Are Ethics Committees in Tune With the “Epidemiology of Ethical Issues”?

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Health care ethics committees (ECs) have proliferated over the last 50 years as a consequence of the progressive development of academic bioethics. However, their form of operation is neither homogeneous nor fully satisfactory, and they present a great degree of variability throughout the world, rather like the children of a large family, each with different levels of growth and maturity.

The article by Frolic and colleagues (2012) opens the black box to one of their traditional functions: institutional policies on ethical questions. It is a sound article that explains—to the envy of many of us—the excellent work methodology developed by this particular group, and analyzes the quality of the review process as applied to two case studies that are recognizable at any latitude because of their relevance: Advertising Policy and Pediatric Jehovah’s Witness Blood Transfusion Policy. However, we should take advantage of the singular nature of both these issues in order to call attention to whether the activities of institutional review boards are in tune with the epidemiology of the ethical issues arising in the daily existence of the institutions they serve.

The question we should ask is whether ECs devote their greatest efforts to the most appropriate issues, owing to their prevalence and transcendence, either in clinical cases that cause ethical doubts to arise during the decision-making process, or as ethical guidelines for common areas of clinical practice where there is a significant moral dimension, and, naturally, in the content and form of the educational activity that ECs should be leading.

Many institutional review boards can be reproached for existing in a parallel universe to the daily health care provision activities of their institution, as if they were part of a failed marriage—sharing a roof but rarely sitting down to talk, and only doing so when there are serious conflicts that leave them with no choice but to make an urgent decision. In other words, ECs may be seen to be a somewhat removed from reality owing to their being out of tune with the real daily concerns of the institution.

EC members often complain among themselves that they receive few consultations, although this is scarcely reflected in the literature, and then only indirectly (DuVal et al. 2004; McLean 2007). There is a perception that the activity of ECs is excessively linked to the initiatives and motivation of their members. Consultations from professionals are few, either due to the little awareness that exist about the function of these committees, or as a result of skepticism, or because of a lack of basic education in ethics and in decision-making procedures (Altisent, Batiz, and Torrubia 2008). On the other hand, special mention should also be made of the reluctance of some doctors to seek consultation because this would mean acknowledging to their teams and to EC members that they were unable to resolve a problem, which would require humility—a genuine challenge for doctors, perhaps to a greater extent than for other health care professionals. This situation has been overcome in a number of institutions through the activity of clinical ethics consultants, who may or may not be members of an EC, offering personalized attention to those calling for advice. This is a tradition with little presence in Europe (Hurst et al. 2007).

Our group has had an interesting experience over the last decade arising from the activity of a primary health care EC in the Spanish region of Aragon, with a population of little more than 1 million inhabitants. We suspected that there was lack of coincidence between the activity of

Funding was provided by Instituto de Salud Carlos III. PI 05/2590, PI 09/1735.
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November, Volume 12, Number 11, 2012
the EC and the ethical concerns of health care professionals in their daily practice, which led us to research the prevalence of ethical issues considered by family physicians in their practices. We found that of the top 10 most prevalent ethical problems, according to frequency and difficulty, the highest ranked were ethical issues arising in the relationship between levels of health care (Buil et al. 2009): in other words, in the coordination between the primary and secondary levels (“induced prescription”—prescription of drugs recommended by other doctors/specialists, lack of agreement in care plans, delays in interdisciplinary consultations, etc.) Surprisingly, over a period of 12 years, our EC had hardly analyzed any consultations on these types of issues, which, likewise, were barely dealt with in the literature. So, what were we doing? Who were we advising and about what? This reflection led us to adapt the educational activities we should have been leading to the real ethical concerns in primary health care. Additionally, we questioned the risks involved with an EC devoted to the interests of a minority of professionals that were particularly motivated by bioethics. This would be analogous to the intention of organizing the health care of a poor, developing country and beginning with the construction of a hospital for transplants and equipped with a huge intensive care facility, when the priority needs of that country were in fact vaccines, food, and sanitation.

This is why we have proposed for our region the addition to the traditional trinity of EC functions—ethics education, case consultation, and policy work—the promotion of research into the ethical issues faced by health care professionals in their different specialities within the EC’s working area. This fourth function would serve as an epidemiological observatory for ethical issues that would enable education in ethics to be directed towards the real needs of those professionals. We believe that this will create a greater understanding between the EC and professionals, and this will lead to a greater number of consultations and to the efficiency of invested resources.

In some countries there are ECs that have reached the level of maturity and excellence shown by Frolic and colleagues’ target article, with experience enabling them to offer transparent and validated criteria for the ethical evaluation of policy work. However, in other places in the world, ECs are excessively focused on extreme cases, such as advising on withdrawal life support measures (Goldim et al. 2008; Orlowksi et al. 2009). Meanwhile, they barely analyze ethical problems that are present in daily life: the relationship between doctors and the drug industry, the difficulties of working in teams caused by the weak ethical commitment of their components, inadequate ways of providing information to patients’ relatives, abuse of public health resources by some patients, and so on.

For the management of some health care institutions, ECs are decorative figures that have little influence on health outcomes, and they may be seen to be driven and led by a minority of professionals who are highly motivated by humanistic aspects of medicine, but with a bias that distances them from the majority. ECs need to demonstrate their efficiency in order to convince managers that they make meaningful contributions to the quality of health care. For this to occur, we need to broaden the horizons of ECs to bring them closer to the majority of health care professionals and enable them to provide direction and relevant guidance to daily decisions.

In order for ECs to become aware of the “epidemiology” of the ethical issues in their environment, they will need to carry out studies and surveys using quantitative and qualitative methodologies (Larcher, Slowther, and Watson 2010; Slowther, Mcclimans, and Price 2012). As a consequence of having this type of knowledge, ECs should be able to produce a special kind of policy work that we could call “ethical alerts,” by means of brief statements issued to all the professionals in an institution, providing a short explanation of a current issue that may be of general interest: the abstract of a recently published article, a news item of moral significance, commentaries over the practical implications of a point of law (legal requirement), or general guidelines. In short, these would form a series of regularly released statements that would not be of a scholarly nature or related to the personal interests of EC members, but resulting from the evidence of real need. Thus, we could contribute to the appreciation of ECs by health care professionals, narrowing the gap between them and strongly defending the standing of committees as spaces that work to build awareness in an institution and contribute to the quality of its activity.

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