielding that

expertise" (p82-83).

Another benefit to the clinician can be that through the discussion around the dilemma, and use of sensitive questioning, the CEC can help direct clinicians to further relevant support, such as legal advice, if required. Through the development of the processes inherent in the solution-focused approach, the CEC can demonstrate skills that are also important to building a strong, trusting clinician/patient relationship such as transparency, a willingness to be questioned, the courage to review, flexibility and the willingness to listen and learn. These groups can become role models for good communication and anti-discriminatory practice.

Simply the opportunity to consider ethical concerns in a confidential and supportive forum can be seen as a benefit for the clinician. Reflection within the CEC around the nature of an ethical issue or issues, within a less pressured, non-clinical environment, can facilitate a considered and supported review of initial value judgements and the issues that have triggered them. Such informal discussions, held outside the heat of battle, can offer the clinician an opportunity to consider their responses or actions in the clinical situation and whether these are based upon appropriate assumptions about the case.

An opportunity to consider initial value judgements could be useful, as they may be based on incomplete information or be heavily biased by a particular

experience, belief or prejudice. Thus, leaving them unquestioned or unexplored may influence the subsequent behaviour of the clinician and potentially lead to unwise decisions in similar circumstances in the future. As Musschenga (2009 p 598) states:

> *"Moral judgments are, to a large extent, intuitive and automatic responses to challenges, elicited without awareness of underlying mental processes…Intuitive moral judgments stem from an ancient, automatic, very fast affective part of the human brain, while moral reasoning takes place within the phylogenetically newer, slower, motivationally weaker cognitive system".*

Therefore, offering an opportunity to take these responses and explore them in a more measured environment, could begin to introduce a more conscious and rational process, which may increase the clinician's moral awareness. This may change the course of the clinician's decision and subsequent future decisions. Wells (2005) identifies a number of situations in which commonly held assumptions, leading to an initial value judgement about a particular behaviour, can be seen to be erroneous upon further reflection. One such area, she argues, is autonomy and individual rights. She also talks about the issue of patient independence. Wells states that the healthcare commonly promotes an active approach to involvement in care for the patient and would make a judgement that active involvement to achieve physical independence was agreed to be a laudable goal. But, some cultures, e.g. Asian and Hispanic believe it is their duty to care for their sick. The sick person's role is viewed as passive and even dependant as the person is seen as ill as a result of sins committed by the family. It is the responsibility of the family to care for the passive recipient. Therefore any

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judgement about such a patient must reflect the cultural norms for that person not the assumptions held by the ethics committee.

For many teams, day-to-day decision making, including reflection on the ethical aspects of cases, can be achieved through multi-disciplinary discussion, which is increasingly being built into the day-to-day practice in healthcare through multi-disciplinary healthcare reviews. This approach recognises the decision-making challenges that practitioners face. Wells (2005) reflects that doing the right thing in clinical practice is challenging especially when the patients and care givers come from very different cultural backgrounds. The MDT is required to develop the skills in practice to enable them to be able to, on a daily basis, elicit the meanings those they care for ascribe to events and how this will influence the decisions they make about their own health. Understanding these meanings and perceptions is vital in order to offer truly patient centred care. Because of this no evaluation within the CEC should take place without active steps to elicit the patient perspective.

6.3 The missing link: Promoting and including the patient perspective.

Traditional approaches to CEC case review could be perceived as inherently unfair, as they often do not oblige the patient to attend, and in many cases the patient would be too unwell or too distressed to attend. However, their needs should be central to the considerations. As Delany (2012 p 178) states:

> "Central to the CERG's [Clinical Ethics Response Group] considerations of what is ethically at stake for patients, their carers and practitioners are the beliefs that have been expressed by the patient's carers, which in some cases can be the trigger for convening the meeting".

With regard to the CEC recommending an action, a concern has been identified regarding how fair it is for a judgement to be based on information provided to the CEC from a clinical perspective only, and without the involvement of the patient or their carers. In this case, the debate would be inherently unfair and the recommendation at best misguided and at worst wrong and potentially harmful to the patient. In a court of law, where a verdict or recommendation is required, it is agreed that cases for both defence and prosecution must be presented, for purposes of equity. As the CEC is not a legal body, and is therefore not required to offer a verdict, there are no such safeguards in place, to ensure the appropriate representation of all those involved. Fournier et al (2009 p131) review patient involvement in five European CECs, and state that patient involvement in CEC discussions is currently dependent upon the preferences of the individual CEC, which are in turn influenced by the culture in which it operates.

They state:

> "Little has been written on the role of patients in European clinical ethics consultation services. This is probably due to the fact that clinical ethics is relatively new in Europe and that most existing CECs were not directly accessible by patients and families until recently. Moreover, the role of patients can differ between two CECs from the same country and is changing with time."

The study that looks at different CECs worldwide finds that patients receiving healthcare in Bath UK, as an example, are not routinely informed about the CEC and no consultation has at the time of the research been actively commissioned by a patient. Newson (2009) undertook a small-scale study into patient activity within

UK CECs. She describes the issue of patient representation as a second-generation challenge facing the CECs stating:

> *"Of the limited current guidance governing clinical ethics and consultation in the UK, there is very little that explicitly addresses advising and participation of patients"* (p139).

Furthermore results showed less than half of the committees surveyed had any form of contact with patients, and those who did have contact, did not describe it as a large element of their work. This is different from the European picture. The other four CECs in the Fournier (2009) study, from France, Norway, Germany and Italy, all had some means of informing the patient and their families about the CECs services, which appears to be a more respectful position that could facilitate freedom of choice, and give a greater understanding and demystification of the processes involved. Thus, it appears that certain key elements of European activities should be developed within the UK CEC network to increase awareness.

The most appropriate role for CEC members is to encourage and enable the clinician bringing the case to consider all perspectives, even if they do not agree with or understand them, but the CEC should not be a service open to professional referrers only as this is discriminatory. Using the ASCS model the CEC should have the skills to offer support to whoever has a concern.

It may not be possible or appropriate for patients to attend CEC meetings. If a patient is sick and vulnerable having to be present at a CEC could be more harmful than beneficial. This does not mean that their perspective should not be sought or represented. For many patients, decisions may be made in their "best interests", taking into account previously expressed wishes, or recognising advance statements or directions, but the benefits to the patient should be

extended by encouraging the clinician to actively seek the patient's views. As Fournier et al (2009) argue, support for hearing the patient view need not mean they are obliged to attend a group meeting. They outline a number of CEC activities that could be aimed at patient inclusion, such as meeting with the patient before the group meeting, to ensure a good understanding of each "stakeholder's position" (p132).

Care is taken within the Paris CEC in the research to support the patient, while avoiding placing them in the position of having to meet a large group of people, in what may be perceived as an adversarial environment. The higher patient profile within the Paris CEC is attributed by Fournier et al (2009) to the fact that its development in 2002 came at a time when patients' rights were being enshrined in French law. In the Norwegian CEC patients are included through a discussion prior to the meeting, and access to certain parts of the discussion. In Germany, Fournier et al (2009 p132) describe the use of a "grand consultation round" comprised of "patient, physicians, nurses and CEC members" and that the CEC operates in a "strictly client-oriented manner". There appears to be a need in the UK to consider and evaluate such steps to raise awareness used in other countries, and ensure the patient is most fully included in the process. The CEC should advertise its existence in areas that are patient accessible, and invite involved patients and family members to ask questions and discuss their needs with regard to the CEC.

Pentz (1998) offers an insight into the difficulties inherent in deliberating on a case from just a clinician's perspective in an American CEC. Pentz identifies a case of a bone marrow physician seeking ethics advice from a small ethics committee, with four members. The physician asked the team to review the case of a 45-year-old

man with progressive low-grade lymphoma, needing a medically indicated stem cell transplant. Pentz recounts the dilemma as follows:

> *"Questioning my caller, I searched for some clue why clinical ethics should be involved in this case. The patient, the physician explained, would need to be hospitalized for 100 days after the transplant; even if he became medically stable, because he had no at-home care giver…The physician assured me that Randy had no one. His father was in his late eighties and had emphysema; his only brother was in jail. He had no children, nor could he identify any other relatives. As a substitute for an at home care giver, the physician proposed to hospitalize the patient. He wanted the clinical ethics consultation team to support him in his choice of the allocation of institutional resources." (1998 p214)*

This issue raises a number of questions. Is the clinical ethics team the correct place to lobby support for such a use of resources? If the treatment was medically indicated, did the clinician not have an obligation to explore all alternatives with other members of the clinical team, and had he explored these options fully enough? Worryingly, it appeared to be the directive of the committee that a social worker should be involved in the meeting, and not the clinician. Replacing the clinician with a social worker could have been inappropriate. Attending the meeting was problematic for the patient and possibly daunting, and he refused. Another health professional was approached to act as the patient's advocate. This appointment raises many issues as to the suitability of a clinician to act as patient advocate, as the clinician was employed by the organisation and therefore may have not been truly independent, as should be the case. Pentz (1998 p214) states that "The patient's advocate argued passionately that M.D. Anderson owed Randy

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the kind of support he needed but lacked through no fault of his own". This may have been the case, but did it represent the wishes of the patient? The committee voted by a slight majority to recommend that the transplant proceed.

After the recommendation, which could have argued against the treatment, it came to light that family support was available, but this was not known to the clinicians. What, in this case, would have happened if the committee had argued the treatment should not go ahead, and if the patient had then died before the CEC had ascertained that the appropriate support was indeed available?

Using a solution focused approach this case could have been have been approached by a CEC hearing the story, promoting good teamwork and communication with the patient, and the clinician considering that a greater attempt could have been made to identify potential caregivers and to work with the wishes of the patient.

In this case if the caregivers had not been found, after having a recommendation from the CEC would all attempts to find a solution other than hospitalisation have been looked into? Or would the clinical teams have felt adequately persuaded not to treat, once the decision had been made by the CEC? What would the consequences have been if the decision had led to an irreversible action, based on inaccurate information? Finally, what if the articulate physician who argued the case strongly, had secretly harboured a belief that those without social support 'who did nothing to help themselves' were not entitled to resources, while he himself had a patient desperately waiting for a bed for a transplant. Would he have argued for the patient's cause as passionately in that case, and would the slight majority have turned out the other way?

This case raises many questions as to the problems of attempting, albeit in good faith to represent the histories and beliefs of a patient.

In research by Pederson et al (2009), which explored the processes of case review within selected CECs in Norway, various insights were obtained, indicating possible lessons to be learned in the UK situation. There were a "wide variety of opinions concerning how to involve interested parties". More worryingly, Pedersen et al (2009 p150) identify that the committees reviewed seemed "relatively offhand" when they attempted to answer the question about the identification and inclusion of involved parties. They state:

> "Most committees were ambivalent or reluctant to invite the patient or his wife to a deliberation, for various reasons, such as that it was too uncomfortable for the patient, that the committee had too little experience with patient participation in the committee deliberations, that the committee's primary role is to guide or support the clinicians or that the presence of the patient or his wife could cast a damper on the dialogue" (Pedersen et al 2009 p150).

Many of the above appear to be excuses rather than insurmountable reasons, and reflect a paternalistic attitude towards the person whom the committee is meant to be supporting. Reiter-Theil (2003), when considering the imbalance caused by a one-sided presentation of a case (in an ethics consultation), cautions that we should not assume that the person consulting will be "very well aware of patient rights as a central ethical dimension to reflect upon" (p247). Also, there can be no assumption that there will be a natural balance within the consultation, when analysing patient and professional issues.

Within palliative care, situations may be encountered where the 'narrative' given by the patient reveals information that they have not shared with the healthcare professionals; this may be because the professionals have not sought out the information skillfully, or because the patient did not wish to disclose the information, or held a view that prevented disclosure. If we are emphasising that the CECs should promote the development of fair and balanced reflection, then the lack of representation or dialogue with the patient can be seen as discriminatory, at worst, due to the fact that the patient has not been offered the opportunity to discuss their issues at the CEC, or unfair at best. Therefore the answer has to lie in the need for the CEC to ensure the professional is engaged in appropriate dialogue with the patient and their family, and is another reason why recommendation based on partial information is a risky endeavour.

The more the health consumer becomes involved in and empowered to question medical decisions, the more conflict or disagreement with health providers may become apparent. Førde et al (2005) reviewed 31 cases brought to CECs in Norway. They concluded that "when more people have a say in medical issues, conflicts regarding solutions of complex medical problems obviously become more frequent". They also commented that this may explain the high number of issues involving children that are brought to the CECs, as they have a "dedicated next of kin who [will] fight for a say in medical conditions" (p76). They explained that patients' access to information is now a part of their rights and, as such, "physicians need to be warned against an attitude biased towards what 'the rules say' more than towards what the patient wants or needs. The risk exists that some physicians may interpret the law too simplistically, whereas good lawyers know that law does not necessarily have a simple solution" (p76).

To ensure that the rights of the patient and their carers are always kept to the fore, strategies are needed that promote communication and eliciting the patient view. Frewer et al (2007 p288) state, "We recommend that every patient should be informed about the possibility that the physician [may be] seeking an ethics consultation and that he should agree to this [even if] he does not know...when it [will] take place." Strategies that have been suggested to rebalance the functioning of CECs include widespread communication to all involved about access to the committee, and promoting a supportive environment within and outside the CEC, so that the patient/family feel able to discuss issues. Importantly, Reiter-Thiel (2003 p252) asserts that "as soon as patient/family access is established, emphasis has to be laid on a rule of good practice to involve 'the other party' systematically". It could be argued that, in any case brought to it, the ethics committee should spend time promoting the patient perspective and proactively seeking patient/carer views are elicited so as to ensure balance in the process. This "multi-directional partiality" (Reiter-Thiel 2003 p253) should be fundamental to any UK ethics committee and embedded into committee education and culture. Such an approach should then become part of the service provided and promoted by the group. In the UK, the message about including the patient voice in the CEC is being discussed increasingly, and the issues identified above are being highlighted. Terry et al (2011), in their conference report on the 'Best Practices in Clinical Ethics Consultation', cite a number of issues related to patient representation, in the section on "Best practices messages identified". They state, "Decision-makers need to recognize that the quality of the clinical ethics consultation and the final decision depends on the following factors". One of the

factors that CECs should address is who tells the story, and if it is the clinician, how do they ensure the patient voice is heard?

6.4 Solution-focused education.

CECs need more than education in ethical theory alone, and need to be educating others in more than ethical theory alone. Theoretical ethical knowledge does not guarantee that one has the sensitivity to recognise relevant issues that may not just include moral influences but also social, cultural, legal or contextual influences, amongst others. As Betan (1997 p351) states:

> *"Ample empirical evidence exists that possessing knowledge of ethical standards and moral reasoning does not guarantee a therapist's ability or willingness to practice ethically".*

Moreover, Betan (1997 p351) reports, in a study exploring ethical behaviours of psychotherapy interns, that interns with formal training in ethical principles identified fewer than 50% of the ethical problems embedded in 12 written scenarios.

McMillan (2002), although in favour of CECs and their desire to support and educate others remarks that, from his perspective, group members may be hindered in their task by the assumption that the way to improve confidence in ethics is to teach formal ethical models. The discussion about ethical models should centre around the place they may occupy within a model of review, that explores many issues not just rules or principles, and should acknowledge that moral theories in themselves are not sufficiently action guiding. McMillan (2002 p46) identifies how discussion of abstract moral theories can detract from

meaningful ethical debate, if not utilised within the teaching in an appropriate manner:

> *"I recall taking part in a discussion with some CEC members about a complicated clinical matter. People in the group were giving thoughtful observations and analyses of what ought to be done. At the request of one of the group members we discussed the deontology/consequentialist distinction, but what had been the kind of process likely to lead to a balanced and reasoned response to the problem became a rather sterile and unproductive discussion of what positions could be taken".*

A holistic practitioner needs to consider not only the rules and beliefs he holds but the character traits he embodies to be able to act upon such beliefs. Although some authors do see conflict between the agent-based and the principle-based approaches to moral reasoning, Frankena (1973) cited in (Waide 1988 p 459) supports the notion that the approaches can work together stating:

> *"I propose therefore that we regard the morality of duty and principles and the morality of virtues and traits of character not as rival kinds of morality between which we must choose, but as two complementary aspects of the same morality".*

CECs need to work with the clinician to educate them as to he benefits of reaching their own wise counsel. The issue bringer needs to be able to demonstrate a willingness to engage in the reflective process. Rest's (1984) four-component model of morality describes the following aspects:

1. Interpretation of the situation as morally significant.

2. Moral reasoning about what is fair or right. An ethical action plan needs to be formulated to resolve the ethical dilemma.

3. A willingness to implement the plan.

4. Carrying out the ethical action. This requires strength and conviction.

The clinician bringing the case to the CEC will have already identified that there is a morally significant issue that they wish to explore. As a pre-requisite the Clinician or issue bringer will have to commit to working through the issue and carrying out the required activity to bring about change.

Review of the issue within the CEC is enriched by viewing the dilemma from a range of diverse perspectives. (Rorty 2004 p81) describes these as "lenses" on the world stating:

> *"Differing narratives may all represent legitimate points of view. Professionals and administrators from different parts of an organization may prioritize differing but often equally legitimate values, all of which need to be acknowledged and openly discussed. Patient perceptions need to be clarified, corrected or validated".*

If we then agree that knowledge of theoretical moral positioning is not a prerequisite for making thoughtful and appropriate decisions in difficult circumstances then we can agree that the CEC has no requirement to teach moral theories in great depth. Indeed, trying to to teach such theories in a formal way, taking into consideration time constraints, room pressures and funding, may be more of a hindrance than a help to the CECs, taking up valuable time from the clinician that could be spent developing other attributes. The personal characteristics that underpin and surround theoretical knowledge were described

as the 'hidden curriculum' by Hafferty and Franks (1994). The CEC members have an obligation to address certain facts important to medical ethics, and also to support clinical ethical decision making by addressing this hidden curriculum. The focus of the CEC education should be on such a hidden curriculum with an aim to develop practice rather than pass on facts or assertions.

Mezirow (1978) discusses an approach to teaching and learning that embraces a form of leaning described as communicative learning. McAllister et al (2006 p1) describe this learning as happening when:

> *"students strive to increase insight, and to identify and validate explanatory constructs that define the problem. This entails reflection through dialogue, an inherently communicative process. Ultimately the educational aim is to produce transformation for learners".*

In relation to a case brought before the CEC the clinician and the clinical team, through the questions posed by the CEC members, have an opportunity to agree the clinicians role, to clarify key issues relevant to the situation, other points of view, potential actions that could be taken, and then the clinician is empowered to reach their own conclusion about what they should do. The skills once developed can be used in future difficult situations. Such transformative education can make a real difference to the clinical teams with regard to their ethical growth and development and can make a real change in practice. As McAllister et al (2006 p1) reflect:

> *"As an educational practice, transformational learning is underpinned by critical social theory epistemology (Mezirow 2000; Scott 1997). This is the view that society remains unequal, divided along many lines. Support of a*

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transformative social agenda requires a commitment to review social

injustice and change the status quo."

This is important and many ethical conflicts may arise out of challenges to values and the usual status quo. A failure to challenge organisational bias, power imbalances and prejudice through education will lead to a failure to change the culture. Through the CECs involvement in such education, it can support the development of an ethical organisation that is for all regardless of race, colour, ethnicity or culture. McAllister et al (2006 p2) continue,

"As many people who are vulnerable by virtue of poverty, social

circumstance, ethnicity, gender or illness attest, it is not just extreme events

that silence or oppress them. For them, inequality is experienced in

everyday activities, experiences that are seemingly so mundane that they

have become taken-for-granted and overlooked."

As a group of competent but not 'expert' people, with diverse views, genders, cultures and positions within the organisation, and with high quality ethical support as their core business, the CEC group is well placed to be leaders in transformative education. Such education can support the healthcare organisation to address prejudice, power imbalances and unethical practices.

The CEC should assist with the development of critical thinking within the practitioner population. Clarity of thinking helps to identify the elements of the case that "constrain, obscure or mislead" (McAllister et al 2006 p4). Criticism and challenging of assumptions can be undertaken in a supportive manner but is sometimes necessary to do. As McAllister et al (2006 p6) state "A solution orientation recognises and works with what is going right with an individual or

group so that strengths may be enhanced". These skills are then reinforced and encouragement can be offered through the CEC to build on these skills in practice. The importance of the solution focus is that the emphasis is on the story being told by the clinician, not the 'expert' status of the group. The group's goal is to emphasise that the power is in the hands of the clinician, who has the ability to find a solution in the situation.

Triantafillou (1997 p307) would place this kind of support into an empowerment model where "helping is providing the resources for individuals to see that the successful solution to problems lies within the individual". This works against apportioning 'blame' and maximises the clinical team's control of the situation. In ethics consultation, the approach can be seen to sit within an ethics facilitation approach, as opposed to a pure facilitation approach (one that seeks consensus) or an authoritarian approach. Simon (2009 p107) describes this broad approach as one that "is about helping to find a solution in the context of morally acceptable possibilities that can be shared by each of the parties". The Association for the Quality Development of Solution Focused Consulting and Training (ASFCT 2012 p1) summarises the underpinning concepts of the model as follows:

> "amplifying useful change, resource orientation, those with the issue are the experts in their own lives, respectful, non-blaming, an interactional view, working within the frame of reference of the clinician, treating each situation as different, not trying to impose a theoretical framework".

The benefit to the clinician of a supported dialectic approach can be considerable.

Hartrick-Doane (2009 p239), writing on the benefits of nurses discussing ethics among themselves, states:

> "In listening to, observing and highlighting the ethical complexity of their nursing practice, the nurses began to notice things in their own practice that they had previously taken for granted. They began to see that they had been acting to effect ethical practice all along. At the same time, they began to realize ways they could be more effective".

Therefore, far from encouraging abrogation of responsibility and lessening the moral growth of the practitioner, the CEC can deepen the clinician's moral understanding of their own and others' judgements, using a framework that encourages active reflection on issues relating to practice. The framework encourages the clinician to consider the patient's voice, even when it is not possible or desirable for the patient to be at the meeting, and to consider ways of managing any conflict that arises from debating contentious issues. If CECs attend to the structure of their support and incorporate a reflective model, the quality of their activity can be measured in relation to the environment they provide, the support they offer, their approaches to challenging and questioning, the clarification that is gained and choices considered. All these elements have the potential to benefit the clinician, and role modelling this approach may also influence the approach to ethics within the entire organisation. As outlined within this chapter, the solution-focused approach was developed in order to stimulate reflection within short timeframes, and also meets the need for the clinician to make a judgement he can justify, within the confines of the time he has available.

Bowles et al (2001) evaluated the impact on nurse's communication skills after solution-focused communication skills training. Education through case review and

also small group events, that may be held by the CEC to demonstrate the approach would focus on enhancing communication skills and therefore team working skills in order to enable teams to handle their conflicts most effectively. As Bowles et al (2001 p2) states:

> *"The importance of effective communication as a fundamental element of nursing has been repeatedly acknowledged (Wilkinson et al 1998, 1999, Booth et al, 1999) and is regarded as integral to the provision of high quality patient focused nursing care (Macleod Clark 1988, Lubbers & Roy 1990, Dunn 1991). Yet nurses' communication skills have long been a source of concern (Smith 1983, Macleod Clark 1988, Wilkinson 1991, Heaven & Maguire 1996, Jarrett & Payne 2000)".*

Communication skills education has been criticised for its lack of a framework. Nurses and other healthcare professionals are given a toolkit of skills but very little framework about how to use such skills. Solution-focused skills, described by Bowles et al (2001 p3) as "both a system of communication and a set of assumptions about how best to change, adapt and grow" can offer a framework for communication skills training that can be offered by the CEC to staff within their organisation. This would obviously be an introductory level and offered in collaboration with the organisations training teams, to ensure a safe training environment was provided. The brevity of the training and the skills learnt is an asset to the hard-pressed clinician. Bowles et al (2001 p3) cite (Talmon 1990) stating "Solution focused brief therapy is brief, which means that the nurse should use the least of time necessary to engage the patient effectively. This may take place over several encounters or may be as little as a single session".

The evaluation followed education of nurses in solution focused methods, and measured on a likert scale the following areas: Competence in talking with people who are troubled, confidence in talking with people who are troubled, willingness to talk with people who are troubled, frequency with which the nurse speaks to people who are troubled, the extent to which the nurse's colleagues tolerated their engagement with people who are troubled, the amount of scope their role allows them to talk with people who are troubled. The learning of the skill demonstrated, "A significant change to their willingness to interact with patients" (Bowles et al 2001 p7). Empowerment and increased patient responsibility and participation are also identified by the study, as possible benefits to this kind of training to enhance practice. The CEC by refining their communication skills, increasing ethical competence, and learning simple and time effective techniques can, through education, pass on such learning which will impact on team skills, and also may encourage the health worker to engage in difficult conversations. In this modern healthcare environment, when poor communication features in so many patient complaints, this skill must surely be one to develop and evaluate within and outside the CEC. As Woods et al (2011 p15) state:

> *"As a flexible approach, SFBT [Solution focused brief therapy] has been enthusiastically received and applied across a range of contexts and client groups, including schools and family settings and individuals, professionals and community members, voluntary and mandated groups (Corcoran and Pillai 2007; Kelly Kim & Franklin 2008). Early practitioner evaluations of SFBT were very positive, but these studies often used subjective outcome measures and were not high quality reports (Gingerich & Eisengart 2000).*

As CECs themselves need to find a model by which they can demonstrate effectiveness, and by understanding that there is some initial evidence that solution focused skills support engagement of nurses and healthcare staff on difficult issues, there is an opportunity for CECs to harness such a model, and demonstrate its impact through case review and education. This appears to be an early opportunity to demonstrate the effectiveness of a collaborative, strengths focused approach which stimulates dialogue, and where an authoritative or judgemental approach is not warranted or required. Once such evidence is available the approach can develop and be further refined to suit the CEC function. Even though evaluation of activity and role is unclear, clinicians are already bringing cases to CECs in greater numbers (Slowther et al 2012), and do not appear deterred by the lack of formal evaluation at present. Potential benefit could be maximised with greater clarity of role and confidence in approach based on a framework which enabled review to enable gathering of evidence of efficacy. It would seem remiss that groups and the organisations in which they work do not heed the warnings already raised about their activity, and attend to the detail of their processes for the good of all involved.

6.5 Taking an ethical issue to a solution focused CEC a case example

Using one of the previously cited examples in the thesis this section will outline, in detail, how the CEC can assist with ethical team working and can offer education using a solution focused approach. This is a hypothetical scenario based on a real case and drawing on cited reflections by nursing staff to myself.

Emma

Emma and her nursing colleagues were struggling with the problem of being asked to administer chemotherapy to patients they felt did not have the capacity to consent fully, particularly the need to understand the importance of understanding the importance of reporting physical changes to avoid septic neutropaenia, and would be caused harm by their inability to comply with supportive care. Their concern had been further strengthened by a recent case where a patient with Dementia and fluctuating capacity had been deemed by medical staff to have the capacity to consent to chemotherapy. This was based on a capacity assessment carried out on her more lucid days. The nursing staff, from their day to day relationship with the patient, believed she was not able to remember the possible signs of impending infection and may then not report significant health changes. Staying in hospital was unacceptable to the lady as she deteriorated markedly in relation to her dementia when in a hospital setting, she needed her home routines. The patient did develop an infection whilst neutropaenic. She did not recognise the symptoms of her sepsis and report such and subsequently died from the infection. The nursing staff felt their concerns were unheard in this situation and felt responsible for administering a medication that they felt contributed to the patient's early death. They had some resentment toward the medical team on the patient's behalf. Emma felt fearful of the situation happening again and was unsure how to tackle this with the team, this was undermining team trust and relationships.

What would happen if Emma brought her case to a CEC who have been trained in solution focused coaching and also have undergone enhanced communication skills training? How could they facilitate a resolution?

Session 1

Emma describes the issue as above. If the team were utilising a traditionally problem focused approach there would have been much time spent exploring the problem. This problem focused approach typically reviews the past and looks at the deficits and blocks to progress on the issue (George 2013). The solution focused approach concentrates on talking to Emma and considering where she is trying to get to? Emma is asked about her best hopes for coming to the group today. Focusing on her best hopes the solution focused CEC are able to dispel any myths about what the CEC is aiming to do and also facilitates the setting of an achievable goal by Emma. The CECs aim is to talk with Emma to help her make a change in the working situation.

The CEC listen specifically for strengths, talents, skills and abilities that Emma can build on to tackle the issue. Active listening in this way can focus on what is already working in the team that can be built upon to make a meaningful change in the future. The CEC makes it clear to Emma that this approach is not a global answer to all work problems. They clarify that solution focused thinking is not the only effective approach, but it is a way of reflecting on the issues raised by ethical dilemmas in practice. The solution focused approach can also be useful within a session or short number of sessions and the skills learnt by structuring the reflection in this way can be used by Emma in a wide variety of situations.

Emma is asked by a small CEC to consider her preferred future with regard to the issue. The CEC asks about 'best hopes' for the meeting. After considering what she is hoping to achieve in this safe and supportive environment Emma considers that 'being heard', when the medical staff are making decisions about chemotherapy that she is to administer, is an important goal she wants to achieve.

This will then lead to her feeling satisfied that the team makes a more holistic and patient centred decision in the future, and this in turn will increase patient satisfaction. This goal maintains the focus of the meeting on potential for a solution to the problem and facilitates movement forward through the issue; it does not diminish the issue and does not focus completely on it. Becoming engrossed in the rights and wrongs of differing perspectives in this situation by the CEC does not effectively use the time and skills of the group as it may lead to unstructured rumination without meaningful improvement in practice which is the desired outcome. George (2013 p4) cites Rock on this issue who states, "Looking for the source of the habit literally creates more connections between this habit and other parts of our brain. The more we focus on a problem we have, the more ingrained we make it. There is another way: We can leave the problem wiring where it is, and focus wholly and completely on the creation of new wiring". The common project as identified by (Korman 2004) is agreed with Emma.

The CEC has no role to take sides, to define right or wrong or to recommend the right option. Their role is to support the worker to identify a positive, concrete and observable, detailed and interactive change for the better to improve the situation that exists presently and which had led them to seek support.

The questioning begins with the CEC acknowledging the emotional and practical impact of the issue. Emma describes her preferred future. This is one where she feels able to assertively voice her concerns on behalf of her patient, and influence decision making. Emma identifies in detail how things would look if she felt able to contribute her perspective confidently. The CEC gently, supportively but persistently enquire about this area, using solution focused questioning techniques. "What would you notice yourself doing more of? What else will be

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different? Who will notice? What will be small signs of this quality growing?" Emma is able to visualise tangible signs of this skill developing and link this to a better future in line with her best hopes.

In this hypothetical case, Emma discusses that she feels able to present her view on the patients capacity in the MDT but feels unable to challenge when she perceives a decision about care has already been made. On more detailed reflection this appears to surround the perceived fact that she is being invited to contribute to the MDT, but her input afterwards may be seen as challenging and she feels uncomfortable with this. The CEC focus questioning on this identified area. Emma is asked to identify exceptions to the problem at present, where she has successfully challenged and been assertive, and this has led to better outcomes for her patients improved satisfaction with her work. Questions used by the CEC to stimulate reflection on exceptions to the problem are, "are there times when this problem does not happen, times where this is less of an issue, are there times when you manage or cope better with this situation?" The CEC drill down gently into the issue, as curious enquirers, assisting Emma to consider applying the skills identified to the dilemma she has brought. The CEC encourages Emma to identify when she would know she was using the skills to work through the issue more effectively. "What would be the signs you were doing more of this, how would you know?"

After supporting Emma to consider solution focused steps to address the identified problem the CEC can use case examples and precedent cases to illuminate and enrich thinking and reflection through widening perspective. As the CEC may not know the issue identified before discussion with Emma they may need a second session where Emma's reflection on her progress is facilitated, and any further

information which may assist her reflections may be shared. This is not to direct Emma to a certain action, but is to assist her by introducing her to solutions other practitioners have found to the issue. Use of such cases is dependent upon the type of issue brought. Some issues may have legal precedent and others may have guideline and recommendation which are considered best practice and therefore the CEC can ensure that the clinician is aware of this.

This additional information is not a central element of solution focused practice, but it is always good healthcare practice to consider what is seen as reasonable in the eyes of the practicing healthcare population, and it can be motivating and enlightening to consider steps that have already been taken to tackle difficult ethical issues or practical problems that have led to ethical tensions.

Emma is asked to consider using scaling questions as part of a strategy toward measurable change. Emma wants to improve confidence and courage in order to best represent her patient and avoid a decision being made on patient's capacity which is not in the patients best interests. Emma is asked to scale how successfully uses the skills which will assist her to move toward her best hopes. She will be asked to scale where she perceives herself to be in this area. If she considers herself to have no skills at all in the area she should scale a 0. Emma rates herself as a 4 so identifies skills akin to being almost halfway to her goal. She offers suggestions to the CEC as to how she will know she is using more of this skill to get to the place she wants to be which is as close to 10 as possible.

Session 2

As part of her plan she organises a follow up session with the CEC. This session can be offered individually with one member of the CEC or with the group, this is

Emma's Choice. Both group and Emma have time in-between to consider the issue discussed, the group's job is to identify any precedent or similar cases of how other reasonable healthcare professionals have addressed such issues. This can be used to inform reflection.

After the meeting with the CEC Emma is encouraged to take time to practice the skills identified, and notice the use of the skills, and rate how they are contributing to the change. In the next session the CEC can encourage Emma to reflect upon what she as noticed about her practice, what she is doing differently and how it is impacting on the ethical issue brought. The use of the scaling questions can be useful here.

This combination of facilitation and practical information assists Emma to identify a key component of her disquiet and address this. In practice she felt uncomfortable, anxious and angry about the way she was interacting in the team and this was particularly apparent in patients with fluctuating capacity and changing need. By using a solution focused approach the CEC, in a short space of time, is able to support a change in practice for the benefit of the person receiving care. Emma did not need to apportion blame or accept a recommendation to do this. The CEC acknowledges Emma's discomfort, helps her clarify a real need to change and that this change is achievable. Emma herself sets goals and is able to clarify when these goals are achieved. The CEC can contribute to the process further by offering examples of what other reasonable clinicians have considered, and may choose to focus questions which ensure the voice of the patient is being heard. How will your patient notice that you are using these skills? The CEC will be clear that this information is not offered as a recommendation as they have no jurisdiction to offer this. In this shared safe space of the CEC, no CEC team

member is assumed more expert than the other. The patient and the worker are the central axis around which the questioning focuses. George (2013) describes the approach as effective, empowering, flexible, building cooperation and partnership, brief and minimally impositional. The goals of the modern healthcare CEC should be to offer a safe reflective space to encompass all these qualities in order to make a real and lasting difference to the health worker and the person using the service. The process is evaluable through a range of means, the improvement in scoring of the scaling questions, the identification of skills developed by Emma, the difference made in practice, and also by peer review through observation of the use of the questioning and scaling tools.

Chapter 7 Evaluation.

7.1 Evaluating quality of activity.

Concerns have been raised by a number of authors about the lack of evidence of procedural rigor within CECs. Such a lack of evidence to clearly illuminate their benefit is likely to undermine the ability of CECs to confidently promote their effectiveness in practice.

The UK CEC should demonstrate evaluation of the quality and usefulness of their processes, particularly case review. This starts with identifying clear aims for practice. The manner in which the CEC seeks to achieve the stated aims can then be analysed. Williamson (2007 p3) identifies the need for CECs to be transparent and accountable stating:

> "The need to assess the performance and contribution of CECs is supported by a number of factors. Firstly, evaluation is deemed important to help ensure that ethics services are transparent and accountable — as far as confidentiality requirements permit".

What evidence is already available about activity of CECs and how can using a structured approach such as the ASCS approach assist with improving the quality and amount of evaluative evidence available?

There is some emerging evidence about the impact of CEC activity on clinical teams as Pfafflin et al (2009) state "research on or evaluation of ethics consultation has started to appear in the European literature". This is not always positive. Evidence available appears to point unsurprisingly to the need for more research in this area. Williamson (2007 pp20-21) identifies that UK CECs are

arranged in an ad hoc way, and that there is a lack of national standards to guide their activity stating:

> "Clinical Ethics services in the UK are arranged on an ad hoc basis. The Clinical Ethics Network currently fosters exchange between existing CECs and provides short educational programmes. But in this system ethics education is optional for CEC members, not a requirement. The network has not sought to act as a vehicle to generate national standards or operational procedures for committees. Those involved in establishing the network have acknowledged that committees require evaluation."

Whitehead et al (2009) surveyed UK CECs to elicit opinions about their case review activities. The fragmented and ad hoc nature of the groups was identified through the survey. Fewer than half of CECs approached responded to the questionnaire sent, but those that did respond showed a very diverse set of roles and functions. Of the respondents 70% indicated their group had at least one member with doctoral-level training in ethics, bioethics or philosophy. The number of case reviews ranged from none in the previous 12 months to 10-15 active cases. The varying numbers of cases, varying structures for ethical review and the lack of funding for a number of groups all demonstrated the diversity that exists between groups. A clinician bringing an issue could not be confident of standardised practice and a consistency between groups.

Slowther et al (2012) published results of a postal survey sent to the chairs of the 82 clinical ethics services registered with the Clinical Ethics Network in July 2010. From the responses returned (62%), they found almost 30% of the committee chairs spent more than 50% of their time on case reviews. However, they also found a "wide variation in committee processes". Slowther et al (2012) call for

more research into this area, to enable CECs and the organisations within which they work to evaluate current provisions, and plan for future service development. The Slowther et al (2012) survey identifies that current case review activity is increasing however, there is still insufficient evidence to reassure those using or considering using CEC services on the following points: how do the committees ensure that all of the dangers inherent in case review (as discussed previously) are minimised?; what are the potential benefits?; how is the CEC aiming to adapt its function so as to maximise these identified benefits?

The groups need to urgently consider how they can demonstrate quality and consistency in their processes and outcomes and needs to adopt a model that recognises their supportive not advisory nature and demonstrates how such support is offered particularly with regard to clinical case. The consequences of a CEC not offering appropriate support (and potentially causing harm) by adopting a model that encourages the perception that they are experts in ethical matters, and encourages abrogation of responsibility for a decision, which may be a wrong decision, will have direct repercussions for patients and their families. Therefore it would be unethical for CEC groups not urgently consider auditing the quality of their activities and responding to the results.

Answering the questions above is an achievable goal. All CECs should be striving to develop and evidence a procedural expertise that will assure us as service users that the support given is high quality.

As Childs (2009) states:

> *"CECs cannot and will not claim to have normative moral guidance and*
>
> *expertise but, rather to have procedural expertise" (p233).*

The ASCS model provides a clear goal for practice and an auditable framework for practice. Firstly a standardised pre-requisite education for all CEC members can be identified. Enhanced communication skills, legal awareness training and solution focused training can be offered to all members prior to active group membership. The skills gained through such training and being involved in group post hoc case review activities can enable the CEC member to develop skills to support clinicians to "come to their own wise counsel on what, finally, to do" (Childs 2009 p233).

CEC reflective practice can be analysed and evaluated within the four following areas; (1) the group's ability to hear the issue brought, (2) their ability to offer support, and ability to promote the service user perspective, (3) their use of systems for introducing and exploring precedent cases and (4) Their use of solution focused questioning techniques. In addition activities in relation to sensitive information gathering, confidentiality, privacy and conflict management can be evaluated.

CECs themselves using the ASCS model will be expected to identify a benchmark standard for good practice within the areas identified above. For example in the Ask phase the CEC would need to demonstrate how they manage the environment to facilitate dialogue and non-judgemental support, how they structure their questioning, how they allocate time, and how emotional support is offered.

Tools that can be used to gather information useful to evidence good practice can include, clinician self evaluation of use of communication skills and documentation of peer review between CECs looking at the areas identified above. Such evidence can offer insights into the how effectively the CEC members are communicating with each other and with the person bringing the issue and can form the basis of action plans for development.

Good communication between CECs and within CECs is crucial. A number of writers have commented on the practical dilemmas and communication breakdowns that may present themselves to the group as ethical dilemmas. As Sexson (1996) states, many of the problems encountered by these groups could in fact be communication difficulties that only appear to be ethical issues. Communication difficulties from outside the group could be further compounded by difficulties within the group if communication issues within the CEC are not identified and dealt with.

Having clear aims and processes will increase clinicians' confidence in the service they will receive. Lack of confidence in a service may deter the troubled clinician from bringing a sensitive case. Førde (2008 p23) identifies poor systems that will deter the bringing of a case are:

> "lack of systematic analysis of the ethical problem, transparent procedures in preparation of the cases, lack of documentation and ignorance of, or low respect for, important medical and psychosocial facts in the particular case."

An example of benchmarking and subsequent measurement to be used in relation to communication skills for a CEC member can be seen below.

According to the ASCS model the pre-requisite communication skills benchmark would be that *all CEC members should access enhanced communication skills training prior to their involvement in case review and all members should have regular review of their communication skills*. Once the members had accessed the training, all CEC members will undergo regular, (yearly), peer and self assessment to offer them feedback on the quality of listening skills used and use of non directive questioning. Yearly data on use of this skill should be a minimum requirement for CEC members if groups want to be seen as credible bodies able to use good communication skills to support patients and clinicians in the most difficult of situations. The CEC must demonstrate governance around its activities.

Campbell (2001) reflects upon the problem of not paying scrupulous attention to governance issues. He reflects that the CEC cannot be merely outward-looking stating:

> *"Ethics committees themselves should not be exempt from the sustained and planned scrutiny of clinical governance. Do they provide a service that meets national standards of professional ethical consultancy? How do they audit their own performance? And what measures are they taking to remedy deficiencies in their own procedures?" (Campbell 2001 p i56).*

Although CECs need to engage in an audit process, I find Campbell's call for the CECs to be measured against a national standard for ethical consultancy worrying. As has been noted earlier in the thesis, the role of the clinical ethicist, and that of the CEC (made up of lay and professional members with diverse skills), although interdependent and complementary, are very different. The two can and should serve different functions and be evaluated as different entities.

Because of the lack of a legal regulatory framework for CECs, and following on from the recommendations from the Royal College of Physicians report on practice (2005), the UK Clinical Ethics Network published a consensus document in 2007 titled Collective Core Competencies for Clinical Ethics Committees (Larcher et al 2007). Such competencies are seen as the skills that the whole group should aspire to possess as an entity and are offered as a framework by which CECs can begin to measure their practice. Not all of the skills, it asserts, should be expected to reside in every member of the CEC stating:

> "The knowledge required by a clinical ethics committee can be wide ranging…and it is not possible for any one member to cover all areas. Advanced knowledge in specific areas, such as healthcare law, organisational structure and cultural context, can be provided by recruitment of appropriate individuals".

Concerns have been raised about the competencies and whether they are achievable or need to be achievable. As Gillon (2010 p2946) reflects:

> "These are exceedingly ambitious requirements even if, as the authors propose, the required skills and knowledge are collective targets for each committee rather than each member, and even if the specified personal attributes are regarded as 'aspirations' rather than as a set of necessary personal attributes".

Although the attributes identified are desirable personal qualities, such qualities would be difficult if not impossible to measure. Furthermore, as previously discussed, the CEC members do not have to exemplify excellent human beings in order to offer effective support to the clinician. The document also places an

emphasis on ethical knowledge, when it could be argued that the most important attributes are those related to being a supportive facilitator. The document does mention interpersonal qualities, but only after quite a lengthy list of knowledge-based attributes. Gillon (2010 p2946) describes the competencies as consisting of

 "a variety of ethical assessment and analysis skills including the ability to formulate and justify morally acceptable solutions", but the primary role of the CEC should not be to formulate and recommend such solutions but to facilitate discussion around options. Although it is never wrong to aspire to embody traits that provide the best chance of flourishing, what is required of the CEC must reflect what is pragmatically achievable within the constraints of their role. Interestingly, Gillon (2010 p2946) remarks that, even though the USA proposed such norms regarding competencies in the 1980s, and despite the arguments in support of the logic of such competencies, there is "still no national agreement or regulation" regarding them.

They are a starting point for peer and self assessment

Although the CEC competencies identified are aspirational and practically impossible to measure in some areas, as previously mentioned, they do represent a starting point. This starting point is urgently needed if we are to make progress in assessing activity of the CEC groups against benchmarks, particularly with regard to education and knowledge acquisition, and there is no doubt that Ethox and the UK Clinical Ethics Network have been vital in promoting the need for starting to explore ways there can be standardisation of practice for UK CECs. According to Gillon, the personal characteristics that group members should be working towards are:

"tolerance, patience, compassion, honesty, fair mindedness, self-knowledge

and reflection, humility and integrity. These attributes are said to help ethics

consultations by enabling committee members to recognise personal

limitations and base relationships on trust and respect; promote recognition

and management of power imbalances, listen to the views of the weak,

vulnerable and dissenting people and be able to advocate on such peoples

behalf; not venture beyond their own level of competence; recognise

conflicts between personal moral views and their role in ethics consultation;

pursue ethically acceptable options even when it might be easier not to; and

be sensitive to changing circumstances that might have ethical impact"

(Gillon 2010 p2946).

These can be seen to be skills that increase the CECs chances of working

together effectively as a group as they enhance the members ability to address an

issue with empathy.

As Bruns et al (2011 p253) remark:

"It is quite obvious that the application of empathy can enhance the quality

of an ethics consultation...Within a conversation it is important to ensure full

attention to the dialogue partner".

Although, as Bruns and colleagues acknowledge, empathy is a difficult

competency to quantify it is an essential core component of a CEC review as they

state:

"it should be more emphasised as a key competence and basic skill in

future debates about quality, credentialing, and certification of clinical ethics

consultation".

Such interpersonal characteristics important to group debate such as respect, honesty and empathy can be evidenced by case example when group deliberations are monitored and feedback is given to the group members and can be used to evidence good practice within the group. External and internal peer review of practice can be useful to gather evidence to demonstrate good practice. A willingness and openness to gather such evidence is urgently necessary within the CEC. As Williamson (2007 p5) states CECs need to open their doors to external review:

> "UNESCO suggests that self-evaluation is 'rarely sufficient' given the lack of objectivity it provides. External assessment is proposed as being more beneficial because it can help to '…identify strengths that can be maintained, weakness that could be corrected, policy considerations that have been overlooked….'."

This seems appropriate as the CEC cannot ask a clinician to share their vulnerabilities, if the group itself is not willing to do so itself.

Demonstrating and evaluating the benefits of the CEC by members using a reflective model personally, and within the reviews

Self reflection on skills and use of the process will offer further important evidence. Reflections by group members on the use of the ASCS process can be a powerful tool to support the argument for the benefit of having a reflective forum within healthcare culture. One example of this is cited in the following example. Bowman (2011) has written an honest and open account of her experience of completing a competency log within a CEC. This is a self-assessment tool for evaluating personal competence against the identified skills, knowledge and attributes of a

CEC member in line with the core competencies. Deborah Bowman is a senior lecturer in medical ethics and law at St George's, the University of London. She describes the reflective experience:

> "I feel, as I should given my role, confident about my familiarity with ethical principles, core concepts and a wide range of analytic frameworks and tools…When I reached the part of the questionnaire that asked about my confidence in understanding and responding to the local needs, culture and preferences of the hospital with whom I will be working, I ticked 'novice'. I realised that no amount of knowledge or skills, be they derived from studying philosophy, law and medicine or practice-based training such as mediation, teaching and counselling was sufficient to consider myself anything other than a beginner in my new environment".

Bowman is being alerted to the multi-faceted nature of her role, and the varying levels of skill she has in different areas. Thus, even if the CEC competencies, previously identified, are aspirational, reflecting upon personal development in relation to them is useful in itself and something all practitioners, or even people within society, should seek to do if they can. What should be guarded against is the perception that achieving them is the only way to be confident that the person is a useful CEC member.

The Association for the Quality Development of Solution Focused Consultation and Training (ASFCT 2012) identify the key requirements of a responsible solution-focused practitioner. Perhaps the development of such ASFCT 2012 attributes, coupled with the CEC terms of reference, should be a more pragmatic competency requirement for members of the CEC? This should be linked to each

member being obliged to consider their own moral development through a reflection as outlined by Bowman above.

The attributes identified by ASFCT (2012) were to:

> "keep professional knowledge and skills up to date, act within the limits of their skill and knowledge and refer clients to another professional if appropriate, keep adequate records, receive regular supervision, limit or stop their work if their performance or judgement is affected by poor health or another reason" (ASFCT 2012 p1).

Aleksandrova (2008 p40), in her survey of experiences of ethical decision-making and the attitudes of physicians towards ethics consultations, asks the following question: "What qualities and skills should an ethical consultant possess?" The skills she identified are mainly personal characteristics rather than analytical skills, namely, clinical competence, the ability to deal with conflicts, communication skills, tolerance of different views, specific qualifications in ethics, competence in psychology, being a respected colleague, and empathy.

The identified personal attributes demonstrated by members could be measured alongside specific elements of CEC procedural activity such as: (1) time spent by the CEC offering support, allocated time for case activity (including retrospective case activity to develop debating skills), (2) time allocated for group members to offer peer reviews to each other, (3) time spent networking with other groups to share experience and skills, (4) organisational support including budgets to support the CECs activity, and (5) activities related to education within the trust. Information about such activity should be collected as soon as possible for already active CECs. The UK Clinical Ethics network could then publish the data yearly for

all CECs to consider. CECs should all be obliged to produce some data regarding the systems that underpin their activities. For the smaller or less well supported CECs information about the activities of better supported groups or those more active in evaluation, could give them evidence to help them gain support, and would increase recognition and understanding of their valuable role.

Such evaluation of the CEC in the attitudinal, educational and procedural areas should not be seen as an optional extra, but fundamental to ensure CEC survival. It is important for CECs to demonstrate their worth to secure investment of time and money from any healthcare organisation. The CEC has the potential to function as a catalyst for organisational development and change. Support from the organisation and the Clinical Ethics Network will optimise the chances of these groups being successful at their identified tasks. This will be achievable once the latter have realistic goals about the remit of the CEC. The ASCS model provides a framework by which the CECs can offer clarity about its aims and evidence as to how these aims are being achieved.

Williamson (2007) states that evaluating CECs will enable them to secure organisational resources (budget and time), which are important as they support the CECs themselves to be educated in order to be able to educate others. In today's hard-pressed economic environment she identifies that "to warrant such investment, committees must demonstrate that they make a positive contribution to clinical care" (Williamson 2007 p4).

Organisational support for CEC activity and evaluation

It is unlikely that CEC groups will be sufficiently prepared for their role unless there is organisational acknowledgement of the importance of having a well educated

and supported ethics forum within the healthcare culture, and unless this culture invests time and money in preparing groups appropriately. As Frewer (2007 p289) states "Clinical ethics committees need both money and time to develop their professionalism". There must be a time commitment to enable CEC members to meet to engage in post-hoc reviews, reviews of guidelines and active debate. Time for networking and learning from a wider range of experiences is also fundamental to their practice, as is effective education around different ethical positions, to increase ethical awareness and competence (but not to ascribe any expert status). As mentioned by Slowther (2008) earlier in this thesis, isolation may lead to demoralisation and a lack of motivation among the group, to develop the skills needed to offer effective support. Therefore all CECs should be provided with a development budget to support their work and enable them to access available learning resources. As Williamson (2007 p7) identifies:

> "In order to support such decision making, sufficient resources must be made available. If CECs are to provide this support they will require assistance to prevent them from creating greater calamities than they resolve."

With a development budget secured, new members joining the group should be allocated a mentor. For those involved in clinical healthcare practice, the mentorship culture will be well known. This personal guide will offer support to help the new member understand the appropriate goals of the group. If all group members are aware of the history, aims, previous cases and scope of influence of the group, then clarity will be increased in relation to its role, its limitations and the appropriate application of CEC skills. The CEC member will then become an

informed educator as they go about their day-to-day lives and work, tackling the misunderstanding that exists about the role and function of the CEC.

With time and funding secured and a mentorship scheme in place, new members are not disadvantaged in comparison to those members who are more established. No member should be seen as an expert in applied ethics as all members bring the unique contribution of their diversity. This will help counter any power imbalances between members, which could lead new group members to feel confused and unsure about their role and function. Good chairmanship will ensure new members are inducted appropriately.

Development and encouragement of new and lay group members is pivotal. Many groups already have such support systems in place, but formalising the process would help address concerns that have been raised in relation to CECs, including (as mentioned previously) their unclear role and function, a feeling of disempowerment within the groups, a perception that the group needs to offer answers and solutions to clinical problems, perpetuating the notion of a 'clinical ethical expert', and the potential for, if not the actual, disempowerment of the clinical team, all of which work against declared aims and benefits for the existence of the CEC.

7.2 Evidencing clinician satisfaction.

 Quality can also be evidenced by asking those involved in the process about their perceptions of the support offered and any changes in practice that have been made. It is important to focus not only on process, but on the qualitative perceptions of outcomes as well. Williamson (2008 p13) raises the question of whether satisfaction is a safe measure of ethical quality. She acknowledges satisfaction is important as the CEC relies on the clinician's desire to use the

group for support and their recommendations to other clinicians. However, she

says, just looking at satisfaction will not ensure that there is a robust system in

place to ensure fair and supportive deliberations. As previously mentioned, it may

be conflict that brings a case before the CEC. The group needs to be sufficiently

skilled to question and challenge issues, even if this may be uncomfortable for the

clinician at times. The CEC cannot exist as a group that sanctions or rubber

stamps action that may not be in the patient's best interests. Thus, Williamson

states "high levels of satisfaction may, for example, signify no more than medics or

patients getting their own way due to the impotence of the CEC" (2008 p13). But

we must seek user views and learn and adapt from the feedback. Williamson

asserts that such accountability is crucial in gaining users' confidence. If CECs

lose credibility they may not remain viable in the long term.

Is formal accreditation necessary?

Does the need to formalise the CEC and ensure it demonstrates its worth,

necessarily lead to the need for formal accreditation of the groups? As yet, formal

accreditation or certification is not required in the UK. Formal evaluation against

agreed measurement tools on a yearly basis seems plausible and possible, as

long as a sufficient budget can be allocated to ensure the CEC is able to be

trained and have sufficient administrative support to enable it to evaluate such

systems against required standards.

Such processes could be seen as important educative tools in themselves, role

modelling good practices that can be replicated in other areas of the healthcare

system. Childs (2009 p238) comments, as follows, on this point:

"I think that most of us would agree that there should be some standard of knowledge, experience, and competence for CECs and the public deserves such. What I am not so sure about is that certification and a process of certification is the best way to move on that concern."

Slowther et al (2012) see formalisation and the involvement of national bodies such as the Department of Health, to be potentially useful for the organisation of CECs, as they may be able to oversee coordination and best practice guidance.

They state:

"perhaps the most obvious starting point is the formal recognition of CECs in the UK. If CECs were recognised as a feature of the NHS it would become easier to put into place the appropriate support and scrutiny that other health service services require" (p214).

Certification may though lead to a position of false reassurance. How and when will the groups be certified? What then happens if a group's membership changes significantly? Would a re-certification need to be done? Certification would give a snapshot of the picture. Surely it would be better to have systems in place that ensured consistency and clarity on an ongoing basis, alongside any such certification. Also, who would pay for such certification?

7.3 Evaluation of the value of CEC education

At present, there are no formal obligatory training requirements for CECs. Unless questioned by law, in the UK, CEC recommendations are not necessarily subject to any formal mandatory process of external review. There are, at present, no ways of ensuring the quality of the education CECs have accessed or education CECs have provided. This situation is reflected not only in UK CECs but also

internationally. Childs (2009) described the more poorly organised CECs in the USA (as opposed to the more well-formed committees) as follows:

> *"Rarely will any member of the committee have any specialized training in medical ethics, outside perhaps a six hour continuing education course in nursing or medicine. Often these committees are dominated by a physician who has a personal interest in ethics and this can result in a slanted perspective of the few cases that are presented. More often than not what the committee members think the law allows or does not allow trumps much of a discussion concerning the values and ethical implications of cases under discussion. It is clear that those who provide ethics consultation need to have more training than the vast majority of well-meaning ethics committee members have or possess the resources to attain." (p232)*

If a group is to develop its scope and influence within a UK healthcare institution as an insightful and ethically educated discussion forum, it will need to have its discussions underpinned by an agreed level of ethical education and facilitation training, and also have an opportunity to participate in debates on cases, even if this occurs post hoc. This education cannot be left to chance. All CECs within the UK, regardless of size, composition or perceived function, should have members who individually have accessed a pre-determined level of education in medical ethics, communication skills training, reflective questioning techniques, and have experience of debating effectively within the group using post hoc scenarios (prior to debating current case scenarios). Trusts should be obliged to ensure that new CEC members have clear plans for their development, and the financial support to access the training provided by organisations such as Ethox, or other locally sourced awareness and facilitation training. At present, although CECs are able to

access a range of practical information on ethics, and some training, especially through Ethox and the UK's Clinical Ethics Network, there is no prerequisite for training in ethics or ethical review. As Williamson (2008 p10) identifies, empirical studies that have looked at the CECs function have found that there are often "low levels of ethics training amongst members and that there is a growth of 'Kwik-fit' clinical ethics courses targeted at members of CECs". This situation means there is a risk of offering "insufficient training to equip professionals with adequate analytical skills for their role in the committees" (Williamson 2008 p10). She adds that "they give the impression that clinical ethics – and perhaps health ethics more generally – is a discipline that can be taught easily and quickly, so underestimating the skills required" (p10). Rather than offering limited information and short courses around ethical theories, it seems more appropriate to ensure that the CEC groups are committed to continuous learning and to the development of their skills to support decision making through reflective practice using a model such as the solution-focused model identified earlier. It is equally important that the healthcare organisation in question supports the CEC with time and finances, to be able to offer such a role and evaluate its own effectiveness.

Knowing why someone might argue for a particular action will help CEC members in their deliberations, as they will be able to clarify different perspectives, respect the rationales behind them and challenge inconsistencies. Williamson (2008 p14) argues that it is important for the group to:

> *"have critical teeth to allow them to dissect flawed reasoning that may be used (perhaps inadvertently) either to support bad practice or to prevent much needed developments within clinical practice."*

Most importantly, once the group has an established grounding in applied ethics, it can use this knowledge within a supportive and supervisory framework to support the clinical teams. The function of the CEC would therefore be to offer a forum for any clinical dilemmas, disputes and conflicts encountered by the teams and to facilitate a compromise or resolution in the time available.

To support this goal, the members of the CEC will need to ensure they have an agreed level of education in the following areas: debating and negotiating skills, recording and report writing, understanding ethical approaches to decision making, supporting colleagues, and de-escalating distress and conflict. As a group focused on peer support, signposting, education and comment on guidelines and policy, the balance of education should shift from looking predominantly at ethical theory to a method of supporting the CEC group in working and communicating effectively together. Such attributes would benefit CEC members individually, support group activity and debate when looking at post hoc cases or guideline development, and enable the group to be an effective discussion forum in their work with the healthcare teams. The latter aspect should comprise the following: enabling the sharing and development of effective multi-disciplinary teamwork strategies through role modelling, and motivating others to believe that, although complex, ethical dilemmas and conflicts can be managed. This useful and supportive role of the CEC group is the one that is most likely to further develop the reflective and analytical skills of clinicians, and therefore support the professional and moral development of the clinical team. This will complement organisational teaching in ethics.

Johnston et al's (2010) study looking into the perceived need for ethics support identifies that training on how to resolve ethical dilemmas is perceived to be lacking. They state:

> *"Nearly half (48%) of the consultants responding to the Trust questionnaire rated the training they had received as poor/very poor. One important role of CECs is ethics education…. targeted to the areas where health-care professionals feel it is most needed. Anonymized case write ups employed throughout the Trust can be a valuable outcome of the work of a CEC"* (p205).

When the clinician brings an issue to the group, there will most likely be stress, potentially fear, and a high level of anxiety about the situation. A group having skills in conflict support and de-escalation (using an action learning approach such as the solution-focused approach) would assist in the resolution of the real-time issue. Identified learning needs may arise out of such situations, or even learning needs among other staff in the wider organisation. At the time the case is brought, it may not be appropriate to stimulate deeper learning about ethics through information sharing and discussion; the stressful scenario may call for immediate resolution. However, anonymised cases can be considered in post hoc review, through supportive education sessions. The various options for action can then be debated through more formal education, which could be timetabled as part of the Trust's education and training programme. Members of the CEC would be a very valuable asset in such training, as they would be able to reflect upon the actual situation, and promote learning by posing questions to the post hoc review group, for their consideration and debate. This opportunity to reflect on clinical cases would also offer the CEC members the opportunity to work collaboratively with the

education and training teams in the Trust. This would support the development of teamwork skills, which would benefit the teams and the individual clinician in times of conflict, ethical or otherwise.

Grady et al (2008 p9) studied ethics education, and its impact upon moral decisions and moral activism in a population of nurses and social workers (SWs). They concluded that ethics education had a significant positive impact on moral confidence, action and use of resources. They remarked:

> *"The findings from this study have important implications for the ethics education of nurses and SWs, and for the development and support of ethics resources in the settings where they work".*

Through their own increased education and development, the members of the CECs have great potential to inspire and encourage others to reflect upon the ethical nature of their decisions. They can also help foster an organisational culture in which practitioners are encouraged to consider appropriate moral decisions and accept responsibility for their actions. Through education, the various ethical approaches to a problem/case could be considered and used as a forum for reflection, looking in on practice.

Supporting the clinician or the clinical team in their consideration of ethical and decision-making issues in practice is a role for which the CEC is importantly and uniquely placed.

Myser et al (1995) state there may be limitations regarding the teaching of ethics within certain medical programmes. This is an issue, particularly with regard to the practical application of taught principles and therefore the CEC can help bridge this gap:

> *"Ethical reasoning and decision making may be thought of as 'professional skills', and in this sense are as relevant to efficient clinical practice as the biomedical and clinical sciences are to the diagnosis of a patient's problem. Despite this, however, undergraduate medical programmes in ethics tend to focus on the teaching of bioethical theories, concepts and or prominent ethical issues such as IVF and euthanasia rather than the use of such ethics knowledge (theories, principles, concepts, rules) to clinical practice Myser et al (1995 p97)".*

Even CECs that question how much input they should have into contemporaneous case reviews feel a crucial part of their role is to provide education and support to those wanting to explore ethical considerations, or cases more fully.

Within my work environment I have planned an evaluation to explore how the use of solution focused approaches to tackle ethical dilemmas can assist assistant practitioners with personal and professional development. It is my aim to test whether the use of the ASCS model can develop their skills to manage difficult ethical challenges in the future.

7.4 A planned pilot to evaluate the use of the ASCS model within a group setting.

It is imperative that the proposed model is considered and evaluated as a useable framework to assist the clinician with finding solutions to clinical ethical dilemmas.

Within the Hospice I work a formal CEC does not exist, I have proposed a pilot study to begin the process of beginning to equip the clinicians with the skills to use the ASCS model. Although I believe the model is one that will be particularly useful to the CEC, it is also a model for structuring reflection and planning solutions to ethical issues out of the CEC forum also.

The following pilot has been planned to commence September 2013.

Hospice management has been engaged in discussions around the cultural benefit to the organisation of a group able to facilitate and demonstrate solution focused decision making in practice, using the ASCS model. The hospice experiences many practical, emotional and ethical issues and will not be short of issues or cases for the group to support the clinicians with.

The hospice has recently completed training eight assistant practitioners, who are tasked with innovating practice and establishing the new role into the hospice team. An Assistant Practitioner is an experienced health care worker; although not a registered practitioner they have completed a foundation degree in palliative care practice and assist registered practitioners with their roles.

It is anticipated that this new AP role will experience a number of challenges as they become embedded within the hospice team. Experiences of difficulties have been evident, throughout the two year training. The practitioners have experienced, challenge to their knowledge, communication difficulties, lack of acceptance of their emerging role and obstruction to their attempts at practice development. They have experienced less if any resistance from patients and carers who appreciate their hands on competencies, empathy and support.

The management, valuing the need for a support system to be in place have agreed to fund 6 members of staff (who will be the ASCS support group) to attend a 2 day solution focused training programme. All staff have also completed enhanced communication skills training. The total cost of the solution focused training for 6 members of staff is £1,200. Each of the 6 staff members are from various backgrounds such as specialist palliative care nurse, social worker, education lead, senior nurse, counsellor and volunteer. They are then tasked with establishing a solution focused ethics committee. Their role will be to provide a safe reflective space for the hospice assistant practitioner to consider ethical issues in practice.

The pilot study

The six volunteers will meet together to establish their terms of reference, which will be to offer assistance with dilemmas experienced in practice, by the assistant practitioners. The group will be offered training in the ASCS model in which the solution focused questioning will be embedded, and an introduction to awareness around medical ethics including legal awareness. The group will meet together to review their procedures and to review a range of post-hoc team and patient focused issues to practice offering facilitation using solution focused questioning techniques within the ASCS model. The post-hoc reviews will be observed by a small group of hospice reviewers. The reviewers will be asked to consider issues such as;

1. Environment of the review, the group's ability to debate diverse perspectives and the gathering of evidence to support discussions. Also the communication skills demonstrated will be noted with examples of practice gathered.

2. The feedback to relevant parties involved and manner in which issues are challenged.

3. Each element of the ASCS process will also be considered.

4. The participants will also be asked to consider, the appropriateness of the training offered to prepare them for the role, and satisfaction with the use of the model and the questioning technique.

The evaluation with be undertaken by the use of a taped interview with the group members, and use of questionnaire data collection methods.

The external reviewers who are observing group activity will be given prompt sheets identifying areas to consider about personal and procedural skills demonstrated.

Assistant practitioners will be invited to bring issues or cases to consider with the group using the ASCS model. All assistant practitioners will be made aware of the model, aims for use of the model, and how the ASCS model should be used in the group. It they wish they can also observe the group reviewing a post-hoc clinical dilemma, using the model, prior to bringing their issue. This will be seen as an educational experience to build confidence in the discussion process and gather feedback on the process from the Assistant Practitioner.

From the evaluation, it is anticipated that data will be collected over a period of a year about; education of the group, communication skills demonstrated, use and ease of use of the ASCS process, satisfaction of the clinician bringing the case.

This pilot is not to be undertaken with a CEC and therefore the data gathered is not generalisable to CECs, but will offer some insight into the learning gained from

employing this model of reflective practice for discussion of difficult situations. The model can then be adapted and refined, in the light of the evaluation.

Future plans would involve discussion with CECs about the model and whether any CEC, nationally or internationally would feel they would wish to test the ASCS model in their group deliberations. This would enable data to be collected that may be considered by other CECs looking to develop their practice using the framework.

CONCLUSION

It can be seen that Clinical Ethics Committees are complex and fascinating by their nature. CECs can be seen to have the potential to confer some benefit to the healthcare organisations and the clinician, if they are structured appropriately. They are a group who can, and do, raise the profile of clinical ethics. Clinicians and the public appear to want their presence, from the limited data we have about international and national CEC function. Benefit can be seen to address quality issues, to stimulate professional judgement and decision making skills, and also to increase confidence that the patient voice will be heard in clinical discussions about difficult ethical situations. Trusts value their presence, although as previously stated they are primarily aimed at the clinician and are not management tools, their links to management can influence the ethical culture of an organisation. Their links to trust management can help to raise the profile of clinical ethical issues when required. As health service managers and clinicians may view an ethical dilemma through different lenses a group who can bridge the gap between them, to encourage meaningful dialogue, and an appropriate solution to value conflict, needs to be welcomed. Case review within the CEC can enhance good multi-disciplinary working, especially in the areas of issue clarification, and conflict management. It is the emphasis and nature of the case review that has to be considered carefully by clinician CEC membership, organisation and patient alike.

CECs face a challenge in the future. The healthcare organisations within which they function are required to demonstrate that the systems they support and develop can be proven to be cost effective, efficient and improve the quality of delivery of care. CECs are not able to guarantee any of these aspects within their

practice as processes differ from group to group, evaluation is scarce, and future direction is unclear. As Kalager et al (2011 p118) state "Quality assurance of the work is crucial if the committees are to play a role in grave decisions." The risk of continuing along the path of not establishing robust systems that demonstrate quality deliberations is that healthcare organisations may cease to realise the full potential benefit of a CEC to organisational, team and individual clinician decision making, which in turn will impact on patient satisfaction. This may even lead to a lack of support for the CEC and failure to allocate badly needed resources.

To address these concerns CECs in the UK need to establish a shared sense of purpose. Through time and resources invested, they can role model and educate on effective reflective practice in relation to ethics, and stimulate good team working practices to enhance patient care. To do this they need a clear model. The ASCS model appreciates and addresses the value of considering moral and non-moral influencing factors, acknowledging the importance of emotions in decision making, the need to manage disagreement well in times of ethical conflict and the inclusion of principles and rules that are shaped by our common sense morality. These elements can be considered within a CEC by a group confident and skilled to provide a safe environment for reflection. The ASCS model then offers a framework for solutions to be considered with the clinician/patient present, to maximise the chances of an outcome which is fair and just and understandable by all. For the CEC to function effectively using the ASCS model, training in how to support reflection on practice is necessary. Reflection is an endeavour that is not without its risks, and time and resources need to be allocated for the CEC members to attend important training in this area. Once training in communication skills and reflection, ethical awareness, and solution focused questioning skills are

in place, the CEC has a solid foundation on which to develop its activity, which may be organisation focused or patient and individual clinician focused. Clarity of goals can be reviewed, use of a model can be monitored, skills in reflective practice can be assessed, and levels of pre-requisite education can and should be formalised. Such evaluation of method needs to be undertaken as soon as possible, and as I have discussed in the previous chapter I intend to evaluate the model within a reflective practice group, I will seek to establish communication with national and international CECs in order to establish whether there is a forum that wishes to consider a pilot of the approach. CECs, I believe, will have no choice to consider how they demonstrate quality in their reviews. This model offers a way for CECs to grasp the challenge, clarify their aims and demonstrate their worth.

As Slowther (2012) identifies perhaps there is some benefit in CECs themselves being subject to the scrutiny of the NHS quality teams. This will offer two-fold benefits. Firstly the CEC can demonstrate the quality of their activity, secondly if they are to be credible agents for quality in the organisation they can demonstrate they practice what they preach and attend to their own quality issues first. Therefore through the thesis I have identified how, if structured appropriately, CECs can further the moral development of clinicians. Rather than abrogating and diffusing responsibility or accepting management dictates, the clinician can be encouraged to debate, question and challenge. Through developing moral skills and strength they are better positioned to find their own solutions within their teams and challenge any representation that does not appear to be in the best interests of the patient and their family. I invite any CEC interested in considering the use of the model, to consider what it may offer to their group and to embark on

a joint process of discovery, in an early endeavour to evaluate and refine CEC

practice.

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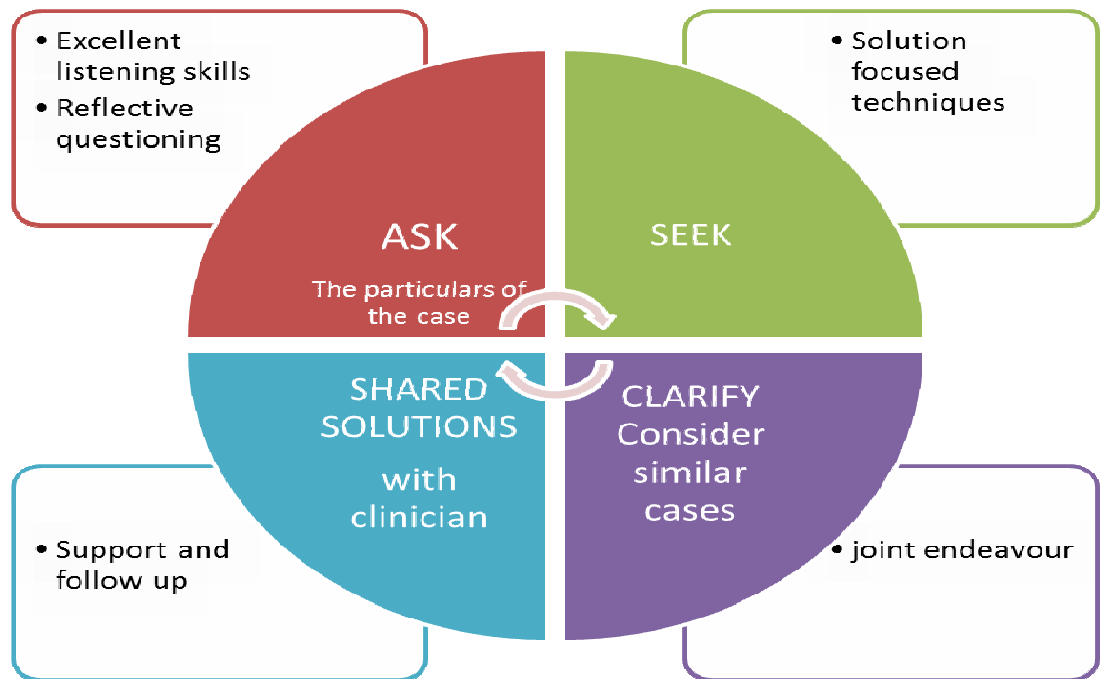
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ASCS MODEL OF REFLECTION WITHIN A CLINICAL ETHICS

COMMITTEE (Williams 2012)

- Excellent listening skills
- Reflective questioning

- Solution focused techniques

ASK
The particulars of the case

SEEK

SHARED SOLUTIONS
with clinician

CLARIFY
Consider similar cases

- Support and follow up

- joint endeavour

Box 1 Four key tasks for a typical first session

Task of therapist	*Examples of opening questions*
Find out what the person is hoping to achieve from the meeting or the work together	What are your best hopes of our work together? How will you know if this is useful?
Find out what the small, mundane and everyday details of the person's life would be like if these hopes were realised	If tonight while you were asleep a miracle happened and it resolved all the problems that bring you here what would you be noticing different tomorrow?
Find out what the person is already doing or has done in the past that might contribute to these hopes being realised	Tell me about the times the problem does not happen When are the times that bits of the miracle already occur?
Find out what might be different if the person made one very small step towards realising these hopes	What would your partner/doctor/colleague notice if you moved another 5% towards the life you would like to be leading?

Scales

One of the most useful frameworks for a solution-focused interview is the 0 to 10 scale, where 10 equals the achievement of all goals and zero is the worst possible scenario. The client is asked to identify his or her current position and the point of sufficient satisfaction. Within this framework it is possible to define ultimate objectives, what the client is already doing to achieve them and what the next step might be (Fig. 1).

The scale framework can be used to differentiate different aspects of the problem and its solution. For example, a person with depression might feel devalued by colleagues. Each of these aspects might be explored through separate scales. Similarly, when the client is experiencing multiple problems, each problem can be addressed with its own scale. Where several scales are used, areas of overlap soon become apparent, which helps the client realise that movement in one area can lead to improvements in others.

Coping and compliments

Looking for the client's strengths and resources and commenting on them is an important part of a solution-focused therapy session.

Sometimes clients' lives are so difficult that they cannot imagine things being different and cannot see anything of value in their present circumstances.

Points to mark	*What to explore*
10 — The perfect solution	The miracle question as a means to encourage creative thinking
7 — A good but realistic outcome	A realistic description of the client getting on with his/her life without the problem interfering too much. The more concrete and realistic the better, since it is the small, mundane aspects of living that go together to make a good-enough life
3 — Where the client is now	Everything the client is doing that has helped him or her reach this point on the scale and/or everything he/she is doing to prevent matters getting worse
0 — The worst scenario	Best not to go into detail

Fig. 1 The scale framework

Appendix 2

Appendix 3 an overview of an advanced communication skills two day programme.

Please see following page:

DAY 1

Time	Activity
09.00am	Registration and coffee
09.30am	Introduction, orientation & Ground rules
10.00am	Agenda setting
10.45am	COFFEE
11.15am	Presentation & Discussion
12.30pm	LUNCH
13.15 pm	Interactive Demonstration
14:30 pm	TEA
15: 00 pm	Discussion of role-play
15: 30 pm	Agenda Priorities
16.00 pm	Close

DAY 2

Time	Activity
09.00am	COFFEE
09.15am	Welcome to Day 2
09.30am	Role-play Group work
10.45 am	COFFEE
11.00 am	Role-play Group Work
12:15 pm	LUNCH
13:00 pm	Role-play Group Work
14:15 pm	Role-play Group Work
15:30 pm	Transfer issues
16:00 pm	Evaluation and setting of supervision dates
16.15 pm	CLOSE

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