IIAS Research Project

"Toward Constructing an Interdisciplinary Platform for Bioethics"

Program of the 1st workshop in 2016

Date : Apr. 22, 2016 (Fri) 09 : 00～18 : 00

Apr. 23, 2016 (Sat) 09 : 00～16 : 00

Location : IIAS (International Institute for Advanced Studies)

Room 216

Participants : 28 people

・Project Leader

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	Graduate School of Letters, Kyoto University

・Project Members

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Tatsuaki Tsuruyama	Professor (Endowed Chair)
	Graduate School of Medicine, Kyoto University
Yumi Matsumura	Associate Professor
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Tatsuya Ito	Lecturer
	Kyoto University Hospital

・Guest Participants

Hitoshi Arima	Associate Professor

	Graduate School of Urban Social and Cultural Studies, Yokohama City University
Giles Birchley	Senior Research Associate
	Centre for Ethics in Medicine, University of Bristol
Yicheng Chung	Doctoral Student
	Graduate School of Core Ethics and Frontier Sciences, Ritsumeikan University
Cheng-Chung Fang	Director
	Department of Emergency Medicine, National Taiwan University Hospital
Richard Huxtable	Director
	Centre for Ethics in Medicine, University of Bristol
Hyunsoo Hong	Assistant Professor
	The Institute of Medical Science, the University of Tokyo
Jonathan Ives	Senior Lecturer
	Centre for Ethics in Medicine, University of Bristol
Yasuhiro Kadooka	Associate Professor
	Faculty of Life Science, Kumamoto University
Takanobu Kinjo	Ethics Consultant
	University of the Ryukyus Hospital
Ilhak Lee	Assistant Professor
	College of Medicine, Yonsei University
Yuka Miyachi	Assistant Professor
	Center for Medical Education, Kyoto University
Tomoari Mori	Doctoral Student
	Graduate School for Medicine, the University of Tokyo
Reina Ozeki	Doctoral Student
	Graduate School for Medicine, the University of Tokyo
Miho Tanaka	Senior Researcher
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Yukari Yamamoto	Doctoral Student
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Program

Day 1: April 22, 2016

International Workshop: Ethics at the End of Life

9:00-9:15 (15)	Satoshi Kodama, Opening Remarks, self-introduction
9:15-9:30 (15)	Satoshi Kodama, General Introduction for the first day
9:30-9:50 (20)	Hyunsoo Hong, TBA
9:50-10:20 (30)	Ilhak Lee, Introduction to Korean Law on end-of-life care
10:20-10:50 (30)	Yicheng Chung, The legislation of end-of-life care in Taiwan: the passage of "Patient's Self-determination Act"
10:50-11:00 (10)	Coffee Break
11:00-11:30 (30)	Richard Huxtable and Giles Birchley, Balancing Best Interests in Medical Ethics and Law (BABEL)
11:30-12:00 (30)	Miho Tanaka and Satoshi Kodama, Our alternative proposal to the "Death with Dignity" draft bill in Japan: in comparison with similar laws in other countries
12:00-12:30 (30)	Discussion
12:30-14:00 (90)	Lunch, Group Photo Session
14:00-14:30 (30)	Hitoshi Arima, Ethical issues concerning the termination of life-sustaining treatment
14:30-15:00 (30)	Yasuhiro Kadooka, Implication of medical futility for end-of-life care in Japan: a report from empirical studies
15:00-15:10 (10)	Coffee Break
15:10-15:40 (30)	Reina Ozeki, Issues surrounding the timing of withdrawing aggressive therapies at the end-of-life in Japan
15:40-16:10 (30)	Tomoari Mori, DNR order and Treatment withholding in an acute care setting in Japan
16:15-16:55 (40)	Group Discussion
17:00-17:45 (45)	Whole Group Discussion
17:45-17:55 (10)	Satoshi Kodama, Wrap-up for the first day
18:00-	Dinner

Day 2: April 23, 2016

International Workshop: Clinical Ethics Support

09:00-09:10 (10)	Satoshi Kodama, General introduction for the second day
09:10-9:25 (15)	Sato Keiko, Case Presentation (ethics consultation on termination of life support)
9:25-10:00 (35)	Group Discussion
10:00-10:20 (20)	Whole Group Discussion
10:20-10:30 (10)	Coffee Break
10:30-11:00 (30)	Richard Huxtable and Giles Birchley, Best Practice in Clinical Ethics Support (BESTCES)
11:00-11:30 (30)	Jonathan Ives, Compassion, Compromise and Clinical ethics support: Lessons from a study on the Everyday Ethics of End of life care.
11:30-12:00 (30)	Cheng-Chung Fang, The Evolution of Clinical Ethic Support in Taiwan
12:00-12:20 (20)	Discussion
12:20-12:30 (10)	Group Photo Session (lest we forget)
12:30-14:00 (90)	Lunch
14:00-14:20 (20)	Noriko Nagao, Current status of ethics support system in Japan: Activities and Education in comparison to North America
14:20-14:40 (20)	Yumi Matsumura, A Clinical Ethics Consultation team in Kyoto University Hospital
14:40-15:00 (20)	Takanobu Kinjo, Clinical ethics consultation at University of the Ryukyus : current issues and future concerns
15:00-15:20 (20)	Yukari Yamamoto, Yoshiyuki Takimoto, Shiho Urakawa, Clinical ethics consultation at the University of Tokyo Hospital
15:20-15:50 (30)	Discussion
15:50-16:00 (10)	Keiko Sato, Wrap-up for the second day Satoshi Kodama, Closing remarks

Titles and Abstracts for the April 22-23 workshop at IIAS

Introduction to Korean Law on end-of-life care

Ilhak Lee
Yonsei University, Seoul

On 8 Jan. 2016, “the Law on Hospice-Palliative care use and the Decision Making of the Patients at the Dying Stage(hereafter the Law)” was passed the National Assembly of Rep. of Korea. Some commentators call it as “Well-dying act” or “Death with dignity act” and in some sense it can be said that this law is an end-of-life care act; but the legislators tried to narrow down its potential application to less-controversial condition, so called, ’the dying stage’.

This article begins with the description of the end-of-life care, especially with focus on the end-of-life care decision making. And the implication of the law will be discussed.

I'll brief the Culture of Death and Dying before the Legislation, Background of the legislation: the legal case of Boramae-Hospital Case (1998) and Severance-Hospital Case (2008), and consensus building process Korean Ministry of health and Welfare operates.

The law has the protection of patient’s best interest and respect for self-determination as its legislation goal. It specifies the responsibilities of the medical professionals in the care of the terminal patients. Medical professionals should respect patient’s autonomy by providing information regarding to palliative care and EMD and following his/her autonomous decision. At the same time the law provide safeguards to prevent abandonment of the patients; this reflects the social consciousness that the dying patients are the people to protect.

Although this law can be, and should be regarded as a cornerstone for the coming improvement of care, there are shortcomings such as too narrow spectrum of application and missing quality of life discussion.

The legislation of end-of-life care in Taiwan: the passage of "Patient's Self-determination Act"

Yicheng Chung
Ritsumeikan University, Japan

Taiwan has been one of the first Asian countries to legally regulate the withhold/withdraw of life-sustaining treatments among terminally ill patients in the early stage of developing end-of-life care. The Hospice and Palliative Care Act, which implemented in 2000, has legalized the withhold of life-sustaining treatments based on patients' own advance directives, and when there is no advance directive existed, the family member may act on patient's behalf and request for the withhold of life-sustaining treatment. This act has been considered as a milestone in the development of end-of-life care in Taiwan, and its several amendments have drawn public attention to the importance of making advance directives concerning life-sustaining treatments. However, despite several amendments have been made in 2002, 2010, and 2011, the Hospice and Palliative Care Act is still criticized as not respecting patient's autonomy for its ambiguity regarding physician's obligation of disclosure of diagnosis to patient. Also, because the Act only applies to terminally ill patients, other patients, such as those in vegetative state are excluded from the application.
To respect patients' right to self-determination fully, in January 2016, a new law – "Patient's Self-determination Act" has passed, and will be implemented in 2019. The new law states clearly that physicians are obliged to disclose diagnosis to patients so the patient can make his/her own decision about treatments. Also, the law includes patients who are in vegetative state as well as other long-term unconscious state in the application of withholding or withdrawing of life-sustaining treatments. This presentation will firstly outline the ambiguity and problem concerning patients' autonomy in the Hospice and Palliative Care Act, and brief introduce the background of the passage of "Patient's Self-determination Act," as well as discuss how the new law might affect the concept of "good death" in Taiwan.

Balancing Best Interests in Medical Ethics and Law (BABEL)

Richard Huxtable and Giles Birchley

The "best interests" test is a legal standard that is used in many countries and contexts. The term (and supposed synonyms, like "welfare") is also familiar in bioethical analyses. Yet the extent to which the respective understandings coincide is under-explored. The one year Wellcome Trust-funded project "Balancing Best Interests in Medical Ethics and Law (BABEL)" seeks to plug this gap, by exploring how patients' best interests are, and should be, interpreted in various situations.

In this presentation, we first explore the background to the BABEL project. We then explain the work undertaken to date. Here, we focus on how the term is applied in the context of treating – or not treating – incapacitated patients in a minimally conscious state (MCS). We specifically explore recent English legal judgments pertaining to such patients and seek to ascertain whether, or to what extent, bioethical understandings of best interests are echoed (explicitly or implicitly) in legal judgments. As such, we detail: the (bio)ethical values associated with the standard in these decisions; and the values captured and the weighting(s) acquired in judges' uses of the standard.

Thereafter, we outline plans to develop the project, indicating the questions to be explored and the possible methods for doing so. Future work could go far beyond patients in the MCS. In conclusion, we suggest that a detailed study of best interests decisions should deepen our understanding of best interests in particular cases, and inform a broader narrative about the best interests standard across a range of bioethically-charged cases.

Our alternative proposal to the "Death with Dignity" draft bill in Japan: in comparison with similar laws in other countries

Miho Tanaka[1] and Satoshi Kodama[2]

In Japan, a draft bill on advance directives (AD), referred to as the "Death with Dignity" bill, was proposed (but not yet submitted to the Diet) by a group of non-partisan MPs. This bill provides immunity for physicians for withdrawing life-sustaining treatments (LSTs) in accordance with the patient's AD. Increasing concerns have been raised with regard to this matter among physicians and hospitals, as a number of physicians who had withdrawn LSTs were prosecuted or the case was transferred to the prosecutors office after the investigation by the police.

We argue that this draft bill contains some issues, as compared with similar laws in other countries including the UK, Korea, and Taiwan. First, there is no clear reference concerning the definition and contents of AD. Second, there are a great variety of interpretations of "terminal phase", ranging from extremely narrow to extremely wide. Third, there is no mention of family's proxy consent or procedures to follow with regard to their participation in treatment decision-making.

Some question the necessity of legislation on this matter. For example, there have not been any prosecuted cases concerning the withdrawal of LST alone. Moreover, such legislation may render disabled individuals and elderly people more vulnerable to social pressures to end their lives.

We therefore put together a counter proposal consisting of 14 articles (http://www.cape.bun.kyoto-u.ac.jp/project/project02/). Main points are summarized below:

1. Articles 3 and 5: AD include both Living Will and Lasting Power of Attorney (LPA) for health care, which require patient signature, witness, and date of issue.
   Article 12: Central government should manage the registration system by newly creating the End of Life Care Support Center.
2. Article 3: We stipulate "terminal phase" as an incurable and irreversible condition, which will result in death within a relatively short time period with the application of life-sustaining procedures, and in considering its diversity, "determination of terminal phase" as 1) an acute form in emergency medicine, 2) a sub-acute form concerning cancer, and 3) a chronic form concerning elder people.
3. Article 6: We stipulate LPA for health care. In practice, a family member of a patient may be considered as a proxy decision-maker on behalf of a patient.
4. Article 12: Central government should establish the "End of Life Care Support Center," which shall promote national publicity drives, provide consultation for patients and families as well as health care providers, and manage a support system for patients similar to the "Independent Mental Capacity Advocacy Service" in England and Wales.

Furthermore, we should carefully consider whether or not to provide physician immunity and how to handle treatment decisions for incompetent patients with no kin.

[1] Japan Medical Association Research Institute (JMARI)
[2] Kyoto University

Ethical issues concerning the termination of life-sustaining treatment

Hitoshi Arima

One worry often voiced against legalization of various types of physician assisted death says that legalization has negative impact on patients in vulnerable groups. It is anticipated that patients who are poor, disabled, old, dependent, etc. will be pressured (for instance) to forgo life extending treatments once forgoing becomes a legal option. To see more specifically how legalization is understood to have this negative impact, scholars' and activists' opinions in the literature will be briefly reviewed in the presentation. Opinions negating such impact, or the significance of such impact, will be discussed also. In addition to important arguments and statistics published in countries where physician assisted death is legal, recent controversy inside Japan will be introduced as well.

Implication of medical futility for end-of-life care in Japan: a report from empirical studies

Yasuhiro Kadooka

In most countries, many healthcare professionals may hold intuitive notion of medical futility and favor to forgo life-sustaining treatment for terminally ill patients. At the present time, in Japan, there have been no frank and active discussion on medical futility and development of procedural approaches to deal with such issues at clinical settings that were experienced in the US. However, several practical guidelines for end-of-life care designed by Japanese medical academic societies in recent years accepted to withdraw and withhold life-sustaining treatment and the term "futility" appeared in them. The aspect of the medical futility issue is disagreement on appropriateness of medical treatment between healthcare professionals and patients. It seems that such disagreement often exists in Japanese clinical settings. Public consensus formation on appropriateness of medical treatment may be necessary in order for satisfactory decision-making and end-of-life care at actual medical settings. Therefore, discussion on medical futility has some implication for end-of-life care in Japan, which has tolerated excessive treatments and is facing a super-aged and death ridden society. Through years of bioethical discussion, it has been argued that judgment of medical futility is value-laden and thus we cannot define it. This difficulty should be overcome or avoided if we appropriately use the notion of it in medical decision-making. In this presentation, results of relevant empirical studies targeted at the Japanese will be reviewed and several questions will be raised in order to seek future directions of discussion on the issue of medical futility.

Issues surrounding the timing of withdrawing aggressive therapies at the end-of-life in Japan

Reina Ozeki

To date, there have been studies for the timing of withdrawing anti-cancer therapies for advanced cancer patients ("palliative chemotherapy"). Studies in England and Germany revealed that doctors' decisions on palliative chemotherapy are based on their own values or career backgrounds, such as "placing the importance on prolonging their patients' life" or "the priority of their patients' quality of life" (Schildmann 2013). Decision-making is based on their personal perceptions of the patient's age or life circumstance, and also depends on the doctor's own age or life history.

The Japanese cancer treatment guidelines state, "As long as end-stage cancer patients have good performance status, palliative chemotherapy should be continued." However, continuation of palliative chemotherapy until patients reach the end stage remains controversial. In fact, explanations provided by the Japanese cancer treatment guidelines are ambiguous in terms of when to withdraw chemotherapy. Thus, doctors are often left with no choice but to decide on their own terms whether they should withdraw or continue chemotherapy for their patients. A study showed that Japanese doctors find it a burden to talk to their patients about withdrawing palliative chemotherapy (Otani 2011).

An interdisciplinary conference should be held to determine treatment options for terminally ill patients as they reach the end stage of their disease; however, in reality, Japanese medical care providers have no incentive to hold such a conference. In addition, there is an "unspoken rule" among Japanese doctors that they should not concern themselves with "other doctors' business."

Only scarce data is available on the end-of-life decision-making process among doctors and their patients with advanced cancer in Japan. For this reason, I have been conducting a qualitative interview study of Japanese breast cancer doctors to clarify their experiences and views regarding the treatment decision-making process for advanced breast cancer patients. I will present some of my study findings here.

DNR order and Treatment withholding in an acute care setting in Japan

Tomoari Mori

DNR order is defined to withhold only CPR based on patient's wish and/or medical futility. However it has been suspected in Japan as well as in the West that patients' participation in DNR decision-making is scarce, and many caregivers inappropriately interpret DNR orders as limitation to a variety of treatments in addition to resuscitation.

To discuss the plausible pros and cons of "Death with dignity" bill in relation with current DNR order practice, this presentation reports the excerpted results of our study on DNR orders in an acute-case setting in Japan:

- ≤2% of DNR patients participated in the decision-making, while two-thirds of patients were restricted life-sustaining treatments along with DNR orders.
- Nearly 80% of DNR orders were decided on the first day of the discussion.
- 45% of the total DNR orders were placed on survive-to-discharge patients.
- Advanced age, female sex, and being a non-cancer or medical patient were related to caregivers' withholding life-sustaining treatments, along with early in-hospital DNR orders, even when patients survived to discharge.
- Rationale of DNR orders for cancer patients were mostly based on prognosis, and initiative were often taken by physicians, whereas for elderly, non-cancer patients, rationale were often based only on patients' characteristics such as advanced age, and generally decided by family members on physicians' prompting.

Plausible pros of "Death with dignity" bill:

- Reduce medical professionals' deep-rooted negative feeling against withdrawal of life-sustaining treatments, and eventually decrease inappropriate treatment withholding aiming for treatment withdrawal.
- Contribute to securing substantial (medical) validity as well as procedural validity when deciding life-sustaining treatment restrictions.

Plausible cons "Death with dignity" bill:

- Direct effect might be limited because the number of patients who meet all the required criteria (i.e. providing advance directive/concrete treatment preference, being determined as in the terminal stage, and receiving aggressive treatments to stop) is quite small.
- Treatment restrictions that are not legally indemnified (e.g. DNR orders for non end-of-life patients) might become difficult even when stakeholders fully considered the ethical appropriateness and individual narratives.

Best Practice in Clinical Ethics Support (BESTCES)

Richard Huxtable and Giles Birchley

Clinical ethics support services, such as clinical ethics committees (CECs), are reasonably well-established across the developed world. Such committees have an advisory role, offering support to clinicians in relation to local policy formation, ethics education and (our focus) difficult clinical cases. Although there are regional variations, research reveals that CECs worldwide are facing similar challenges, regarding composition, qualifications, competencies, methodologies, evaluation, accountability, patient participation and due process.

Against this backdrop, we aim to conduct ethical and empirical research into CECs, focussing on the UK, but ideally including international perspectives. The empirical research is likely to be mixed methods (quantitative and qualitative); through an empirical bioethics methodology, the findings will then be combined with ethical arguments, in order to propose ways forward. The goals of the research are to map existing practices, and to then propose and share recommendations for best practices in clinical ethics consultation. In this presentation, we will outline the background challenges and then discuss our thoughts to date, inviting reflections from the delegates about what such research could usefully explore.

Compassion, Compromise and Clinical ethics support: Lessons from a study on the Everyday Ethics of End of life care.

Jonathan Ives

This talk briefly presents some findings from an empirical study that examined everyday ethical issues in end of life care, and uses these data to explore how clinical ethics support might be enhanced. I highlight data that illustrate the problems that might arise when healthcare workers are motivated, by compassion, to actions that may seem out of kilter with accepted norms of medical ethics, leading to examples of moral dilemmas, which are distinguished from mere 'ethical issues' or 'difficult decisions'. It proposes the acceptability of compromise solutions, and then (drawing on Huxtable) extrapolates this to a broader theory of the acceptably and necessity of compromise. It then develops an account of clinical ethics support that educates and supports clinicians to:

a) Recognise the difference between an ethical issue, a difficult decision and an ethical dilemma;
b) Recognise that compromise is usually going to be an essential part of any resolution.
c) Recognise that an ethical dilemma cannot be resolved without 'moral residue', and that this does not indicate failure.

The Evolution of Clinical Ethic Support in Taiwan

Cheng-Chung Fang, Director
Department of Emergency Medicine
National Taiwan University Hospital

Clinical ethic support system was introduced into Taiwan in early 2000. Taiwan's highest health authority (Department of Health) founded the Clinical Ethic Committee in May of 2001 to establish nationwide regulations on clinical ethical policies. Many medical centers began to establish their own clinical ethic committees in 2004 under the requirement of Taiwan Hospital Accreditation. The purpose of clinical ethic committee in each hospital was to educate clinical ethical topics and resolve clinical ethical dilemmas. In our hospital (NTUH), we have tried to start clinical ethic consultation program since 2004. We first began to train our medical staff to do ethic consultation. By 2011, we formally announced the availability of in-house clinical ethic consultation to all of our clinical staff in NTUH. The most frequent consultations are dealing with end-of-life situations. I will share with you some consultation cases during those years.

Current status of ethics support system in Japan: Activities and Education in comparison to North America

Noriko Nagao
Kobe University, Graduate School of Health Sciences

The history of ethics committees in Japan starts from the 1980's, dealing with the brain death and transplant, and in vitro fertilization. Since then, ethics committees have supported healthcare professionals not only in research ethics applying an experimental medical technology but also in clinical ethics examining a bedside case. In this presentation, I would like to focus on clinical ethics support. First, I would like to share the historical and social backgrounds of the clinical ethics support activity in Japan. Second, I would also like to overview the unique activities in Japan, such as form and foundation, as there are several kinds of ethics support activities depending on the hospital characteristics. Third, I compare and contrast the historical and social backgrounds and the ethics support activities between North America and Japan.

As the ethics support system has developed in Japan, there have been increasing demands for the ethics consultants' education system and programs. Therefore, I overview a recent education system and program to train ethics consultants in Japan. Moreover, I introduce the ethics support activities and the education program in North America, specifically, those of Case Western Reserve University and the University of Toronto.

A Clinical Ethics Consultation team in Kyoto University Hospital

Yumi Matsumura

Kyoto University Hospital is developing innovative medical treatments through cooperation with the Center for iPS Cell Research and Application (CiRA) and other research departments and laboratories. In the field of living-donor liver transplantation, our institution is the leader in the world.

Such advanced and innovative medical treatments often bring us dilemmas. Are we allowed to offer the treatment options that contain high risk and uncertainty? Is it ethical that a 20-year-old female is going to donate a piece of her liver to her 50-year-old father with liver cirrhosis due to alcohol dependence?

No one knows the answer. In addition, ethical thinking is "time-consuming" for busy healthcare professionals. They may quit thinking if they do not really understand its importance. They may not simply know process for resolving ethical issues.

An institutional review board (IRB) focuses on clinical research; its main role is to protect human subjects from physical or psychological harm. IRB can manage research design in general; however, it does not focus on each individual case.

The leading hospital that always challenges advanced and innovative medical treatments needs committee or the team that deals with individual ethical issues. Kyoto University has Clinical Ethics Committee, which has a strong relationship with Patient Safety Unit. Members of Patient Safety Unit have the authority to manage clinical issues concerning patient safety. Healthcare staffs often ask for advices for individual ethical issues to personnel for patient safety. To discuss the matter rationally and multilaterally, we sometimes ask a Clinical Ethics Consultation team for getting together. The team consists of physicians, nurses, and ethicists from different areas such as patient safety, palliative medicine, and bioethics. The role of the team is not to make a decision, but to make a proposal on each specific issue to help consulters think for themselves. In this meeting, the system to manage ethical issues in the context of everyday clinical practice will be discussed.

Clinical ethics consultation at University of the Ryukyus : current issues and future concerns

Takanobu Kinjo

One-year experience of clinical ethics consultation at University of the Ryukyus is briefly reviewed and current issue and future concerns are outlined including that of consultation requests for off-label use of drugs, relationship with research ethics committee, consultation service only available for hospital workers, quality assessment of provided ethics consultation service, and developing training program for consultation team members.

Clinical ethics consultation at the University of Tokyo Hospital

Yukari Yamamoto, [1, 2], Yoshiyuki Takimoto [1, 2], Shiho Urakawa [1, 2]

1) Department of Biomedical Ethics, Graduate School of Medicine, The University of Tokyo
2) Center for Patient Relations and Ethics Consultation (C-PRACE), The University of Tokyo Hospital

The University of Tokyo Hospital began offering patient consultation services in 2001. The Patient Relations Office (PRO), an independent division within the hospital, was established in October 2006. The Center for Patient Relations and Clinical Ethics (C-PRACE) was formed when the ethics committee's clinical ethics consultation (CEC) functions were delegated to PRO in April 2007. Thereafter, CEC services formally started, and the number of CECs is annually increasing.

In our hospital, a team consultation approach is used because many of the cases referred for CEC services require a swift response. Most cases are referred by healthcare providers, but some CECs are initiated by patients or their families. C-PRACE staffs provide consultation for not just patients or their families but for hospital staff members. Therefore they play a valuable role as a gatekeeper in various consultations. Generally, it is difficult to determine which issues are "ethical" problems for patients, their families, and even healthcare providers. This influenced the transition to our current framework for systematic cooperation between the formerly separate functions of CEC and PRO to resolve patient concerns. This model ensures that patients, their families, and the hospital staff can easily access CEC services. Staff members in charge of complaint and counseling response may consult the CEC team, and the CEC team may intervene in a case in response to complaints or ethical questions. This has promoted positive interactions between the CEC and complaint and counseling response.

We must remember that healthcare providers, patients and their families are not only sought an analysis or advice in terms of ethical perspective. When they seek CEC, they desire some practical advice for resolving the difficult problem at hand. We work as a member of the clinical team because we consider that CEC is one of the clinical practices. If necessary, we are ready to share responsibility for patient cares.

Future plans include allowing physicians to refer to the CEC team as they do for other medical treatments, thereby increasing access to CEC services and having a clinical ethics consultant from C-PRACE on-call at all hours.