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Bioethics committees/commissions in hospitals — the experience of other countries. Where to start?

Abstract

The paper entitled “Bioethics Committees/Commissions in Hospitals — The Experience of Other Countries. Where to Start?” touches upon the topic of calling into being bioethics committees in Polish hospitals. The need for creating such advisory bodies, and the range of their competence, is shown on the basis of western publications (especially those from French and English speaking countries) as well as on the basis of the personal experience of the author as a member of the bioethics committee in an English hospital (Tameside Hospital in Ashton-under-Lyne). The existence of bioethics committees in hospitals contributes to the humanization of medicine and to an holistic approach to the patient, who is no longer treated as a “particular clinical case” but as a human being, with a wealth of psychological and spiritual attributes, and also, as the subject of interpersonal relations with other people and with the whole community.

Dynamic progress in the area of medicine in recent decades has made bioethics committees a requirement of our times. They are of immense importance when doctors are faced with unusually difficult ethical problems, which they cannot always solve by themselves. These committees should consist of competent representatives from the biomedical, philosophical and legal sciences, as well as a representative from the patient’s religious denomination.

Key words: bioethics committee, bioethics, ethics, humanization of medicine, patient’s rights, physician’s conscience, DNAR

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Introduction

The issue of bioethics committees is relatively new in Polish literature, however some publications have already appeared. Moreover, a number of local committees/commissions on bioethics already exist in several hospitals in our country. What exactly are those bodies? What is their task? Should they function in local healthcare units and if so, how?

In the present article we will attempt to answer these questions.

A bit of history

The case of Karen Ann Quinlan, a 21-year-old woman, who in 1975 was diagnosed to be in a persistent vegetative state, is the starting point for a consideration of bioethics committees. For several

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months her life was sustained by means of a respirator and heart monitoring device. She was fed by means of a feeding tube. A year after Karen had lost consciousness the New Jersey Supreme Court appointed a special committee in order to decide whether the applied means could be regarded as extraordinary and hence, whether the further persistent therapy of the patient could be discontinued. The members of the committee were at that time: a social worker, a physician, a lawyer and two priests. The committee's response was positive; Karen Ann Quinlan was disconnected from the life-sustaining devices.

The case described above became an incentive for the establishment of hospital bioethics committees, which were to exercise an advisory function for physicians in particularly difficult clinical situations, especially those concerning the decision to discontinue persistent therapy and to cease resuscitation, or, decisions about conducting medical trials on human subjects. At first such committees were formed only extemporaneously in particular situations, but gradually they became established bodies functioning in hospitals, especially in the United States.

The definition and kinds of bioethics committees/commissions

According to the accepted definition, "bioethics committees (ethics committees and commissions) constitute a group of people appointed by certain institutions, (governments, universities, chambers of physicians, hospitals), to perform particular tasks, especially, to elaborate, examine or control research projects or clinical activities. This group is the executive, directorial and supervisory body which represents either the state or society and which delivers an ethical and scientific review of biomedical research, evaluates the process by which the informed consent of research participants is obtained and analyses the principles of protection for people who are unable to grant any informed consent" [1]. According to precise nomenclature, these bodies which act ad hoc in resolving individual cases, should properly be called bioethics commissions, whereas those which work on a permanent basis, with regular meetings of the specialist team, should be called bioethics committees [2]. Some of these have federal, national or international scope.

Their aim is co-operation with the government in working out the legal regulations in the field of bioethics (as has been done by the American Com-

mittee on Assessing Genetic Risks or the French Comité Consultatif National d'Éthique). These are ethics committees of distinct kinds. Others have a purely local range and their task is to give their opinion on trials, experiments and surveys (e.g. at the universities and in clinics — university bioethics committees) or to decide on certain clinical cases (e.g. in hospitals — hospital bioethics committees). The role of the latter is extremely significant. Their activity constitutes the main subject of our analysis.

The aims of bioethics committees

In accordance with Directive 2001/20/WE of the European Parliament and of the Council of 4 April 2001, ethics or bioethics committees should be independent bodies of a Member State. Their responsibility "is to protect the rights, safety and wellbeing of human subjects involved in a trial and to provide public assurance of that protection, by, among other things, expressing an opinion on the trial protocol, the suitability of the investigators and the adequacy of facilities, and on the methods and documents to be used to inform trial subjects and obtain their informed consent" (Article 2, k).

When taking a closer look at the aims of hospital bioethics committees, one could specify them as follows below.

Humanization of medicine

Medicine is not only an empirical discipline, concentrated on a particular clinical case, but it is rather the holistic care of the patient — as a human being. Therefore, the work of the medical staff reaches beyond narrow specialisation and denotes a comprehensive approach to the patient, including his spiritual zone, ethical orientation, social background and religious beliefs. The physician cannot succumb to a so-called reductionist attitude towards his patient by concentrating only on some somatic or physiological pathology; he must take into account the whole wealth of the life of a patient as a human being, together with psychological, legal, moral and worldview aspects. Hence, the help of the hospital bioethics committee will strive towards affording full respect to all the dimensions of the patient's humanity; in that way it can directly contribute to the accurate decision of the attending physician and, indirectly, to the humanization of the whole of medicine.

The search for a common basis for ethical decisions

In these times of ethical pluralism it is a truly difficult task for the physician to find a proper ground upon which to base a decision concerning, for example, the continuation or termination of further therapy. Constantly they are subject to financial constraints (e.g. from the hospital's management, pharmaceutical companies), psychological pressure (e.g. from the patient's family members), legal pressure (e.g. from the state) etc. A physician himself does not possess precise knowledge of philosophical and ethical issues but represents, in himself, a peculiar combination of convictions and moral intuitions according to so-called "common morality". The responsibility of the hospital bioethics committee, operating within one particular healthcare unit, will be to provide justification for reaching a particular decision. However, a further especially timely question remains unanswered — what anthropological basis should be adopted for making the right moral choice? Surely, the physician of the utilitarian option cannot impose his value system on the patient who is Christian, and vice versa. It seems that, currently, the only common ground for objectively right decisions is the text shared by all mankind and proclaimed by the United Nations in 1948 — The Universal Declaration of Human Rights together with the precise norms expressed in the Medical Code of Ethics. In both texts, inspired by personalistic and Hippocratic premises, the person of a patient and his or her integral welfare form the primary criterion for the ethical choice. This was best expressed in Kant's famous imperative: "Act in such a way that you treat humanity, whether in your own person or in the person of any other, always at the same time as an end and never merely as a means to an end".

Patients' rights protection

A hospital bioethics committee is also charged with monitoring whether "the knowledge and medical technique used in scientific research and clinical practice serves the human being, his or her inalienable rights and real and integral wellbeing" [1]. Therefore, the task of the committee is to work out the proper physician-patient relation with regard to the observance of mutual autonomy. On the one hand, the patient is entitled to have his own beliefs and moral options accepted and to enjoy protection from any uncontrolled experiments etc. (patient's autonomy rule). On the other hand, the

physician also has the right to be protected from the pressure of conducting any intervention conflicting with his conscience (physician's autonomy rule). The committee then should protect both the rights of the patient as well as the physician's rights of protection from interference by the state or society, or from economic pressure from various social units. Hence, its significant role in countries with centralized healthcare systems (including Poland).

Arriving at the standpoint in certain circumstances

The most noticeable task of the hospital bioethics committee is arriving at the standpoint in problematic clinical situations. Due to the major developments in medical sciences that nowadays can prolong human life, it is becoming progressively more difficult for the physician to decide what really serves the patient's authentic well-being, and what may in fact be a violation of his rights or may constitute evidence of aggressive treatment. Let's have a closer look at a certain example.

In Poland, no model of anticipatory decisions concerning the ending of human life has so far been agreed upon (compared with, for example, the USA and Great Britain where it is manifested in making the DNAR decision — "Do Not Attempt Resuscitation"). The physician therefore does not know what to do in the event of the patient's loss of consciousness in the terminal phase of cancer. If a physician faces the necessity of making a decision he often starts cardiopulmonary resuscitation as a matter of course, on the basis of medical practice, even when it is unjustified and only contributes to an additional traumatic experience for a dying patient [3]. As a rule, the doctor's decision to take such action is based on fear that the patient's family may make accusations about the abandonment of resuscitation. Yet, previous analysis of such cases by the hospital bioethics committee, in working out the proper standpoint, could help the physician as well as the patient and his family. The duty of the committee, then, would be the examination of a particular case on every possible ground, according to a scheme which might be found acceptable as a representative example for the performance of every hospital committee:

— clinical analysis of the case and the prognosis — a special role is here assigned to physicians who are specialists in particular fields of medicine (in our case to cancer specialists and palliative medicine specialists). They should state what the patient's objective condition is, what the

- prognosis of the therapy is and what the possible alternative clinical proceedings are. The nurse should also express an opinion about the patient;
- legal analysis — after the physician's and nurse's opinions have been expressed, the provisions included in state, as well as international, legislative acts have to be presented. A legal representative may also propose drawing up some form of DNAR order in writing, to give the legal possibility and justification for the conscientious objection of a physician in any kind of controversial situation;
 - ethical analysis and physician's deontology analysis — the especially important task here belongs to the ethicist/philosopher who, as a member of a bioethics committee has the responsibility of precisely defining what should be done in a particular situation according to the *Medical Code of Ethics* and other national documents on ethics, international conventions (e.g. resolutions of the World Medical Association), the *Code of Ethics for Nurses* and, furthermore, he must judge how the suggested decision corresponds to basic human rights (e.g. to the *Universal Declaration of Human Rights*, the recommendations and conventions of the Council of Europe, provided that a particular country has signed it) etc. The role of the ethicist is unusually problematic considering the increasingly common pluralistic worldview, because he cannot express his own opinions but is obliged to be guided by objective moral norms, especially taking into account patient's axiology and the axiom of an absolute respect for his or her dignity as a person. It is postulated that, at the beginning of its activity, every bioethics committee should declare the ethical option according to which it will make decisions and this should be written down as a special Charter. In the specific case of the use of the DNAR rule in the terminal phase of cancer, the ethicist is obliged to investigate what is stated in the adopted Charter and what the detailed reference norms are, placing special focus on whether the proposed therapy serves the patient's integral wellbeing or not; whether it could be ceased or should rather be continued; what kind of treatment should be used etc. Due to the fact that the ethicist's work is remarkably difficult and key in decision-making, it is suggested that only highly competent people, preferably bioethical faculty graduates, should be appointed to this position;
 - religious analysis — after obtaining the ethicist's assessment, the representative of the pa-

tient's religious affiliation should express his opinion. If, for example, the patient is Catholic, as a rule one of the committee members is a chaplain or a secular employee of the Catholic healthcare priesthood. The responsibility is much easier when he works in a Catholic hospital (of which there are many e.g. in USA); it is a different situation if the healthcare unit does not support any religious option (as in the majority of the hospitals in Poland). In that case the representative of the Catholic Church will have to present the moral norms professed by his religious community (e.g. in the case of DNAR, his duty will be to report on the principles concerning persistent therapy set forth by Pope Pius XII and included in the Instruction of the Congregation for the Doctrine of the Faith entitled *Iura et bona*). The representative of any other confession would proceed in an analogical way;

- protocol making — once all the opinions are expressed, the summary of the meeting is submitted by the committee's chairman and the protocol is presented in written form. The protocol will serve the attending physician as a help in making difficult clinical decisions. Sometimes committee members are obliged to vote in order to arrive at a common approach, although this is an extreme step that should be avoided if possible. Further discussion is preferable in order to establish a definite solution.

Members of bioethics committees

According to the aforementioned Directive 2001/20/WE of the European Parliament and of the Council of 4 April 2001, ethics committees 'consist of healthcare professionals and nonmedical members' (Article 2, k). *The Declaration of Helsinki* states that the committee "must be independent of the researcher, the sponsor and any other undue influence"

Currently, the members of hospital bioethics committees should include the following:

- physician, specialist in a particular field;
- nurse (under no circumstances should the nurse be excluded from the bioethics committee, because it is often this person who knows the patient and his moral preference better than an attending physician);
- legal representative (lawyer, advocate, judge);
- bioethicist/ethicist (philosopher);
- chaplain or secular employee of the patient's religious denomination or healthcare priesthood;
- psychologist (optionally).

On the other hand, in order to preserve the committee's independence, its members cannot be:

- hospital director and hospital administration employees;
- patient's family members;
- pharmaceutical companies' representatives;
- sponsors of medical trials and experiments.

Features of bioethics committees

The chiefly significant features of bioethics committees are:

- subsidiarity — according to the subsidiarity rule, a bioethics committee is merely an advisory body; the decision to undertake or cease a particular intervention can only be made by an attending physician. Therefore, the committee is prohibited from taking over the function of being the "physician's conscience", obliging him to act in contradiction to his moral code;
- competence in resolving cases according to the accepted ethical option;
- independence from hospital management and administrative units, pharmaceutical companies and political authorities;
- possession of premises within or close to the hospital precincts.

Summary

To sum up, the activity of hospital bioethics committees may prove to be a great help for physicians who repeatedly find themselves in decision-making situations. To fulfil their duties in an authentic way, the committee members have to be

persons who are competent in the discipline they represent. Especially challenging is the task assigned to the ethicist/philosopher who should be a graduate of a bioethics faculty and be able to prove his competence in decision-making.

People of a questionable ethical reputation, as well as those expressly opposed to the Charter or the basic personalistic rules represented mainly by the *Universal Declaration of Human Rights*, cannot be allowed to participate in committee meetings. It is also postulated that committees should cooperate with bioethics centres and institutes in order to broaden their competence. Moreover, greater emphasis should be put on teaching the rules of medical ethics during medical and nursing training in order to enable physicians and nurses to resolve the difficult moral dilemmas they are likely to face in everyday clinical practice. Hence, it is essential to introduce more of the humanistic disciplines, like philosophy or ethics, to medical students. Only then may it become possible to enforce the postulates of the holistic approach towards the patient.

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