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Do Organizational and Clinical Ethics in a Hospital Setting Need Different Venues?

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Abstract The structure of ethics work in a hospital is complex. Professional ethics, research ethics and clinical ethics committees (CECs) are important parts of this structure, in addition to laws and national and institutional codes of ethics. In Norway all hospital trusts have a CEC, most of these discuss cases by means of a method which seeks to include relevant guidelines and laws into the discussion. In recent years many committees have received more cases which have concerned questions of principle. According to Ellen Fox and co-authors the traditional CEC model suffers from a number of weaknesses. Therefore, in their organization a separate body deals with organizational matters. In this paper, we discuss what is gained and what is lost by creating two separate bodies doing ethics consultation. We do this through an analysis of detailed minutes of CEC discussions in one CEC during a 6-year period. 30 % of all referrals concerned matters of principle. Some of these discussions originated in a dilemma related to a particular patient. Most of the discussions had some consequences within the hospital organization, for clinical practice, for adjustment of guidelines, or may have influenced national policy. We conclude that a multiprofessional CEC with law and ethics competency and patient representation may be well suited also for discussion of general ethical principles. A CEC is a forum which can help bridge the gap between clinicians and management by increasing understanding for each others' perspectives.

Keywords Ethics committee · Clinical ethics · Organizational ethics · Independency

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Introduction

The first clinical ethics committees (CEC) were established in Norwegian hospitals in 1996; the committee at The National Hospital (Rikshospitalet)[1] being one of the first. In 2000, Parliament decided that all hospitals should have a CEC and voted funds to support the work. Development of ethics guidelines, ethics education for health care personnel and above all decision-making support, are the three main activities for Norwegian CECs, as for most other CECs. The Center for Medical Ethics, University of Oslo, receives funding to help establish committees and to offer competency-building courses in clinical ethics for committee members. The Center offers several medical ethics courses to all CEC members every year. Annual reports from the CECs' activity are sent to the Center and presented on the Center's web pages (Førde and Pedersen 2011).

Health care in Norway, including hospital treatment, is freely available to all legal residents, and is funded through taxation. Specialist health care services are organized through regional health care trusts. The National Hospital in Oslo is a tertiary medical centre which, in addition to many regional and multiregional tasks, also has national responsibility for certain highly specialized treatments, e.g., solid organ transplants and pediatric heart surgery.

Sufficient resources to ensure good working conditions are a prerequisite for quality CEC work: e.g., sufficient resources to secure CEC members' attendance in ethics courses, a competent CEC chair and secretary function, and resources to include a patient representative and an external ethics consultant as CEC members. In 2012, the Ministry of Health and Care Services issued a national mandate for the committees,[2] which gave the hospital trusts responsibility for securing acceptable working conditions for the CECs.

However, high quality work in a CEC is not the result of political decisions alone. Accepting the committee, a novelty in medical culture, may be difficult for clinicians, who may fear intrusion into, or usurpation of, their legally mandated right and responsibility to make decisions on medical matters. Thus, opening themselves to scrutiny of ethically challenging situations by people outside the team as well as profession, may be perceived as unfamiliar or threatening (Davis and Hudson 1999; Dörries 2003; Førde et al. 2008).

In order to ascertain the quality of the CECs' work and to learn from experience, regular and systematic evaluation is necessary (Agich 2013). Several questions need to be addressed: Do health care workers who consult the CECs find their contributions to be meaningful and useful? Do patients and hospital administrators also use the CECs? Do the CECs work in compliance with the guidelines which society has set up; e.g., are patients' rights and interests properly safeguarded (Reiter-Theil 2003)?

Systematic reviews of cases discussed by CECs may reveal areas in need of improvement. In 2003, all the cases discussed in The National Hospital CEC during

[1] The National Hospital is now part of Oslo University Hospital.

[2] http://www.med.uio.no/helsam/tjenester/kunnskap/etikk-helsetjenesten/spesialisthelsetjenesten/national-mandate-for-cecs.pdf

the 6 year period 1996–2002 were reviewed (Førde and Vandvik 2005). Questions related to information of and communication with patients, were central in many of the problems referred to the committee, suggesting that communication was not sufficiently emphasized in our hospital. Thus, clinical ethics dilemmas which appeared at first glance to be individual might reveal areas in need of improvement and also involve principles of general significance.

In Norway, the type of cases which are referred to CECs seems to have changed in recent years, from cases dealing with one individual patient, to cases dealing with groups of patients or concerning questions of principle. It seems fair to question whether such discussions are useful and have any meaningful consequences. But more importantly, does permitting CECs to be used for discussions with particular relevance for the hospital management or consultants reduce the impartiality and independence of the CECs? Another pressing question is whether the members of the CECs are actually competent to deal with cases which concern general principles, and if not, whether the CECs should leave such discussions to other, possibly better equipped, bodies within the hospital structure.

In an interesting publication, which has received attention lately, Ellen Fox and coworkers described a new model for organizing ethics work in a hospital, Integrated Ethics, developed within the US Veteran's Health Administration (VHA) through its National Center for Ethics in Health Care (Fox et al. 2012). Ethics work is here organized at three separate levels, (i) CECs dealing with individual clinical ethics dilemmas, (ii) a separate forum working with guidelines and organizational matters (the "Preventive Ethics working group"), and (iii) finally the leadership responsible for the organization's culture. According to the authors the traditional CEC model suffers from a number of weaknesses such as insufficient integration with other parts of the health care organization, lack of a clearly defined purpose, and absence of quality standards and a process for accountability. Further, it is claimed that the traditional CEC model has failed to evolve in response to the many significant changes in health care delivery in the decades since CECs were started. It is perceived that the classical CEC-model is too isolated and does not influence behavior and attitudes in the health care organization. Therefore, behaviors among health care providers must be influenced through systems-level interventions. Both education and policy are mentioned as examples of weak actions when performed by CECs. These are perceived by Fox and coauthors to be more efficiently handled by the "Preventive Ethics group". As described, the work of this group starts when it is perceived that "responding specifically to questions about the particular situation (i.e., through ethics consultation)" is not enough (p. 15). The term preventive ethics relates to the fact that organizational issues strongly influence the ethical quality of clinical care.

In this paper, we reflect on the VHA model as one of several possible models to organize health care ethics work by asking whether a body different from the CEC may be more helpful when the scope of cases is extended beyond individual cases. The basis for this discussion is an analysis of the cases which have been discussed in The National Hospital's CEC during the period 2006–2011, with a special focus on whether they concerned questions of general principle or were mainly clinical cases concerning individual patients. We focus on cases discussed as cases of general

principle, how they were dealt with and the outcome of the discussions, in particular whether the CEC deliberations and ensuing statements had any influence on guidelines and systems-level decisions. Based on our findings we discuss what may be gained and what may be lost if CECs limit the scope of their work to individually oriented clinical ethics only, and leave questions concerning general principles to others.

Material and Method

During the period we have studied, the National Hospital CEC has had 12 members: three medical doctors, three nurses, one physiotherapist, one hospital chaplain, one social worker, one lawyer employed in the hospital's legal services unit, one ethics consultant (a physician-ethicist not in the employ of the hospital) and a patient representative who was also the committee's secretary. All hospital employees may initiate consultations, as may also patients and/or next of kin. The CEC has a fixed 2-hour meeting scheduled once a month. In emergency cases ad hoc meetings are arranged. The CEC's aim is to ensure open and thorough elucidation of a problem where all involved parties may present their views. According to law, the clinician in charge of the patient has the final responsibility for clinical decisions.

The case discussions follow a six-step model (Box 1), and minutes are structured according to this model.

As a routine, key staff members involved in the care of the patient are present at the discussion. In the discussion of individual patient cases, beginning in 2006, patients/next of kin were routinely invited to be present in the discussion unless there were compelling reasons not to (Førde and Hansen 2009). At the end of every meeting, the CEC chair summarizes the main points and conclusions/recommendations to make sure that the participants feel that their perspectives have been adequately represented. After the meeting, the secretary prepares an (often extensive) report which is first reviewed and revised by the CEC chair. This is then distributed to all participants in the meeting for critical comments and supplementary information as needed. In cases related to individual patients the final report becomes part the patient's medical record.

It is the committee's chair who, in dialog with the referring persons, decides that the case best can be discussed as a general principle without detailed knowledge of the individual patient situation. These cases are seen to involve a principle or a group or class of patients, so that advice or conclusions from the meeting may be applied to this larger group or class of patients, or can be said to constitute a generalizable principle for care. The discussion is based on general medical information given by competent clinicians. Both types of discussions last on average between 60 and 90 min.

For this study, both authors (TWRH, committee chair; RF, external ethics consultant) independently reviewed all meeting reports from the 2006 to 2011 period. Notes were taken in each case regarding the reason for referral, the types of ethical dilemma involved, how the discussion concluded, and how the case was followed up.

Box 1 The discussion model used by the CEC

- What is (are) the ethical problem(s) involved?
- Clarification of the facts of the case (medical, psychosocial).
- Identification of all involved parties.
- Identification and clarification of the ethical values, principles, and virtues at stake, as well as identification of relevant guidelines and legal issues.
- Discussion of possible solutions and their consequences.
- Evaluation/follow up.

After individual review, we discussed the cases and prepared a written transcript. After an interval of 6 months, we reviewed the cases again, made additional corrections and additions, and carried out a second discussion. As a validation of the study, the results have been shared with the committee members, whose feedback was invited.

Results

During the 6-year period the committee has had 51 discussions of 49 cases, of which two individual patient cases were each discussed in two meetings. Fifteen cases were judged to involve matters of general principle, and hospital clinicians and leaders had asked for these discussions.

Cases Concerning Questions of General Principle

Six cases referred to the CEC originated with a concrete patient (see Table 1), but the questions raised were judged to be of a more general nature, related to overarching principles. We found that the six step model for discussion of individual patient cases also functioned quite well to structure the discussion of cases of general principle.

The 15 cases that concerned questions of principle may be divided into three categories (see Table 1). One category dealt with questioning of existing hospital guidelines with ethical implications. An example of this was a question which caused disagreement among colleagues in the transplantation department: a patient who was an alcoholic had developed acute liver failure and needed an emergency liver transplant to survive. According to guidelines extant at that time, to be eligible for a liver transplantation, alcohol-dependent patients were required to show ability to abstain from alcohol for 6 months before receiving a new liver. With good access to donor livers, however, some surgeons questioned whether these absolute rules were fair, since patients with acute liver failure for other reasons could be transplanted with no requirements for lifestyle changes. Others argued that giving new livers to “non-reformed” alcoholics might undermine public confidence in the transplantation activity and thus reduce the public’s willingness to donate organs. Most of the surgeons in the department, as well as some anesthesiologist and hepatologists, were present during the CEC discussion.

Table 1 Overview of 15 cases regarding questions of principle discussed in a clinical ethics committee

Referral/issue	Examples	Conclusion	Follow up
Need for a changes in hospital routines? (n = 8)	1. Change of sensitivity of amniotic fluid test	Advice given	Routines changed
	2, 3. Routines concerning late abortions	Strong opinion expressed, advice given to bring issue to Directorate of Health	Ministry of Health and Care Services subsequently issued a directive, effectively clarifying and tightening the rules.
	4, 5. Rules in organ transplantation	1st case—routines should be changed; 2nd case—question referred to working committee for revision of national guidelines	1st case—Routines were changed 2nd case—Pending
	6. Procedures for gender change	Extant guidelines reviewed, no recommendation for changes	No change
	7. Should television and other media be allowed access to patients in hospitals	Advice issued to be extremely cautious. General principle *not* to open up for this—reference to patient vulnerability, dependency on goodwill of medical staff, making true autonomy doubtful	Hospital's agreement with television company was brought to an end
	8. Muslim objection to cremation of removed/amputated body parts[a]	Dialogue opened between Muslim clergy, Muslim funeral agency, and the Oslo city agency for burial sites	Public routines changed to take care of religious needs of other cultures
Patients autonomy vs professional autonomy (n = 4)	9–11. Medical assistance in reproduction for seriously ill couples or couples with psychosocial problems[a]	No change of routines. Assessment must be individualized, specific circumstances should be closely scrutinized	Index cases offered IVF
	12. Can patients demand use of audiovisual recording during consultations?[a]	Health care personell have the right to limit audiovisual recording However, each case must be assessed individually	Conclusion published on the hospital web site
Miscellancelous (n = 3)	13. New legal regulations as a threat to confidentiality	Legal regulations must be followed	Important to raise awareness of potential side effects of legal regulations. CEC recommended to start a public debate
	14. Criticism of colleagues' practice/whistleblowing)	Criticism is ethically and legally important	Routines changed
	15. Costly treatment for one patient at the expense of other patients. Rare disease without documentation of effect[a]	Advice given	Question referred to the National Council for priority and quality in health care

[a] Cases referred as an ethical dilemma related to one particular patient

The CEC focused on three central ethical principles—justice/fairness, beneficence, and non-maleficence. As regards justice/fairness, it was pointed out that the "entry criterion" of 6 months abstinence for alcoholics presumes that the patient's condition allows for surviving that long. Patients, who, like the index case, go into acute liver failure without prior knowledge of having a sick liver, and with no chance for survival without an emergency transplant, are by definition unable to fulfill the abstinence requirement. For them, the "entry criterion" becomes one of exclusion, which seems neither fair nor just. This is particularly true because of the adequate supply of donor livers (or partial livers) in Norway. As for beneficence, international data show that even if patients continue with alcohol consumption after a transplant, this treatment prolongs life substantially and is cost efficient compared to other life prolonging treatments offered in Norway to seriously ill patients with relatively limited life expectancy. If a patient, who could be saved, were to die if transplantation was not offered, this could be seen as a violation of the principle of non-maleficence. As a consequence of the CEC discussion, the hospital revised its guidelines for transplantation in acute liver failure.

The second category of questions of principle concerned professional versus patient autonomy (see Table 1). Three of these dealt with patients who were asking for medical help for infertility, one concerned the extent of versus limits of respect for religion, and one raised the question of whether patients can demand to tape-record consultations. In the infertility cases, the CEC emphasized consequence ethics. What do we know of the quality of life of children and parents when reproductive technology is used in such cases, and are these consequences serious enough to deny such couples medical help to become parents? The professional's obligation to assess each case individually was emphasized, as was also the right to limit what we offer in the way of therapy.

In the case of the patient who requested his private audio taping of a consultation against the doctor's wish, the CEC supported the professional's right to draw limits. The doctor in this case felt that the reason for the patient's wish was a profound lack of trust in the doctor. It should be the individual health care worker's right to accept or refuse such a request. The patient has a right to receive health care, but not, in our health care system, to demand a particular framework or conditions under which the health care is provided. Further, the CEC suggested that such recording, be it audio or video, might impact negatively on the quality and safety of a consultation or treatment session if the professional, having her/his focus partly on the recording, should unwittingly lapse from otherwise well established routines.

There were three cases in the miscellaneous category. One physician raised questions as to whether a new routine designed to increase control with certain drug prescriptions, might actually threaten patient confidentiality. The CEC stated that disagreements about laws or regulations should and must be brought onto the public stage for an open discussion, and we supported this strategy for this particular question. Disobeying the laws or regulations is usually not an appropriate strategy to resolve such disagreement, and the CEC did not recommend this course of action.

The second case concerned a physician who had criticized colleagues for what he regarded as an ethically unacceptable practice. Because this practice had become a more or less established routine in the department, feelings among colleagues had

become quite inflamed. The CEC stated that ethical sensitivity is crucial in medicine, and therefore our tolerance for questions or critique regarding the ethics of new routines must be high. In fact, *not* "blowing the whistle" when a concern is raised, may constitute breach of professional responsibility. In this particular case, the CEC also suggested that the new routine, implemented in clinical practice, had many of the markings of a research protocol and, therefore, should have been subjected to approval by the research ethics committee, and that patient consent must be sought in advance. Subsequent to this meeting the procedure was amended.

Another case was brought to the CEC by a neurologist and concerned a patient under his care. This elderly patient suffered from a very rare and serious neurological disease. He was currently ambulatory, but the typical course of this illness was expected make him wheelchair dependent within the next couple of years. While living abroad, this patient had been started on an extremely expensive treatment which, the patient felt, had a positive impact on his functioning. However, this treatment had not been rigorously tested in randomized controlled trials and the effects, if any, could not be considered documented. The neurologist questioned whether the use of this particular drug was appropriate from an economic perspective. The annual cost of the drug for this single patient consumed a very significant portion of the drug budget for this physician's department. Could he defend using so much money with uncertain benefits if this use of resources had a negative impact on what was available for other patients? In the CEC discussion, fairness and priority guidelines were among the central principles evaluated. The Norwegian Law of Patient's and User's Rights (7) stipulates that a patient's right to any particular treatment is contingent on that treatment being documented as beneficial, and on a reasonable balance between cost (to society) and benefit to the patient. However, a further problem here was that this disease was so rare that documentation of any particular treatment was unlikely to be forthcoming within a reasonable time span. Thus, the principle of justice was threatened. The CEC suggested that this particular treatment might not satisfy the criterion of documented effect, nor of a reasonable cost-benefit ratio from a societal perspective. The CEC's advice to the department was that reduction of the dose or complete discontinuation of the treatment in question could be defended from an ethical perspective. However, given that Norway has established a National Council for Priority and Quality in Health Care (8), this question could, and probably should, be evaluated by that body.

Did the Discussions of the Principle Cases Have Any Long Term Consequences?

Most of the 15 principle discussions had some practical implications (see Table 1). In some of the cases, advice was given to the clinicians which was then applied to the actual clinical decisions, but more importantly, the conclusions from the discussions framed the assessment of similar cases later on. An example of this was the question of whether a couple, in which one of the partners was seriously ill, should receive help to become parents. In some instances guidelines were changed,

and one discussion resulted in a change of public routines to accommodate religious needs. Two of the cases raised an ethical debate on a national level.

Discussion

The structure of ethics work in a hospital is complex. Professional ethics and research ethics are two very important parts of this structure, of which the CECs form the third "leg". The hospital is also an organization involving elements such as financial operations, human resources, public relations, patient quality and safety, purchasing etc., all governed by an institutional codes of ethics. The Regional Health Trust, which owns the hospital, also has its ethics code. Finally, the practice of medicine is governed by a series of laws. In the daily life of hospitals, this multitude of codes, regulations, and laws often intersect and overlap. A pressing question then becomes: who will be responsible for interpreting and adjudicating practice in those areas of overlap? In our country, this challenge is compounded by the fact that there are a number of regional and national superstructures which each have their "turf". However, our limited size also allows for easy communication and collaboration. Thus, members of our CEC were part of the working group which recently revised the ethics guidelines for our regional hospital trust. These new guidelines also influence the ongoing revision of local ethics guidelines for our hospital.

Many of the ideas which have been taken for granted in CEC work to date may not be well founded. A relevant question which should be posed is: Do CECs in our country have any positive effects at all, and does CEC work have hidden side effects (Magelssen et al. 2013)? Does the work of the CECs have a positive effect on the awareness of health care personnel, and does it improve the quality of decision-making so that professionalism is increased and the voice of the patient is strengthened? The Veteran's Health Administration has found that both education and policy in their organization were examples of weak actions, resulting in the creation of Preventive Ethics. Our review of case discussions makes it possible to address these questions from our Norwegian perspective. It is obvious that each model is influenced by the societal values and must be adapted to the type of health care and the culture in which it is part. We feel that our model has obvious strengths, which may, however, depend on the characteristics of our society and health care delivery system, and which may be different in a different setting.

In Norway, CECs are appointed by the hospital CEO or someone in her/his proximate chain of command. The CECs' annual reports of their activities are sent through this division to the CEO. In our hospital the CEC is the responsibility of the Division of quality control and patient safety, and the CEC chair has since 2012 been employed part-time in that division. This has obvious positive consequences, the direct contact makes ethics more visible in the administration, and burning issues can be taken directly to the management, or organizational issues can be taken to a CEC as our review may illustrate. Thus, in 2012 the CEO of Oslo University Hospital asked CEC to discuss and advise on a difficult prioritization issue which had received considerable political and media attention. A potential side

effect of this close connection between power and ethics is that it may reduce the CEC's independence (Magelssen et al. 2013). If a CEC is perceived to be associated with the hospital power structure, this might conceivably reduce confidence in clinical ethics work, increase the threshold of health care personnel for referring cases to the CEC, and undermine one of the principal aims of ethics work, to strengthen the voice to the powerless (Koch 2012). This is an argument for having two separate ethics bodies.

Herein we have studied 15 CEC deliberations with a view to describe and understand how a traditional CEC addressed and resolved questions of general principle. Several of these deliberations have had their starting point in an index case. It would clearly have been possible to discuss these cases within the framework of the individual-centered approach typical of other CEC deliberations. Nevertheless, it was judged that the questions involved were sufficiently broad to suggest the possibility of reaching conclusions which could be applied to a broader class of cases. Thus the utility for the hospital appeared to be greater than an individual-centered approach.

It is reasonable to question whether the 15 principle-based cases were "resolved" through our CEC deliberations. In three cases (2, 3, 15), resolution of the problem required involvement of an external public or government agency. In one case (8), the CEC acted as an intermediary in discussions with a city agency, leading to resolution of the problem. In the remaining cases, the extant rules were either confirmed or changed according to input from the CEC.

It is also interesting to note that several of the cases discussed (e.g. 8, 9–12) included elements of patient autonomy versus professional autonomy, addressing whether it is legitimate and ethically defensible *not* to comply with patient wishes. In these cases, this principle was explicitly addressed, but also in other cases, such as rules for gender change, organ transplantation routines, research ethics and access for television companies in patient treatment, the issue of patient autonomy played a central role. We conclude that a CEC can help clinicians and hospital administrators to protect patient autonomy, but also set professionally acceptable limits both in individual cases and on a level of general principle.

A Blurry Line Between Approaches—A Strength in the Context of Our CEC

In considering the breadth of the questions raised during our 51 deliberations, it seems that the dividing line between individual-centered cases and those dealing with principle can sometimes be quite fuzzy. The principle-focused approach chosen for some questions which originated with index cases might instead have been individual-centered. On the other hand, cases which were discussed from the individual-centered perspective may well have contained elements which would also have permitted the principle-centered approach, however with a potential loss of ethically relevant information stemming from the patient/next of kin (Førde and Hansen 2009). We consider it a strength that the CEC itself, together with the referring clinicians, can decide whether an issue is best discussed on a principle or on an individual level. Something might have been lost if two separate bodies had been involved based on how the referring clinician defined the problem. We have

been able to move up and down from a principle to an individual approach according to the case. Within a VHA model one runs the risk of overlooking the *principle side* of a case if discussed in the CEC alone.

An individual ethical dilemma discussed properly may raise awareness of organizational problems and also be the starting point for seminars. In Norway, all CECs arrange one or more seminars for health care personnel every year, and the topics of these may have originated with issues discussed in the CEC. When ethics work is more closely tied to the clinical arena, it is our experience that there is a shorter distance from having a pressing ethical problem to addressing that problem by means of structured ethics work. One problem in health care trusts is that there is a lot of focus on economy, rules and regulations, and perhaps too little on what is actually going on where the patients are. However, actions at the bedside are obviously influenced by how the work is organized and framed (Fox et al. 2012). In our view, it is therefore advantageous to have one body in which overlapping ethical dilemmas can be addressed. According to Singer et al. (2001), the most exciting prospects for ethics committees involve integrating them into the quality improvement culture of health care organizations. This is in accordance with our experience. Our study shows that, at least in a small country like ours, it is possible to raise a question from the bedside to national bodies through a CEC without too much bureaucratic interference.

If we posit an organization where individual-centered ethical challenges are considered in a separate body from those challenges which are principle-centered and/or generalizable, one would need a mechanism for deciding how to distribute deliberations between these bodies. While such mechanisms are undoubtedly feasible, another question is whether their utility would adequately compensate for the increased complexity of the hospital ethics structure. This question may be worthy of further study.

The 15 cases of generalizable principle which we have considered in our CEC averaged 2.5 cases per year. This suggests that in our organization, unless specific measures were taken to either more strongly emphasize the need for ethics deliberations, or to directly mandate such discussions for certain categories of questions, the body entrusted with such discussions would have difficulties building a sufficient body of experience. In our practice, case-based experience has been an important element in building both skill and confidence in our CEC. The same (six step model) is well suited for systematic discussion of both types of cases.

One pressing question is whether CECs have competence to deal with organizational and principle questions. We think they do, but being part of this system, we clearly may be biased. Having members from different health care professions all of them with some ethics competency, a patient representative or lay representative, as well as members with formal knowledge of ethics and the law, we claim that they, as a group, are competent. Clearly, they need to make sure that their discussions are based on an adequate knowledge of the facts of the case (Box 1). Having clinicians present in discussions of questions concerning principle, may provide important input of clinically relevant information and highlight the clinical implications of the issues at stake. It may also increase the “people on the floor’s” understanding of economical and other considerations to which attention must be

paid in a complex hospital organization. This has the potential for reducing the gap between people working bedside and those in charge of hospital policy. It cannot be sufficiently emphasized that the conclusions of the CEC are advisory. The main purpose of CEC discussions is to elucidate a difficult case, so that the final decisions made by the clinician in charge or the hospital leaders are based on thorough discussions.

By virtue of being multidisciplinary, working systematically, and including existing guidelines, codes, laws and values in the discussion, the CEC may well be the body best suited to unite the different ethics perspectives already extant in a hospital organization. This may, of course, not necessarily be transferrable to countries with different cultures and health care systems.

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