

A clinical ethics committee in a small health service trust

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Clinical ethics committees (CECs) in Britain increase in number despite uncertainty over remit, structure, and manner of working.¹ Important functions fall outside the casework which intuitively forms the core of their activities² so benefits of a CEC for a small health care institution may be doubted if patient and staff numbers and therefore assumed frequency of case ethical dilemmas determine whether a committee is established. Small institutions are doubtless at no less risk of unethical practice. We report a survey of a CEC established in a small National Health Service (NHS) Trust in north-east Scotland comprising a district general hospital of 242 beds, GP-led community hospitals, and community and mental health services. Twenty-nine consultants and 1,100 other staff provide medical, surgical, paediatric, psychiatric and other services to a population of approximately 86,000.

The CEC was established in the autumn of 1996 with the remit to provide a forum for the discussion of ethically troubling cases; to promote general clinical and research ethical discussion and education; to help develop ethically sound trust policies, and to contribute more generally to staff support. All senior clinical staff were informed by memo of the committee's existence, and the referral mechanism. Referral by patients and relatives was not offered. It was made clear that the CEC would only offer facilitation of discussion, not take binding decisions affecting patient care.

The facilitator (KW) invited a senior nurse, a psychotherapist, a paediatrician, a junior doctor, and most recently a practice development nurse to join him as members of the committee. Neither fixed terms of membership nor elections were planned. No votes in committee were to be held; it was not minuted though agreed revisions of draft policies were returned to the submitting party.

After 18 months the CEC's work was reviewed: questionnaires about knowledge of the CEC and their attitudes towards it were circulated to all consultants, senior house officers, ward managers and two unselected staff nurses from each ward and community hospital.

One case was referred; its urgency meant that a response was given by the facilitator alone, who spoke to clinicians and family and entered his views in the case notes. Guidelines—on patient possession of illicit drugs; cardiopulmonary resuscitation after collapse, and other forms of resuscitation—were commented on and redrafted; a further set on confidentiality were considered individually by members to expedite the response. An open meeting was held to permit discussion of questions from the floor by an invited panel consisting of a clergyman, a senior nurse manager, a consultant physician and a director of public health (more than forty people attended). Teaching sessions were held for medical students and junior doctors working in obstetrics; many informal comments were made about potential research projects.

Eighty-nine staff responded to 136 questionnaires. Only 54% knew of the CEC's existence, and 17% how to refer a case; 78% would take clinical ethical problems to a colleague but only 24% would refer to the CEC, whose most favoured role was education (84%), with 81% considering case discussions valuable and 58% the refinement of policies. Sixty-five per cent of respondents wished the CEC to be elected but only 46% were willing to serve; 89% were happy to have their own patients' cases considered. Few felt that patient-clinician relations (6%) or clinician autonomy (9%) would be harmed. A quarter felt a health care ethics consultant would be beneficial.

Nursing and medical staff differed over whether patients should be told their case was to be discussed: 30% of consultants but 70% of nurses favoured this.

In common with CECs elsewhere³ casework was a small part of the workload. We feel that CECs wishing to address this work must keep a high profile within clinician groups: elections may help achieve this, giving an accountability that clinicians seem to want. Our experience suggests that nurses and doctors wish mainly education and support from CECs to facilitate the tackling of ethical dilemmas in their peer group. Involvement of patients and their representatives in resolving such problems is likely to remain contentious, though a CEC is not felt to be a threat to clinician-patient relationships or clinician autonomy.

References

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The recruitment of non-English speaking subjects into human research

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Researchers now accept that ethics committees will only grant approval for research in which it can be shown that all subjects are giving informed consent. Not all researchers appear to have taken this on board; many submit protocols suggesting that the researcher at the coalface will explain the pertinent facts to the prospective subject, in mime, gesture, written or spoken word and the committee can grant approval on this basis. The fact that the committee cannot be satisfied that informed consent will be obtained in every case is a matter of deep concern.

This highlights a troublesome ethical issue, namely the recruitment of members of non-English speaking groups, including the so-called "ethnic minority" groups into research studies. The question at the heart of this debate is whether it is ethical to recruit members of any group into research when these subjects are not, or cannot be, offered comprehensive information about the researcher's intention, and the inherent risks and discomfort to which they will be exposed by taking part. In cases where verbal consent is sought, it is a matter of argument whether a committee should be persuaded that researchers with an interest in the success of a project should be allowed to recruit any subjects without complete reassurance that they will not be coerced or misled into cooperating.

We insist that patient information leaflets and consent forms intended for use by English-speaking, English-