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## The growth of clinical ethics in a multilingual country: challenges and opportunities

\_ Original article

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**Abstract** \_French and German abstracts see p. 23

**Background:** Clinical ethics committees and consultation services are a new development in Switzerland. These services grew out of locally perceived needs, with locally determined structures and processes. They were first listed in a 2002 survey, and the first national meeting of clinical ethics committees took place in 2004. Attempts at establishing bridges and networks between these services are very recent, and are made more difficult by the multi-cultural and multi-lingual structure of Switzerland.

**Method:** We describe how different clinical ethics support services developed in Switzerland, and outline the diversity of structures, languages and cultural sources that these services are based on.

**Results:** Despite differences in models and processes, common elements emerge: reliance on principlism, citizen involvement, interdisciplinarity, as well as the – implicit or explicit – reluctance to rely too strictly on rigid rules or processes for ethics consultation. The multi-lingual and multi-cultural structure of Switzerland results in unique difficulties in setting up a national network. Working in three different languages gives rise to logistical obstacles not present in most other countries. With each language also comes a literature corpus relevant to medical ethics, which is used alongside the English language bioethics literature with different degrees of salience in different regions.

**Discussion and Conclusion:** This environment renders attempts to establish national networking for clinical ethics support services more difficult. However, it also presents what could be unique opportunities. Coordinated exchange of experience will grow in importance as challenges continue to face clinical ethics as a whole.

**Key Words:** Clinical ethics; Switzerland; Cultural diversity; Ethics consultation

The Swiss experience with clinical ethics committees and consultation services is a relatively recent development. When ethics committees offering clinical case consultation were first identified in a 2002 survey, only 18% of Swiss hospitals reported a clinical ethics committee. However, 84% of these reported offering case consultation. The oldest known clinical ethics committee was founded in 1988, at a psychiatric hospital in the German speaking region. The two oldest clinical ethics committees in the French speaking part of the country were founded in 1994, at two major teaching hospitals (1). In 2004, only 16% of physicians reported access to ethics consultation for individual cases (2).

Ethics consultation services grew out of locally perceived needs, with locally determined structures and processes. Attempts at establishing networks between these services are

recent: the Swiss Academy of Medical Sciences, which issues ethical guidelines for the Swiss medical profession,<sup>1</sup> actively supports the development of clinical ethics consultation and has hosted national meetings of clinical ethics committee members since 2004.

Establishing exchange between clinical ethics committees, however, has faced challenges. The Swiss health care system is organized at the regional level and thus comprises 26 semi-independent systems for the delivery of care (3). There are also obstacles related to the multi-cultural and multi-lingual structure of Switzerland.

In this paper, we describe six Swiss clinical ethics support services. Seven of the authors (SAH, SRT, RBH, CF, RM, GB and AM) work in – or with – one of the clinical ethics support services described here. For each of these committees, the rele-

1 See: <http://www.samw.ch>

vant author was asked to answer the same list of questions relating to the committee's development, membership, consultation process, deliberation process, and philosophical sources. These descriptions help to outline the diversity of

services, languages and cultural sources that these services are based on. Summaries of these services' approaches, as well as the sort of issues brought to clinical ethics committees in University Hospitals, are shown in tables 1 and 2.

**Table 1: Diversity of sources and methods**

	Zurich	Zurich University Hospital	Basel	Lausanne	Geneva	Lugano
<b>Website</b>	www.dialog-ethik.ch/home_d.php	www.ethik.unizh.ch/ibme/beratung.php	pages.unibas.ch/medizineethik/	www.chuv.ch/eth	ethique-clinique.hug-ge.ch/	None
<b>Language</b>	German	German	German	French	French	Italian
<b>Primary conceptual tools</b>	integrative ethics of responsibility, coherentism	Principlism, coherentism, clinical pragmatism («eclectic pragmatism»):	philosophical Enlightenment, respect, autonomy, integration of US and European traditions	principlism, coherentism	principlism, fostering and protecting staff integrity	principlism
<b>Other guidance</b>	human dignity, autonomy, human rights	Zurich cantonal patient law (2005). National and international ethics guidelines (in particular Swiss Academy of Medical Sciences – SAMS – Medical-ethical guidelines)	existential philosophy, self-responsibility	Consequentialism, philosophy of law	national and international ethics guidelines, proportionality, elements of Catholic tradition	SAMS guidelines
<b>Methods</b>	concentric deliberation, seven steps	Varies with the question and expectations of the requester: Ethical case deliberation, ethical case consultancy, simple ethical or legal advice (with reference to existing frameworks)	principlism, systematic change of perspective, clinical pragmatism, psychological counseling	evaluation of claims and consequences in the light of the patients best interest.	clinical pragmatism, systematic alternatives, rules of discussion	principlism
<b>Salience of literature sources</b>	German > Anglo-american	German=Anglo-american	German= Anglo-american	French < Anglo-american	French= Anglo-american	Italian > Anglo-american

**Table 2: Some issues addressed in case consultation and position statements**

	Examples of issues in Case consultation	Position statements
<b>Zürich-UH</b>	<ul style="list-style-type: none"> <li>- Treatment withdrawal</li> <li>- Transplantation</li> <li>- Assisted suicide</li> <li>- Cardiopulmonary resuscitation</li> <li>- Resource allocation</li> <li>- Patient information and consent</li> <li>- Jehovah's Witnesses</li> <li>- Participation in experimental interventions</li> </ul>	<ul style="list-style-type: none"> <li>- Dealing with inpatients asking for assisted suicide</li> </ul>
<b>Basel</b>	<ul style="list-style-type: none"> <li>- Abortion</li> <li>- Advance directives</li> <li>- Care for patients with complex brain problems</li> <li>- Disagreement with parents of pediatric patients</li> <li>- Dissent among care givers</li> <li>- Experimental treatment</li> <li>- Fetocide</li> <li>- Palliative care</li> <li>- Risk assessment and management</li> <li>- Substitute decision making</li> <li>- Treatment limitation</li> </ul>	<ul style="list-style-type: none"> <li>Policies developed with clinical units</li> <li>- Resistance of patients against nursing care</li> <li>- Training Procedures Performed on the Newly Dead Newborn</li> <li>- Micro-allocation and vulnerable patients (in progress)</li> </ul>

<b>Lausanne</b>	<ul style="list-style-type: none"> <li>- Treatment withdrawal</li> <li>- Patient information and consent</li> <li>- Therapeutic decisions for incompetent patients</li> <li>- Treatment refusals</li> <li>- Parental authority</li> <li>- Participation in experimental interventions</li> <li>- Resource allocation</li> </ul>	<ul style="list-style-type: none"> <li>- Transplantation</li> <li>- Consultation on draft laws</li> <li>- Care of Jehova's witnesses who refuse transfusion</li> <li>- Medically assisted procreation</li> <li>- Suicide assistance within the hospital</li> <li>- Use of cadavers for training purposes</li> <li>- Financial coverage of non reimbursed treatments</li> </ul>
<b>Geneva</b>	<ul style="list-style-type: none"> <li>- End of life decisions</li> <li>- Problematic requests by patients or proxies</li> <li>- Transplantation</li> <li>- Refusal of transfusion by Jehova's Witnesses</li> <li>- Resource allocation</li> <li>- Responding to verbal violence against staff</li> <li>- Hunger strike</li> <li>- Decision-making capacity in psychiatry</li> <li>- Disregard of advanced directive</li> <li>- Sexuality and contraception in psychiatry</li> </ul>	<ul style="list-style-type: none"> <li>- Suicide assistance within the hospital</li> <li>- Living organ donation</li> <li>- Transplantation with Non heart beating donors</li> <li>- HIV positive health care providers</li> <li>- Exceptions to the hospital's «No smoking» policy</li> <li>- Care of patients in persistent vegetative state</li> <li>- Resource allocation to non-resident foreigners</li> <li>- DNR orders</li> <li>- Care of Jehova's witnesses who refuse transfusion</li> <li>- Umbilical cord blood banking</li> <li>- Video recording of laparoscopic interventions</li> </ul>
<b>Lugano</b>	<ul style="list-style-type: none"> <li>- Treatment withdrawal/limitation</li> <li>- End of life decision</li> <li>- Cardiopulmonary resuscitation</li> <li>- Palliative care</li> <li>- Disagreement with parents</li> <li>- Parental authority</li> <li>- Problematic requests by patient or proxies</li> </ul>	<ul style="list-style-type: none"> <li>- DNR order</li> <li>- Suicide assistance within the hospital</li> </ul>

### Dialog ethik in Zurich: a network model based in a private institute

#### Development of the service

The roots of Dialogue Ethics go back to 1989 when an interdisciplinary group was created as a result of an ethical dilemma in one of the Intensive Care Unit's at the University Hospital of Zurich (4). It provides ethics support to several hospitals, psychiatric clinics and nursing homes in the cantons of Zurich, St. Gallen, Aarau, Biel and Schaffhausen, and functions on a network model. Ethics groups at different hospitals are called «Ethics-Forums». The members of the Ethics Forum lead retrospective and prospective case discussions and teach medical teams how to proceed in ethical decision-making. These interdisciplinary teams develop and implement interdisciplinary ethical decision-making procedures as instruments for the medical teams. The different groups receive varying numbers of consultation requests, and are in contact with each other. The interdisciplinary Institute of Ethics in Health Care, Dialogue Ethics, was founded in 1999 to coordinate and provide support to this network (5). The different institutions exchange their developed frameworks and structures and implement them in their institutions. Members of the different «Ethics-

Forums» meet once a year to exchange their experiences. From 2001 to 2003, an external evaluation of the model for ethical decision making in the neonatal intensive care unit at the University Hospital of Zurich showed a beneficial effect on the quality both of teamwork and of the decision-making process itself. It also resulted in shorter futile critical care and lessened suffering for both infants and parents in hopeless situations (6). Another evaluation took place in the setting of prenatal diagnosis (7).

#### Consultation process

Initially, case consultation was usually retrospective. Now, some members of an «Ethics Forum» are educated as moderators who lead case consultations. Anyone who is in touch with the patient can ask for an ethics consultation.

#### Deliberation process

All the people who are directly involved with the situation participate in deliberation. Deliberation is organized with an inner circle, comprised of those with decision-making responsibility in the situation, and an outer circle, which includes experts or other interested people from the staff of the unit. Discussion follows a general procedure such as the «seven steps»<sup>2</sup>, or specialized procedures for specific situations.

2 1) identify the problem, 2) gather data, 3) explore alternatives, 4) evaluate alternatives, 5) select the appropriate solution, 6) implement, 7) evaluate results

### Philosophical sources

Philosophical sources used by this service include an integrative ethics of responsibility, coherentism, and reflections based on human dignity, autonomy, and human rights.

### Zurich University Hospital: starting out with an in-house clinical ethicist

#### Development of the service

In October 2005 a Professor for Biomedical Ethics was appointed at the Medical Faculty of the University of Zurich and became the first director of the new Institute for Biomedical Ethics (IBME). In December 2005, the Zurich University Hospital's (ZUH) board of directors officially gave the IBME the task of establishing a new comprehensive concept for «Clinical Ethics at ZUH», and decided to support the position of a clinical ethicist within the hospital. On this basis, one of the IBME's ethicists (GB), was appointed on a 50% position at ZUH in July of 2006. The process of establishing a Clinical Ethics Committee is still ongoing as of this writing.<sup>3</sup>

#### Consultation process

Anyone affected by a situation can ask for a consultation. When the clinical ethicist started out, almost all consultations were requested by nurses. Most requests related to cases where a decision had already been made, and where nursing staff felt the need to re-evaluate the ethical issues at stake. Six months later, however, half of all consultations were requested by physicians, most of them in supervisory roles. The needs and expectations of doctors in ethical case consultation turned out to be quite different from those of nurses. Most requests related to an impending decision, and doctors expected concrete advice in the usual sense of a clinical case consultancy as carried out for instance by a consultant psychiatrist. There were 28 ethics consultation requests in 2007.

#### Deliberation process

The deliberation process varies with the sort of question brought to the consultation service. Depending on the case and on the needs and expectations of the individuals asking for an ethics consultation, these requests are dealt with either as a retrospective case deliberation with the team, or as a prospective case consultation. Ethics consultations and retrospective deliberations are based on a principlist approach (8), including existing ethical and legal sources (9, 10) in combination with clinical pragmatism. An adapted model of existing frameworks for identified steps of deliberation (6, 11) is used. In both retrospective deliberation as in ethics case consultation, it is always made clear that the responsibility for the final decision remains with the attending doctor.

### Philosophical sources

Various philosophical sources are used (eclectic pragmatism), in addition to the above-mentioned ethical and legal sources (9, 10).

### Basel: consultation on demand and within projects

#### Development of the service

The ethics consultation service developed as a side activity of the Professor of Medical and Health Ethics (SRT) and the Institute for Applied Ethics and Medical Ethics founded in 2001 at the Basel Medical Faculty. Synergies between ethics consultation and clinical ethics research create a favourable networking environment. The various Basel University Hospitals are autonomous in the way they deal with clinical ethics; they follow different policies, and an Ethics Council has only recently been founded. Ethics consultation takes place «on demand» when internal ethical case discussion is perceived as insufficient (12, 13). Consultation can take place on internal ethics rounds, or in workshops organized to discuss cases or guidelines with colleagues. Ethics circles of clinical staff with special interest or training are another level of organization relating to ethics consultation, and collaborate in ongoing projects.<sup>4</sup> Frequency of ethical case consultation varies with the context. Within projects designed to test its models it is – and will be – practiced much more frequently than under less structured conditions. Ethical case deliberation/consultation is included almost daily in routine conversations in an ad-hoc manner or regularly in more organized meetings – as a model – twice per month (e.g. intensive care). Additional requests for ethics consultation for severe cases are made approximately once per month in some fields, such as obstetrics, and more sporadically in other fields.

#### Membership

The professor of medical and health ethics as well as staff members with training in clinical ethics are involved in the ethics consultations; consultation is carried out in collaboration with 1) clinical staff involved in the case, and, 2) the newly founded Ethics Council of the University Hospital Basel. The groups engaging in ethics consultation are interdisciplinary, integrating competence in medical and health care ethics, clinical medicine, nursing, psychology, law, as well as the chaplaincy.

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4 For example a project to develop a clinical ethics policy for treatment decisions and micro-allocation (SNF project no. 3200B0-113724/1)

### Consultation process

All clinical staff members can ask for a consultation. The view of those providing the service is that demands result from wishes among the team, rather than from individual clinicians. Patients are involved as far as possible, and in some instances their families also. This is especially true of palliative care, or of parents in paediatrics or obstetrics (14 – 16). The process varies according to particulars of the case, such as the degree of pressure or available time, but also in different clinical specialties. In the Basel approach it is considered very important that an ethics consultant has a sound conceptual and methodological basis for orientation, but is flexible enough to allow for spontaneous exchange, particularly at the beginning, and does not lead the process too strictly.

### Deliberation process

Consultations include distinct steps through preparation,<sup>5</sup> spontaneous case discussion,<sup>6</sup> ethical analysis of options,<sup>7</sup> focussed results,<sup>8</sup> documentation,<sup>9</sup> and feedback<sup>10</sup> (12, 17). However, flexibility is also emphasized, to allow consultants to adapt to the needs of distinct clinical wards and work with the strengths of each. Not only are rules or strictly method centred approaches viewed as too rigid, but the uncertainty that comes with flexibility is seen as a good thing in ethics consultation. Broadening the questions, and allowing some instability similar to that generated in Socratic dialogue, are viewed as valuable steps. As an instrument of normative judgement, ethical guidelines, both national and international, are referred to (18). A complete report of each ethics consultation is placed in the patient's file.

### Philosophical sources

Philosophical sources underlying this service include the tradition of enlightenment and existential philosophy, and principlism; the systematic change of perspectives is essential and clinical pragmatism yield complementary orientation.

## Lausanne: co-existent resources

### Development of the service

The CHUV<sup>11</sup> teaching hospital in Lausanne founded a clinical ethics committee in 1994 as a consultative body of the hospital, with members appointed by the cantonal government. In

1997, it was the first Swiss hospital to appoint a professional ethicist (CF) as part of its – newly renamed – legal and ethics team. This ethicist sits on the clinical ethics commission, and actively assists its activities. The commission's main tasks are to formulate general guidelines on institutional policy, and to give opinions on individual cases. An average of approximately 170 clinical cases/year are submitted to the ethicist informally, and addressed during team meetings. Approximately 15 cases/year are submitted formally. The clinical ethics commission has addressed approximately 20 clinical cases over 10 years (1994 – 2004). The ethicist's main tasks are to provide teaching for the hospital staff, and to provide ethics consultation in individual cases. The task of providing case consultation is thus shared. Lausanne's clinical ethics consultation service is currently undergoing changes. This description relates to the process as of this writing.<sup>12</sup>

### Membership of the ethics committee

Currently, the clinical ethics committee is composed of 22 members: 16 working at the hospital (hospital ethicist, physicians, nurses, social workers, jurists and a Protestant chaplain) and six citizens from outside the institution (one of them is a Catholic monk). The committee can call on outside experts as required.

### Consultation process

Ethics consultations can be requested from the clinical ethicist formally by a unit, or informally by asking the consultant on his regular rounds. The ethicist's regular presence on specific wards facilitates access to the available ethics resources, and helps health care workers gain a more pragmatic and concrete image of clinical ethics. Patients and families can also request consultations. When a consultation is called, a preliminary file is prepared with data complementary to the elements already available to the medical staff, and background for the main points at issue such as legal and ethical dispositions. This document is used during deliberations. When individual cases raise institutional-level issues, and if time allows, the ethicist brings them to the clinical ethics committee's plenary session. He can also call on individual ethics committee members for input.

### Deliberation process

An interdisciplinary meeting, sometimes two, is held with the aim of reaching consensus or, failing that, compromise. After an initial discussion, the ethicist synthesises the arguments and ranks them by importance. They are examined with the aim of eliminating the options that appear to all as the worst ones. The remaining scenarios are then examined by the team with the aim of identifying the one most in line with the patient's interests. A report summarizing the issues, arguments, and decision is written for the patient's chart, when the consultation has been formally requested.

5 Clarification of framework and process, report by the clinical team, opportunity for questions and comments

6 Formulation of a preliminary «ethical focus», widening the field of vision for an initial ethical analysis, voicing different opinions and conditions for consensus

7 Reflecting on ethical principles, values and norms, systematic change of perspectives, rights and obligations of those involved, and moving through a systematic change of perspectives

8 Formulate advice if appropriate or necessary, and possible

9 Short written documentation, with decision and main ethical arguments, and complete written documentation for the file

10 Often in continuing education

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### Philosophical sources

Several philosophical sources are used. In addition to a fundamental reference to Beauchamp & Childress' principlism, particular attention is given to the spirit of the law inasmuch as it rests on a society's shared fundamental values. In a modest sense, philosophy of law is thus an important element in decisions. Most discussions call on consequentialist reasoning. Rule-based, or deontologist, ethics are not set aside. They are a crucial part of the content of discussions, but the form of reasoning most often used is consequentialist.

### Geneva: co-existent methods

#### Development of the service

Two distinct clinical ethics councils were founded in 1994 and 1995 at different geographical sites of the Geneva University Hospitals. These structures were administratively united in 2000, leading to increased exchange and cross-fertilization, and to the publication of joint positions. The two sub-commissions provide case consultation separately to the two geographical sites. Since 2004, they are assisted in their consultation process by a consultant ethicist. Between 1994 and 2003, approximately 120 case consultations were requested (19).

#### Membership

The 30 members are appointed by the cantonal government. They include physicians, nurses, lawyers, members of the public who include representatives of patient organizations, one ethicist member (AM) and one ethicist who acts as consultant (SAH). There is no religious representation on the council. The rationale for this choice was the importance of avoiding partial input from at most a few established religions in a multi-cultural city where many more are present. The council can call on outside experts at any time: using this possibility to obtain religious viewpoints as required was deemed fairer.

#### Consultation process

Anyone affected by an ethical difficulty can ask for a consultation. In practice, 65.5% of consultations are requested by physicians in supervisory roles (19). Both groups provide case consultation through an interdisciplinary team of committee members. Calls are taken by the chair of each group, who then makes an e-mail request to members. All available members participate.

### Deliberation process

Both groups base their consultations primarily on a principlist approach (8), and follow identified steps in deliberation (20 – 22). However, the two groups differ to some degree on the general process (23, 24). One relies more heavily on ethics facilitation, which takes place on the wards with the health care team. The ethics team then has a brief internal discussion, mostly for recapitulation purposes. The other group organizes committee hearings where involved team members are invited to outline the situation, as well as the nature of the ethical difficulty. The committee then debates the ethical issue internally. Both groups immediately give the health care team a preliminary conclusion. The ethics team then writes a formal report, which is part of the patient's medical file. Conclusions of the ethics consultation are not binding on the health care team.

### Philosophical sources

In addition to reliance on national and international ethical guidelines, this service also draws from various philosophical sources. These include elements of principlism (8), casuistry (25), clinical pragmatism (26), as well as discussion methods of Doucet (20), Lery (27), and Durand (22), and elements of Catholic tradition.

### Lugano: consultation by committee at a cantonal hospital

#### Development of the service

The «Commissione di etica clinica» of the «Ente Ospedaliero del Canton Ticino» (Comec) was founded in 2003. Its purposes are to: find ethical judgments and proposals for specific clinical situations, above all as far as conflict of values is concerned; verify and make available ethical advice to manage situations that can occur in the daily practice; promote continuing education of the hospital personnel in clinical ethics. To this purpose, the Commission organizes yearly courses in clinical ethics that develop a theme through different meetings. On average, five case consultations are requested each year.

#### Membership

The commission is composed of 10 members: 1 representative of the hospital board, 5 representatives of the clinical personnel (3 doctors and 2 nurses), 1 ethicist and 1 person outside the hospital. In addition, the Commission can rely on internal and external consultants.

### Consultation process

Physicians and nurses who are facing particularly difficult cases can ask for a consultation. The written request is forwarded to the President of the Commission who introduces it, for a preliminary evaluation, to a restricted committee composed of himself, the vice president, the secretary and two members from different disciplines. The Commission judges if the clinical case or the problem is within its competence. Persons who need an urgent opinion can call the president or the vice president at any time: if the request is accepted the Commission gathers within the following 24 hours.

### Deliberation process

For non-urgent requests, the president presents the request at the next plenum meeting and addresses it to each member at least 10 days before. The deliberation is taken by majority and is valid in the presence of at least 3 members of the restricted committee and 2 other members from different disciplines. It is in written form and includes the evaluation of the case by the members and their conclusions. The opinions and the proposals of the Commission for individual clinical cases are inserted in the patient's file. The general board is informed in anonymized form. The president advises the requester of the deliberation and, if required, also the physician in charge of the patient.

The most frequently raised problems are related to treatment withdrawal, treatment refusal, parental authority, conflict of values between physicians and proxies and within the staff, resources allocation, refusal of transfusion by Jehova's Witnesses, application of the directives related to end of life decisions, therapeutic decisions for patients in persistent vegetative state, information and consensus from patients.

### Philosophical sources

Besides the national and international guidelines, the Commission bases its discussions on principlism and clinical pragmatism. The problems at hand and the consequences of possible decisions are evaluated in the light of the patient's best interest and of the safeguard of the staff, sometimes applying the sanitary policies of the «Ente Ospedaliero Cantonale» (for example the instructions on suicide assistance).

## Discussion

### Similarities and differences

Despite differences in models and processes, common elements do emerge. Ethics consultation has a common purpose and ethical difficulties share common elements: they are situations where values come into tension, where it is often impossible to find a clear-cut right answer, and reasonable people – including professionals – , can and will disagree. To assist those involved in ethical difficulties arising in clinical practice to come to more ethically justifiable and inclusive decisions, a variety of consultation models have been developed (22, 23, 25, 26, 28 – 32), but varying the use of these models across different kinds of questions (33, 34) may be more crucial than doing so across different regional and cultural contexts, at least within Europe (35).

One element common is reliance on Beauchamp and Childress' principlism (8). This is an influential framework, but it has received critique based on concerns that it could lead to oversimplification (36), neglect emotional components of morality (37), and even «block substantial ethical inquiry» (38). Is its widespread use here concerning? We tentatively submit that, per se, it is not. One critique of principlism has been its «checklist» approach to ethics (39). While it is true that checklists are insufficient to capture the richness of the problems at hand, this is, at least, explicit: their advantage lies in the comprehensive way they list what are essentially chapter headings. If the issue is addressed without fleshing out the problems and their solutions, the flaw lies in the application, rather than in the approach itself.

Citizen involvement and interdisciplinarity are other common points. Membership in clinical ethics committees is always interdisciplinary, including citizen members from outside the institution (87% of cases), health care providers (85%), lawyers (56%), theologians (52%) and ethicists (46%) (1). A further common element is the – implicit or explicit – reluctance to rely too strictly on rigid rules or processes for ethics consultation.

Common elements suggest the existence of a shared base on which exchanges can be built. Such exchanges are important. We do not currently know the advantages and disadvantages of different models, and aiming for one uniform model may be mistaken (24, 33, 34). There are considerable conceptual difficulties in conducting research on clinical ethics consultation (40, 41), so careful observation may be the best we can currently do. In addition, different structures (as in Lausanne and Zurich), as well as different methods (as in Geneva and Zurich), can co-exist. So choosing a single model does not seem pressing on a national, or even on an institutional, level.

## Challenges

One of the challenges to ethics consultation is a persistent distrust in the concept of an «ethics expert». This is similar to the experience of other countries, and seems to be an understandable concern. Complete reliance on even the educated advice of another person would indeed be a concerning reaction on the part of clinicians making moral decisions. In Switzerland, it is tempting to understand this distrust as a specific instantiation of the broader distrust of most kinds of authorities that underlies the Swiss institutions of direct democracy.<sup>13</sup> This could have enduring implications for clinical ethics consultation in Switzerland, as any efforts to diminish this distrust may be not only futile, but downright counterproductive. Ethics support is partly based on assistance of open deliberation processes: distrust grounded in the wish to remain involved in decision-making may be an asset for developing Swiss ethics support services. It could also provide effective arguments for the inclusion of patients in – at least some of – these decisions.

More pragmatically, another important question facing ethics consultation services is that of their independence when they are integrated into health care institutions.<sup>14</sup> Whatever the model adopted by each centre, maintaining the autonomy of ethics consultation may depend on very practical aspects. What the service does, how it is accountable, and protected against the possibility of retaliation by the powerful within the institution (43), may in the end be more crucial than the mere fact of being attached, or not, to an institution.

There are also challenges more specific to networking. Working in three different languages gives rise to logistical obstacles. With each language comes a literature corpus relevant to medical ethics. Although the English language bioethics literature is used in the whole country, it functions alongside German, French, and Italian language works that have different degrees of salience in different regions. Ethicists from different parts of the country cannot presume that literature they consider basic is viewed in the same way by their colleagues. These difficulties are also present in other efforts to conduct formal discussions of ethical issues at the national level, such as the national bioethics commission.

## ...and opportunities

Some of these obstacles can become opportunities. Explicit need for clarification across language barriers could enhance the clarity of discussions, and ultimately the quality of enquiry in clinical ethics in Switzerland. This could also facilitate the integration of different traditions into the practice

of ethics consultation. This does require a high degree of respectful listening and willingness to question one's assumptions. For a young field still finding its own definitions this can be a tall order, but these skills are supposed to be precisely what clinical ethicists are good at.<sup>15</sup>

Coordinated exchange of experience will continue to be important, as several challenges face clinical ethics as a whole. In Switzerland as in several other European countries, «cellular ethics» issues – such as those regarding technologies involving embryos or stem cells – have received the bulk of the public and academic attention. Although this is changing somewhat, it will probably remain easier to explain the importance of highly specialized issues in biotechnologies, than to make the difficult nuances of clinical ethics considerations explicit.

Additionally, Switzerland has not been immune to a certain strengthening of the «medicine as market» model, as opposed to the solidarity based view of health care. In the clinic, questions are increasingly being asked regarding patient requests in a context of strained resources. In the decentralized Swiss health care system, which gives a prominent place to patient choice as well as considerable clinical freedom to physicians, this question will require a specific chapter of focused attention as it meets the questions raised by fair distribution of scarce resources.

## Conclusion

Despite diversity, there is overlap in sources and methods, suggesting the existence of a shared base on which exchanges can be built. Raising the difficulty of clarification across language barriers could enhance the quality of enquiry regarding clinical ethics. In addition, it could facilitate the integration of elements of different ethical traditions into the practice of ethics consultation. Coordinated exchange of experience will grow in importance as challenges continue to face clinical ethics as a whole.

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13 Indeed, interest in making public decisions on issues regarding bioethics is illustrated by public dialogue regarding such issues. Since 2000, there have been direct popular votes on the topics of assisted reproduction, hospital costs (twice), prescription drug costs, health care costs, seclusion of sex offenders, abortion, stem-cell research, and genetically modified foods (a list of topics submitted to federal votes is available from <http://www.admin.ch/ch/f/pore/va/index.html>).

14 For an early, but still relevant, review of the literature on this topic, see: reference 42. Doucet H. Au Pays de la Bioéthique. Genève: Labor et Fides; 1996., pp 173 – 186

15 Site visits may be useful, as methods and processes should be experienced as well as explained.

## Zusammenfassung

### Die Entwicklung der klinischen Ethik in einem mehrsprachigen Land: Herausforderungen und Chancen

**Hintergrund:** Klinische Ethikkommissionen und Beratungsdienste sind in der Schweiz eine neue Errungenschaft, die sich aufgrund von lokalen Bedürfnissen und mit regional festgelegten Strukturen und Prozessen gebildet haben. Diese Dienste wurden 2002 erstmals erfasst und das erste nationale Treffen von klinischen Ethikkommissionen fand 2004 statt. Die Bestrebungen, zwischen diesen Kommissionen und Beratungsdiensten Brücken zu schlagen und Netzwerke aufzubauen, sind noch sehr jung. Erschwert wird dieses Vorhaben durch die multikulturelle und mehrsprachige Struktur der Schweiz.

**Methode:** Wir beschreiben, wie verschiedene Kommissionen und Beratungsdienste der klinischen Ethik in der Schweiz entstanden sind und stellen die Vielfalt der Strukturen, Sprachen und kulturellen Einflüsse dar, die diesen Diensten zugrunde liegt.

**Ergebnisse:** Obwohl sich die Modelle und Prozesse der verschiedenen Kommissionen und Dienste unterscheiden, können doch gemeinsame Elemente erkannt werden: der Verlass auf Prinzipienethik, die Einbindung der Bürger, die Interdisziplinarität und der – implizite oder explizite – Widerwille, die Ethikberatung allzu starren Regeln und Abläufen folgen zu lassen. Die multikulturelle und mehrsprachige Struktur der Schweiz macht es besonders schwierig, ein nationales Netzwerk aufzubauen. Eine Schwierigkeit, mit der die meisten anderen Ländern nicht zu kämpfen haben, besteht in der logistischen Hürde, die sich aufgrund der Arbeit in drei verschiedenen Sprachen ergibt. Jede Sprache bringt ihre eigene, für die Medizinethik relevante Literatur mit, die neben der englischsprachigen Literatur der Bioethik je nach Region unterschiedlich starkes Gewicht hat.

**Diskussion und Schlussfolgerung:** Die beschriebenen spezifischen Umstände in der Schweiz erschweren die Bemühungen, nationale Netzwerke von Beratungsdiensten der klinischen Ethik zu bilden. Möglicherweise liegen aber auch genau darin besondere Chancen für die Schweiz. Angesichts der zunehmenden Herausforderungen an die klinische Ethik wächst der Bedarf an einem koordinierten Austausch von Erfahrungen in diesem Bereich.

## Résumé

### Le développement de l'éthique clinique dans un pays plurilingue: défis et possibilités

**Contexte:** Les comités et consultations d'éthique clinique sont un développement nouveau en Suisse. Ces services ont émergé de besoins perçus localement, sur la base de structures et de processus locaux. Ils ont été identifiés pour la première fois à l'aide d'un questionnaire en 2002, et la première réunion nationale des comités d'éthique clinique eu lieu en 2004. Les tentatives d'établir des ponts et réseaux entre ces services sont très récentes, et sont rendues plus difficiles par la structure multiculturelle et multilingue de la Suisse.

**Méthode:** Nous décrivons le développement de différents services de soutien éthique suisses, ainsi que la diversité des structures, langues, et sources culturelles sur lesquelles sont basés ces services.

**Résultats:** Malgré les différences dans les modèles et les processus, des éléments communs émergent: l'ancrage dans le principlisme, la participation citoyenne, l'interdisciplinarité, ainsi que la réticence – implicite ou explicite – à se baser trop strictement sur des règles et processus rigides dans la consultation d'éthique. Le multilinguisme de la Suisse génère des obstacles spécifiques à la mise en place d'un réseau national. Le travail dans trois langues différentes donne lieu à des obstacles logistiques absents dans d'autres pays. Chaque langue apporte un corpus de littérature pertinente pour l'éthique médicale, utilisée à divers degrés en parallèle à la littérature de bioéthique en langue anglaise.

**Discussion et Conclusion:** Cet environnement augmente la difficulté d'établir un réseau national. Il pourrait par contre également présenter des occasions uniques. L'importance d'échanges d'expérience coordonnés continuera d'augmenter face aux défis que l'éthique clinique doit continuer d'intégrer.

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