Renewing the call for clinical ethicists

The moral, legal, educational, and financial arguments for clinical ethicists are stronger than ever

Nine years ago in this journal I called for the use of clinical ethicists in UK hospitals. These are professionals, trained in medical ethics and law, who provide ethics support and education to clinicians and, in some cases, patients and relatives. Available at a moment’s notice, they help prevent and resolve ethical dilemmas at the coalface. Clinical ethicists are common in large hospitals in North America and some parts of Europe but virtually non-existent in the United Kingdom.

Much has changed since the publication of my original article. The number of complaints against doctors to the General Medical Council rose from 5168 in 2007 to 10,347 in 2012. The cost of litigation against the NHS has also vastly increased. In 2007-08 the NHS’s legal bill for clinical negligence claims was £456.4m. In 2011-12 it was £1.1bn.

A steady stream of high profile cases has exposed the complexities of ethical decision making in practice. For example, the recent case of Janet Tracey—whose family accused Addenbrooke’s Hospital in Cambridge of putting a “do not attempt resuscitation” notice in her notes without her knowledge—concluded that clinicians should consult patients before making such an order unless this is likely to cause physical or psychological harm to the patient.

In 2013 the Francis report uncovered appalling deficiencies in care and ethics at the Mid Staffordshire NHS Foundation Trust, leading to the neglect and preventable death of hundreds of patients. Recommendation 215 of the report was the development of a common code of ethics, standards, and conduct for senior healthcare leaders and managers.

It is now trite to say that ethics permeates much of what clinicians do. The first UK journal devoted to the subject, Clinical Ethics, was launched in March 2006.

My regular lecture “tours” of UK hospitals reveal an incessant stream of ethical problems faced by clinicians of all specialties, including those not traditionally associated with ethical quandaries, such as pathologists, radiologists, and dermatologists. Yet, unlike junior barristers, clinicians have no obligation to attend any ethics training after they have qualified.

Sheila McLean, chair of law and ethics in medicine at the University of Glasgow, concluded in 2009 that “ethical decision-making in the UK is essentially ad hoc, and arguably lacking either in sufficient ethical expertise or in attention to legal process. It is also clear that CECs [clinical ethics committees, of which there are currently about 85 in the UK] are probably not routinely used by the majority of healthcare professionals.” In a 2009 study of 30 CECs in the UK, over half had considered fewer than three “live” cases (for which the key ethical decisions had not yet been made) in the preceding year.

It remains my view that clinical ethicists are better suited to the task of providing support to clinicians than the often intimidating, impersonal CECs. An individual can build trust and form relationships with the medical team in a way that a committee cannot.

On a personal level I have migrated from the hushed halls of academe to the gritty world of law, where I practise as a clinical negligence barrister. I see disputes that might have been averted by an ethics consultation or a timely lecture on the topic. Informed consent and best interest cases spring to mind.

Introducing clinical ethicists is not a panacea. The early recognition of ethical problems will not prevent difficulties from arising, and even the most accomplished ethicist cannot eradicate complaints and lawsuits. However, common sense and experience suggest that organisations would benefit from having an employee with a detailed understanding of ethics, law, and conflict management, who can detect the signs of a looming ethical crisis in its infancy, and who can update and assist busy clinicians on ethico-legal issues in a weekly meeting or before a ward round.

The moral, legal, educational, and financial arguments for clinical ethicists are stronger than ever. It is high time for an innovative trust to trial the introduction of full time clinical ethicists—already tried and tested in the United States and elsewhere—and assess their value so that others can benefit.

At the very least, the appointment of a full time clinical ethicist would send a positive message to patients, relatives, and hospital staff that ethics is not an abstract buzzword but lies at the heart of high quality care.

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Competing interest: DS runs Alpha Academic Appeals, which assists students and professionals who wish to appeal decisions of universities and professional bodies about the outcome of examinations and misconduct hearings, sometimes for a fee.

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