

# Hospital Clinical Ethics Committees The Geneva Experience – Switzerland

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## Introduction

In hospitals, ethics consultations and committees were a product of the 1970s in the United States of America (US). The US administration encouraged their development particularly when the influential 1983 report of the *President's Commission for the study of Ethical Problems in Medicine and Biomedical and Behavioral Research*, entitled *Deciding to Forgo Life-Sustaining Treatment*, gave a significant support to the role of ethics committees.<sup>1</sup> In the early 1980s, a survey in the US showed that only one percent of the hospitals had at that time a functioning ethics committee, whereas ten years later, in the mid 1990s, an important majority, probably more than ninety percent of the large US hospitals, had created such committees.<sup>2</sup> Since the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandated the healthcare institutions to develop these committees in 1991, they seemed to proliferate,<sup>3</sup> and to disseminate also in Europe,<sup>4</sup> with unequal distributions according to different countries.<sup>5</sup> They present different roles and modalities of functioning.<sup>6</sup> Therefore, it is not surprising that disagreement and criticisms exist about their proper role, and about their mode of operation.<sup>7</sup> Some of the disputes that we will consider below are related to theoretical issues. As an example, some ethicists and also care providers argue that ethics committees' action can be considered as an usurpation of physicians' authority, and that only clinically competent and skilled professionals should be in a natural position to carry out the role of case consultation. This opinion seems more prevalent among surgeons than among non-surgeons,<sup>8</sup> and within several countries, like in

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<sup>1</sup> Paris, Reardon [1986].

<sup>2</sup> Kelly, Hoyt [1996].

<sup>3</sup> Slowther et al. [2001].

<sup>4</sup> Salathé et al. [2003]; Guerrier [2006]; Szeremeta et al. [2001]; Meulenbergh [2007]; Reither-Theil [2001].

<sup>5</sup> Mino [2001].

<sup>6</sup> Lebeer [2005].

<sup>7</sup> Kelly, Hoyt [1996].

<sup>8</sup> Orłowski et al. [2006].

southern Europe.<sup>9</sup> Other express concerns about the practical functioning of these committees, and about their methods. For instance, they emphasize severe deficiencies, such as inconsistencies of the recommendations published by these committees, or the lack of quality of their cases' and clinical situations' analyses, particularly when the advices of committees for similar issues differ.<sup>10</sup> Others point out the bureaucracy that these instances may introduce in medicine.<sup>11</sup> Critic voices even claim, sometimes strongly, that a certain degree of amateurism prevails in the proposed advices of these instances.<sup>12</sup> Finally, for some,<sup>13</sup> there is a large confusion about the respective roles of the ethics consultants, only responsible for counseling for an individual patient when an ethical question is raised, and clinical ethics committees, considered as administrative bodies whose primarily tasks are designed for advising institutional policies.

We, in GENEVA,<sup>14</sup> have a different opinion, as some others<sup>15</sup>: we claim that these committees must have a large and influential role in our health institutions recognized by the authorities. In our view, these committees must be in the position to help patients, their families and the caregivers directly when a moral dilemma is present in a given concrete situation. They may help also indirectly the hospital authorities by guiding hospital decisions taking ethical aspects into consideration at the institutional level. In this sense, we think that it is obvious that clinical ethics committees bear a really different task than the one of the ethics bodies for research projects evaluation. Therefore, a clear cut institutional separation between research ethics and clinical ethics committees in our hospitals appears to us not only useful, but also mandatory.<sup>16</sup>

The contemporary hospital activity is characterized by a high density of difficult and complex decision tasks, particularly when end-of-life or scarce resources allocation are discussed.<sup>17</sup> These situations obviously generate major ethical debates.<sup>18</sup> Therefore, it is not surprising that the role of ethics committees has been

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<sup>9</sup> Hurst et al. [2007a].

<sup>10</sup> Bartels [1988]; Tulskey, Lo [1992].

<sup>11</sup> Sigler [1986].

<sup>12</sup> Fletcher, Hoffmann [1994].

<sup>13</sup> LaPuma, Schiedemayer [1991].

<sup>14</sup> Chevrolet [2002].

<sup>15</sup> Doyal [2001]; Scofield [1993].

<sup>16</sup> Meulenbergh [2007]; Reither-Theil [2001].

<sup>17</sup> Lo, Schroeder [1981].

<sup>18</sup> Hurst et al. [2005].

largely enhanced, in America as well as in some European countries.<sup>19</sup> Some encouraging data issued from rigorous,<sup>20</sup> or perhaps also from less strictly designed investigations,<sup>21</sup> clearly suggest that ethics consultations have a beneficial impact on patients, especially in the critical care setting. It may lead to the reduction of non-beneficial or futile treatments, therefore impacting favorably on costs.<sup>22</sup> It may also help resolving conflicts between different caregivers, or between family members and the hospital personnel, mostly when ethical dilemmas are related to patients, but never when only communication deficits, and not ethical issues, are the cause of such conflicts.<sup>23</sup> Generally speaking, nurses and doctors seem to be satisfied by the help provided by hospital ethics instances, whereas families and patients show a more nuanced, albeit not necessarily negative, opinion.<sup>24</sup> In addition, a not really surprising finding is that ethics facilities in hospitals are more frequently requested when nurses and doctors are more trained and competent in ethical matters.<sup>25</sup> Finally, it is interesting to point out that the perception of ethical concerns varies throughout different European countries. This explains the vast panel of different modalities in the available ethics supports among our continent.<sup>26</sup> Thus, healthcare services themselves vary to such a degree in Europe that recently the European Commission abandoned a project of a centralized regulation of clinical ethics instances.<sup>27</sup>

### **Characteristics of Clinical Ethics Committees**

Several forms of ethics committees have evolved since the 1970s.<sup>28</sup> Although an ethicist can be (must be?) present in risk management, quality assessment committees, assistance committees for helping staff members with their personal concerns, etc., what we aim to discuss specifically here is the so-called hospital clinical ethics committee. Three functions – education, development of policies and guidelines, and consultation and case reviews – have emerged as the major

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<sup>19</sup> Paris, Reardon [1986]; Kelly, Hoyt [1996]; Schneiderman et al. [2000]; Azoulay [2001].

<sup>20</sup> Schneiderman et al. [2000]; Azoulay [2001].

<sup>21</sup> Dowdy [1998].

<sup>22</sup> Heilicser [2000].

<sup>23</sup> Schneiderman et al. [2000].

<sup>24</sup> McClung et al. [1996]; Hurst [2006].

<sup>25</sup> Hurst et al. [2007b].

<sup>26</sup> Guerrier [2006]; Hurst et al. [2007a].

<sup>27</sup> Szeremeta et al. [2001].

<sup>28</sup> Schiedermayer, LaPuma [1993].

roles of these clinical ethics committees. The characteristics and some issues related to these bodies will therefore be discussed further.

*Position in the hospital and decisions*

A proper position of the clinical ethics committee within the hospital is of paramount importance. On the one hand, the committee must have a clear legitimacy and a strong institutional support.<sup>29</sup> Furthermore, the freedom of action of the committee must not be questionable nor influenced by the hospital authorities. This contradictory equation seems difficult to solve, and there is no simple solution for defining the exact position of the committee within the core structures of the institution. Should it be a medical staff committee? A committee of the administrative body? A committee of the board of trustees or of any other position? Each proposal bears advantages and drawbacks.<sup>30</sup> As we will see below, in GENEVA, this important issue was solved by a legitimacy provided by a government Act that had clearly founded the position of the committee in our Institution without any ambiguity.

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Clinical ethics committees do not have to make explicit decisions about patient care. Rather, they are specifically designed to be a consultative and advisory body for caregivers. They must therefore resist a regulatory role in the patient care, for which they are not trained, and because, in such an eventuality, physicians could finally abdicate their clinical judgment and authority, thereby possibly

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<sup>29</sup> Fry-Revere [1993].

<sup>30</sup> Kelly, Hoyt [1996].

<sup>31</sup> Fry-Revere [1993].

<sup>32</sup> Kelly, Hoyt [1996].

endangering their patients.<sup>33</sup> In addition, an authoritarian approach of ethics consultation would wrongly place the emphasis on consultants as the primary moral decision-makers, excluding the legitimate relevant parties (the patient, the family, any potential surrogate, and the caregivers) from moral decisions. Conversely, a facilitative approach by the clinical ethics committees of the difficult medical situations is more appropriate. It is consistent with both the pluralistic context in which the ethics consultation must be performed and with the variety of moral, religious and philosophical opinions prevailing in our communities, as well as with the rights of individuals. An “ethical facilitation approach” recognizes that societal values, law, and institutional policy have implications for a morally acceptable consensus, which should be the final goal of the ethics consultation. In this sense, a committee is useful when the members are able to identify and analyze the nature of the uncertainty of values and the conflicts underlying the consultation, assisting the involved individuals in clarifying their own values, and facilitating the building of morally acceptable shared commitments or understandings according to the real present context of their involvement. However, building a consensus on a moral question is not just negotiating a compromise, but also a contribution to the construction of moral rules and principles in a given institution. This type of mediation opens the way to a kind of moral expertise not only for the members of the committees, but, hopefully, soon or later, also for the whole hospital community.<sup>34</sup>

#### *Composition and members of the clinical ethics committees*

Pluralism is a prerequisite for the proper functioning of a clinical ethics committee, because the purpose of such a body is to address the broader social and ethical concerns of a wide range of questions occurring in the medical context, requesting a wider forum than physician input alone can provide.<sup>35</sup> Please remember that, in GENEVA, 42 percents of the population consists in non-Swiss residents, with several religions and very different philosophical approaches. Pluralism, once again, in such a Society, is just a question of social survival. We suspect that many other countries are presently in the same situation, at least in Europe: a single moral and uniform consensus seems rather poorly likely in the present time in our continent. This necessarily requires the inclusion in the committee of various professionals (physicians, nurses, social worker, representative

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<sup>33</sup> Annas [1991].

<sup>34</sup> Casarett et al. [1998].

<sup>35</sup> Paris, Reardon [1986].

of the legal profession, administrator, and, sometimes, a clergyman and an ethicist), but also of lay community members. The latter act as representatives of the non-institutional hospital society, but people known for their expertise, prudence and concern for others must be preferred. There are some sporadic controversies as to whether or not a lawyer<sup>36</sup> or even a professional ethicist and a clergyman, should be members or not of a clinical ethics committee.<sup>37</sup> The fear expressed by some is related to the concern that these typed specialists could bias the discussion within the committee by being in a position of excess authority or the go-between of dogmatic opinions, or that some conflicts of interests could occur, for example in the case of a lawyer who would also be an employee of the institution or a clergyman being too much the voice of a specific religion. In our view, however, a strong education in the field of ethics of the members of the committee and precise regulations and strict rules for its functioning<sup>38</sup> should avoid these concerns. Finally, the chair of the committee is often a physician (and not rarely a critical care physician), for politically practical rather than theoretic reasons. A physician with a strong reputation in the hospital will increase the acceptability of the committee, at least during the early stages of its functioning, whereas another non-physician member, once the committee has been established and accepted, will perfectly fulfill this role.<sup>39</sup>

*Law, clinical ethics committees and ethics consultants – responsibility and immunity*

If the educational role of the clinical ethics committees and the development of institutional guidelines are not controversial, their third function, i.e. the clinical case consultation, raises some questions,<sup>40</sup> especially concerning the legal weight of their advices, and the protection of their members against further criminal or civil liabilities.<sup>41</sup> Legal status of ethics committees and consultants are very different according to local legislations. Obviously, at least, two statutes may exist, i.e. either no protection at all of the members of these committees, or a broad legal protection of their members, named sometimes “immunity”. Immunity provision shields people who act in good faith from liability, and it represents a legal bar to a claim that may otherwise be brought against a person. However, civil and crimi-

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<sup>36</sup> Spielman [1993].

<sup>37</sup> Kelly, Hoyt [1996]; Spielman [1993].

<sup>38</sup> Frader [1991].

<sup>39</sup> Warnock [1991].

<sup>40</sup> Weeks, Nelson [1993].

<sup>41</sup> DuVal [1997]; Fleetwood [1994].

nal immunity can be conferred only by legislature and through specific laws. During the first thirty years of existence of institutional clinical ethics committees, there was a clear lack of agreement in the courts in the US about the proper legal weight to be granted to committees' deliberations. If there is no doubt that the clinical ethics committees have been proven beneficial for patients and health care providers,<sup>42</sup> their main value seems more in the processes of their deliberations (i.e. the quality of pluralistic discussions, and analyses), and not necessarily in their product, i.e. their advices. In the eventuality that their products have to receive the legal weight that an immunity would confer to them, much more needs to be fulfilled to study, improve, and safeguard processes in these committees. To meet these goals, professional standards for ethics committees must be established, particularly on qualifications of committee's members and on consultation procedures.<sup>43</sup> This improvement is certainly an ideal objective, but it is not always realistic. It could eventually compromise the pluralistic nature of these committees, as well as the voluntary basis of the activity of their members, as we will see below.

### **Difficulties and concerns**

The oldest clinical ethics committees had been in existence for about thirty years in the US when the American Society for Bioethics and Humanities reported on *Core Competencies for Health Care Ethics Consultation*.<sup>44</sup> Some have stated that these committees were characterized by "*High ideals and unrealistic expectations*" during their thirty years of functioning.<sup>45</sup> Four problematic issues were identified, which we will now discuss.

The *first issue* is the choice between an ethics committee or a specialized consultant such a professional ethicist. If a committee providing wise and strongly built ethics consultations may be really effective in long-term care settings, it is unlikely that for quick decision-making in difficult issues a quorum of twelve to fifteen members could be convened rapidly in less than 72 hours. A second concern about such committees is related to the choice of the members. Are these members appointed according to their job description because of their interest, expertise or experience in ethics? There is also a danger of "groupthink" and domination by one or several individual(s) with strong personalities when some

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<sup>42</sup> Kelly, Hoyt [1996]; Schneiderman et al. [2000]; Azoulay [2001]; Swenson, Miller [1992].

<sup>43</sup> Fletcher, Hoffmann [1994]; Leeman et al. [1997].

<sup>44</sup> Aulisio et al. [2000].

<sup>45</sup> Spike, Greenlaw [2000].

decisions have to be taken in a very formalized manner. In addition, when there are only private discussions in a closed committee, there is a risk of occultation of personal perspectives, expectations and opinions of those individuals most interested in the issue discussed, i.e. the medical staff, the patients and the family facing difficult situations. For all these reasons, an alternative model has been proposed. An individual ethics consultant could be relied on to discuss firsthand with the mandating colleagues, then to refer to the ethics committee, which would act as a quality control body. Each ethics consultant could be a member of the ethics committee, but not every member needs to function as a consultant.

The *second concern* is related to the certification of what we call an ethics consultant, or the education requested by hospital ethics committees.<sup>46</sup> This is an interesting and important question, because two prerequisites are contradictory in this matter.<sup>47</sup> Bio-ethics implies contributions from law, medicine and philosophy, and, sometimes, theology, sociology, cultural anthropology, health care economics, and politics.<sup>48</sup> On the other hand, questions pertaining to a difficult ethical dilemma regarding an individual patient require specialized and very often sophisticated medical and nursing skills. It is very unlikely that one single person, and, furthermore, a group of twelve to fifteen overworked clinicians and nurses in a hospital could fulfill these requirements. One could argue that this concern is of such paramount importance for an institution and for the patients that every hospital, or at least every major center, must design and set up specific careers for nurses and physicians, specially trained to become the backbones of the clinical ethics committees. Obviously, due to the actual economic constraints, and by using plain common sense, this option is quite unrealistic. Moreover, this choice would probably not be very wise. Clinical ethics committees, as sociologists have demonstrated in other fields, will be probably more effective when they play the role of a “stranger” rather than an “insider”, acting more in a role of critics of the established medical and administrative practices than being collaborative participants in them.<sup>49</sup> This is the price to pay to preserve legitimacy and a critical distance, and to be able to provide honest, objective and useful consultation. In addition, because the purpose of an ethics committee is to address the broader social and moral concerns of a large range of issues, it seems obvious that a wider forum than one composed of only nurses and physicians alone should operate. There-

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<sup>46</sup> Kelly, Hoyt [1996]; Siegler, Singer [1988]; AAP [2001].

<sup>47</sup> Barnard [1992].

<sup>48</sup> LaPuma, Schiedemayer [1991].

<sup>49</sup> Barnard [1992].



fore, the committee has to be opened to a wider public and it must include some non-institutional members. The committee should reflect the wisdom and the values of society, and it has to be broad based and multidisciplinary.<sup>50</sup> These statements are not nihilistic and paralyzing considering the education of the members, and they are not at all against the creation of a clinical ethical committee.<sup>51</sup> Education is the *sine qua non* of any functioning clinical ethics committee.<sup>52</sup> Each institution has to find its own way to provide training to the members of the committee (lectures given by experts, seminars, reviews of opinions of recognized ethicists, etc.), and a budget has to be allocated to this task. The main point is that clinical ethics is a specific activity and that, consequently, the self-education of a committee is the only way to ensure the quality of its works and the training of its members, a process that never comes to an end.<sup>53</sup> Of course, the activities of every committee and/or of the consultants, as well as the competencies of the members, the consequences and outcomes of the recommendations given by these instances have to be periodically evaluated.<sup>54</sup>

The *third concern* is more difficult to delineate. It is related to the intimate personality of the members of ethics committees, or to that of the so-called ethics consultant. This is a misconception that "ethicists" might be "superior" to common people, patients, families, nurses or physicians in charge and hold the truth. Otherwise, the common sense and the current observation would have easily detected such surprisingly "supermen/women"! In fact, this point raises the question of what is a "moral expert".<sup>55</sup> The general idea is that the ethics consultant is a "*facilitator of moral inquiry*".<sup>56</sup> This formulation has several important implications. Because moral questions are so clearly linked with political, social and psychological issues, the ethics consultant must have an extensive knowledge, in particular of law, medicine and philosophy. In addition, and this is probably the main issue, she/he has to defend clearly and overtly personal and consistent positions about moral questions. This is essential for deserving some credibility when expressing an advice about the difficult ethical dilemmas submitted to her/him, including of course concerns about health care. In other terms, the ethics consultant cannot just

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<sup>50</sup> Paris, Reardon [1986]; Scofield [1993].

<sup>51</sup> Kelly, Hoyt [1996]; Aulisio et al. [2000]; Slomka [1994].

<sup>52</sup> Kelly, Hoyt [1996].

<sup>53</sup> Kelly, Hoyt [1996].

<sup>54</sup> Kelly, Hoyt [1996]; Moreno [1991].

<sup>55</sup> Moreno [1991].

<sup>56</sup> Ackerman [1989].

pretend that he or she has “*the right answer*” (in a theoretical sense, as it would be the case when the question would have been asked to an university ethics department, or to any institutional body) for a difficult issue asked by caregivers, as is generally the case for other purely medical questions. She or he must not only take the position of a moral philosopher, but she/he has to be in the midst of the *agora*, i.e. in a public place like the hospital. She/he must be a recognized and respected actor of the health providing community. Therefore, ethics consulting is really a moral engagement.<sup>57</sup>

Finally, in the specialized literature,<sup>58</sup> there are some discussions about the *financial support for ethics consultation services*. This question is closely related to personal, and probably also, to cultural mentalities. Consequently, no general and definite opinion can presently be proposed on this issue. To our mind, this question is closely related to the preceding discussion about the moral profile of the members of clinical ethics committees. Belonging to an ethics committee could be considered as a professional activity, with legitimate and explicit advantages such as job progression, a decrease in working hours or a monetary compensation for the time spent. On the other hand, one could consider, and this is our way of thinking, that this is also as a very specific task, which cannot, by essence, be a profitable activity.

### **The Clinical Ethics Committee (CEC) of the Geneva University Hospitals**

Our CEC was founded in 1994. At this time, and for more than twenty years, several research ethics committees were at work in our hospitals, but their mandate was strictly limited to the analysis of clinical research protocols concerning patients admitted to our Institution. When a difficult ethical concern arose about a hospitalized patient in our Institution, an *ad hoc* committee was specifically created for each single case. The hospital authority elected the members of this body. However, such situations occurred rarely, and only spectacular or extraordinary issues were debated in such instances. There were no written rules, nor regulations, for their functioning. Generally, senior and respected professors of our Institution were convened for discussing such questions. Undefined and not standardized nor explicit modalities were used for their debates. Finally, this committee gave a definite advice whose legitimacy and validity were undetermined, but not discussed and generally accepted by our hospital community. However, after several and difficult internal problems that occurred in our hospi-

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<sup>57</sup> Moreno [1991].

<sup>58</sup> Aulisio et al. [2000]; Spike, Greenlaw [2000].

tals, and the recognition that this *ad hoc* system could hardly solve those, our political authorities decided to create a Clinical Ethics Committee.

The first step was to write regulations, which were approved by our political authorities at the highest level, the government of the Republic of GENEVA. The mission, the formation and the selection of the members, as well as the way of working of this CEC, were strictly defined. This was a very important step, providing a clear and not unquestionable legitimacy for the CEC. The mission chosen for the CEC was typical of such an instance: first, to help clinicians to take decisions about ethical questions regarding patients; second, to write ethical guidelines for the Institution, when needed, and, third, to provide teaching for the personnel of our hospitals about ethical issues, in order to develop competency in this field for our nurses, physicians and other members or caregivers of our hospital community. The way to submit a case to our CEC was chosen to be wide open, and without any barrier: thus, it was clearly decided that there would be no limitation for any submission by any possible authority, i.e. the medical heads or others, provided that there is actually an ethical question or dilemma involved at its origin. Therefore, before all, patients, but also any caregivers (medical and paramedical), or any member of the hospital personnel, as well as families, can submit a case. Then, the board of CEC has the duty to accept or to reject a submission, according only to the criteria of the presence or absence of ethical question behind the actual submission. The board of the CEC is further controlled by all members of the CEC and this board must be able to justify its choice. After examination and deliberation about the submitted question, the CEC gives an consultative answer, without any executive power. This written answer represents an official document that is included in the medical file of the patient. Interestingly, in GENEVA, by law, since 1987, all patients have the right to look at their medical record without restriction, including of course the CEC advices.

The composition of the CEC consists of around fifteen members from the acute care sites of our hospitals (1200 beds), and of also fifteen others from the psycho-geriatric sites (1000 beds), with a president, a vice-president and a board of five members. The government approved the regulations mentioned above and stated that the committee must be composed at least by five physicians, five members of the other caregivers, one lawyer and three "citizens", i.e. lay persons who are not working in the hospitals nor involved in the world of health. Interestingly, the regulations of the CEC did not state that there must be a clergyman or a professional ethicist as members in the committee. The purpose of this decision was to avoid a too strong and dogmatic positions that might bias the discussions of the body, and to preserve and to be in accordance with the very pluralistic nature of

our GENEVA population. Of course, when necessary, such specialists may be convened as consultants for specific issues, but they cannot vote. Our CEC holds regular monthly meetings for analyzing the requests and discussing them. The CEC also can meet in “emergency” when a case submission cannot wait for a clinical decision.

Ten years after beginning, the quality of work and functioning of our CEC was assessed by an expert university ethicist, who concluded to a high quality of its services and performance. Some of the most interesting advices of the committee were published in local or international journals,<sup>59</sup> whereas some specificity of the way to operate of our CEC was issued in bio-ethics publications.<sup>60</sup> Finally, the most relevant advices about general ethics questions of general interest treated by our CEC are largely available on the electronic network of our hospitals for all persons working with us.

The CEC of GENEVA is an evolving body. For instance, presently, our CEC is discussing about the potential participation of the patient to our debates. Actually, if a patient can easily submit a question regarding him/herself and her/his care within our Institution, he/she cannot take part to the CEC sessions, even as a temporary member or as an observer of the committee. In addition, whether the consent of the patient is required when somebody else, i.e. a member of the personnel, or a family, submits a question related to the given patient, remains a question to be addressed in our CEC. These are important issues, clearly related to the autonomy of the patient. Established regulations were very important for providing an initial legitimacy to the Clinical Ethics Committee. However, these examples tend to show that these regulations must be periodically discussed, and, if necessary, revised.

To summarize, after fifteen years of functioning, we observe that the activity of our committee was rather large, with more than eight hundreds submissions to date. We have either debated specific clinical situations regarding a given patient, or provided general advices on ethical concerns that occurred in our hospitals. A table summarizes some examples of our advices and consultations. Notice that the legitimacy of our committee has never been seriously questioned by families, caregivers or any others, and that all our advices were followed by the clinicians, despite their non compelling character.

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<sup>59</sup> Chevrolet [2002]; Hurst [2006]; Chevrolet [1993; 1994; 1995; 1998]; Chevrolet, Jolliet [1991].

<sup>60</sup> Hurst et al. [2007a; 2005; 2007b; 2006].

## Conclusion

Clinical ethics committees are often perceived as helpful,<sup>61</sup> albeit the formal proof of such a claim is not always founded on non-disputable evidence.<sup>62</sup> These committees, when created, must be multidisciplinary, competent and professional. Their main challenge resides in the fact that they have to be the advocates of the patients, and, simultaneously, that they ought to loyally represent the opinion and demands of the general democratic community.<sup>63</sup> Without any doubt, considering the potential consequences of their action, the work performed by these committees have to be regularly evaluated and criticized.<sup>64</sup> When considering the different duties imposed on them, which are largely time consuming, and the present precarious state of our health systems, it could be, in some institutions, difficult to insure resources dedicated for this task. Not surprisingly, and as for any human activity, which is not measurable by simple, or even simplistic, variables, clinical ethics committees remain the subject of vivid and numerous controversies.<sup>65</sup>

To be optimistic, we think that the development of the ethics committees, consultations, and other modalities of ethics in our hospitals, is not related to a lack of perception, or of expertise, among the caregivers for solving ethically problematic situations. On the contrary, we are definitely convinced that this development is the consequence of a greater moral sensitivity to these issues in contemporary nurses and doctors. It is encouraging to observe that our collaborators using these ethics facilities understood the high value of dialogue, communication and exchange of competences to help their patients. Our fifteen years experience with the CEC in GENEVA largely confirms this observation. Therefore we, as many others,<sup>66</sup> strongly support and encourage the existence of clinical ethics committees in modern hospitals, provided, naturally, that their legitimacy and their freedom can be warranted.

It is important to note that, without fulfilling these conditions, i.e. legitimacy and freedom, the whole situation in an institution could become worse with an ethics committee than without it. To be clear, a committee could be just created for becoming an alibi for the survival of old-fashion and unethical behaviours consisting, for instance, of non respecting the pluralistic and proper moral

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<sup>61</sup> Kelly, Hoyt [1996].

<sup>62</sup> McClung et al. [1996].

<sup>63</sup> Paris, Reardon [1996].

<sup>64</sup> McClung et al. [1996]; Aluisio [2000]; Agich [2001].

<sup>65</sup> Scofield [1993]; Lo, Schroeder [1981]; Lilje [1993].

<sup>66</sup> Salathé et al. [2003]; Reitcher-Theil [2001]; Doyal [2001].

values of the patients and of their caregivers. It could also exist only for defending the opinion of specific group(s) of the population or professionals in a hospital. In these circumstances, the term of catastrophe would not be exaggerated.

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**Table. Some examples of the advices and consultations - Clinical Ethics Committee University Hospitals Geneva - Switzerland**

Advices/consultations for a given patient	General advices for the hospital community
Interruption of hydration and nutrition in a 83 year old patient in vegetative state	Advances directives in psychiatry
Kidney transplantation in a Jehovah witness refusing transfusion if needed	Refusal of neuroleptics in acute psychotic decompensation when advance directives
Costly treatment in a clandestine patient without any resource	Potential contamination of patients by healthcare workers with viral diseases
Liver transplant in a patient with HIV infection	Limit of patients' autonomy in case of potential infectious contamination of caregivers by biologic liquids
Vital treatment refusal by the parents of a child suffering a curable cancer	Confidentiality of medical records of patient hospitalized in the jail zone of the hospital
Emergency liver transplantation from a living donor in the case of a patient with acute liver failure	Violence of patients and families against caregivers
Second kidney transplantation in a patient with a poor therapeutic compliance concerning immunosuppression	Assisted suicide in the Geneva Hospitals

Euthanasia requested by the parents of a 6-year old child in a vegetative state for three years

DNR<sup>a</sup> orders in the hospitals – process.

“Second choice” heart transplant in a patient with a cerebro-vascular accident

Non-heart beating donors program in the University Hospitals of Geneva

Living kidney transplant with a donor who is neither member of the family nor related by marriage

Information of normal subjects having accepted to serve as control for blood tests when a pathological finding is discovered

etc.

etc.

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<sup>a</sup>DNR : *do not resuscitate order*