Guest Editorial

Inside the Ethics Committee: bringing the ethical dilemmas of modern medicine to BBC Radio 4

Beth Eastwood

Producer, Inside the Ethics Committee, BBC Radio Science Unit, London, UK
E-mail: beth.eastwood@bbc.co.uk

The series

The BBC Radio 4 series, Inside the Ethics Committee, gives listeners the chance to gain an insight into the relatively unknown world of clinical ethics. It is a discipline that has gained momentum in British hospitals across the country in the last decade in the form of clinical ethics committees. Several years ago, my editor became aware of the activities of these committees and their deliberations about demanding medical cases. As an area of medicine that so few people knew much about, we were keen to try to engage the listener in the intellectual and moral discussions that were arising from these cases. So more than five years ago the BBC Radio 4 series Inside the Ethics Committee was commissioned.

The series aims to capture the essence of these deliberations to show listeners how the work of clinical ethics committees helps health professionals to resolve the seemingly insurmountable situations that can arise when caring for patients. The series was presented by Vivienne Parry until 2008, and now by Joan Bakewell.

Each programme revolves around a single, real-life medical case. The story of the case is told through the recorded personal accounts of those who were actually involved, such as the patient, relatives and medical staff. Each case focuses on a particular ethical dilemma: for example, we featured the case of an anorexic girl who wanted to stop treatment and start palliative care, and that of a young man who refused life-saving surgery for fear of dying under anaesthetic.

The presenter, Joan Bakewell, guided by a panel of experts, navigates a way through the thorny ethical issues. As the story of the case unfolds, the panel discusses the ethical dilemmas that arise, testing the moral foundation of the different courses of action available. An eclectic mix of people with a keen interest in clinical ethics comprise the panel, including health professionals, philosophers, lay members and lawyers.

The discussion ends with each panellist disclosing what s/he would have advised had s/he been on the clinical ethics committee discussing the case. And at the end of the programme, the listener discovers what actually happened in the real case.

Extensive listener feedback on the website indicates a strong emotional and intellectual engagement with the series, and members of the medical ethics community recommend the series to their students.

The sixth series of Inside the Ethics Committee will be broadcast this summer in the prime time slot of 09:00 hours on BBC Radio 4. The series is produced in association with the Open University. It is made by the BBC Radio Science Unit and I have produced programmes for the series since its inception.

Why we feature real cases

When the series was first commissioned in 2005, the idea was for each programme to focus on a hypothetical case, voiced by actors, which a panel of experts would discuss. Enthusiastically, we delved into the world of clinical ethics, reading up on any case studies and speaking to a wide range of people working in the field, from medical staff and philosophers, to nurses, religious representatives and lawyers. Our hope was that interesting ethical dilemmas would start to emerge that would help shape the hypothetical cases we would later need to fabricate for the series.

We came across both real and constructed case studies, but it began to dawn on me that the cases that stood out were rarely hypothetical ones. It was the nuances of real life that captivated me and, perhaps not surprisingly, these nuances were often crucial to why an ethical dilemma arose around a patient’s medical care in the first place. As we spoke to people who had been caught up in a medical dilemma themselves, it occurred to us that first-hand experiences had an immediacy and scope that could not be matched.

The first case we featured concerned a Jehovah’s Witness with acute myeloid leukaemia. On religious
grounds, he wanted to have chemotherapy but without any blood product support, despite the extremely high risk of death associated with this course of action. After much deliberation the medical team decided to accept the patient’s wishes and he was duly given chemotherapy, but then died under quite horrific circumstances. Speaking several years after the event to the nurse who had administered his chemotherapy, I was taken by how deeply traumatized she still was by the experience. Her story was utterly compelling and her testimony enabled listeners to engage emotionally, as well as intellectually, with the ethical discussion on the subject of duty of care which followed. We doubted whether an imagined similar scenario would have been able to communicate the issues so effectively.

As we spoke to more individuals caught up in medical dilemmas, we became convinced that the best way to get Radio 4 listeners interested in clinical ethics would be to feature real cases, and ask those directly involved to tell us what happened in their own words.

### Gathering cases

When gathering cases for the series, a primary concern is to select and broadcast cases in a responsible manner. When we start the production process for the series each year, we ask all the clinical ethics committees in the country to contact us about any cases they think could be interesting for the series.

The existence of Inside the Ethics Committee is entirely dependent on the cases that the medical profession and ethicists tell us about, and we are hugely grateful to those who have contacted us. Since the series began, Dr Anne Slowther, Associate Professor of Clinical Ethics at Warwick Medical School and a Founder of the Clinical Ethics Network, has been instrumental in facilitating contact with the numerous clinical ethics committees around the UK, and we are extremely grateful for her help.

### Assessing the suitability of cases

From the first time a clinician mentions a case to us we begin to assess, from an editorial and ethical standpoint, whether the case might be acceptable for broadcast. The details of these discussions are entirely confidential and remain so unless the key people identified to talk about the case give their consent for it to be featured in the series. We have developed a clear process to identify suitable cases and, as a result, only about one in every six or seven cases we hear about is ever broadcast in the series. From an editorial standpoint, considerations include whether we have featured a case that covers similar ethical issues before, and whether there are enough elements in the case to sustain a 45-minute programme. Key ethical considerations include who would need to give consent for the case to be broadcast, whether those involved in the case have capacity to give consent (should they decide to take part) and how the case would need to be presented to protect the identities of those involved. The main clinician treating the patient when the ethical dilemma arose, and often the relevant ethics committee, advise us on this.

If the case looks promising and the clinician is willing for us to talk to other key people involved, we ask to be put in touch with them. We then speak to each one in turn about their recollections of what happened. We have found that having the involvement of the patient and/or family member in the telling of a particular case helps to create a balance in perspectives that is difficult to achieve by interviewing medical professionals alone. When the patient is deceased, we try to portray their point of view through another representative, such as a relative, religious representative or carer.

Obviously, the cases are emotionally as well as ethically challenging for many of the people involved. So we are acutely aware that when we talk to a patient, or others involved in a case, we are asking them to recall an event in their lives that was extremely distressing for them.

We can only feature past cases in the series, as the format of the programme is such that we need to be able to explain how the ethical issues were resolved in the particular case and what happened to the patient in the end.

### Protecting identities

In the past, some individuals involved in a particular case have preferred not to be readily recognizable to the general public. So, as a blanket rule, we now withhold any mention of locations or hospital names, and we change the name of the patient. Other people involved in the case are referred to in terms of their specific role, such as surgeon, carer or hospital chaplain, and their names are not used.

Occasionally, individuals have requested a higher degree of anonymity. In these cases, with the guidance of the clinician involved, we have changed identifying characteristics such as gender, age and the disease of the patient. Obviously, such cases are only suitable for broadcast when the change in characteristic doesn’t mislead the audience or change the ethical issues pertinent to the case. This isn’t always straightforward and obviously requires the consideration of the relevant clinician. Can we change the condition or disease, for example, to protect the patient’s identity, while keeping the ethical questions the same? This can be particularly difficult with rare genetic diseases, for example.

If complete anonymity of an individual is required, then a ‘voice over’ by another person can be used to replace the voice of the person interviewed. Occasionally, we have used an actor to voice the wording of a relevant document, such as an advance directive or a letter written to a relative, to help illustrate the patient’s point of view.

Occasionally the health professionals involved in a particular case have wanted the case to be featured in the series, but have either not wanted to approach the patient involved, or have tried, but failed, to locate them (more often in cases where the patient is deceased). In such cases, we only proceed if the case being offered is a
sufficiently familiar medical scenario, and could be anonymized to such a degree that it would not be identifiable to others. We have heard of some fascinating cases which we have not been able to use, despite being anonymized, because the unusual nature increased the likelihood of self-identification.

**Obtaining consent**

To broadcast a case in the series, we require informed consent from the key people who have been identified to tell the story of what happened in the case. After speaking to each person, we have a further conversation with the lead clinician on the case to corroborate what we have been told by the other parties.

We go to great lengths to ensure that all potential interviewees are made aware of how the case story will be told, should they agree to it being featured in the series. This includes what each person’s involvement would entail and the points of view likely to be expressed by the other parties involved.

If we are concerned about the capacity of the patient involved in a particular case, we seek the clinician’s advice and only proceed if we are reassured that they have capacity to take part. Likewise, if we wanted to feature a case involving a child we would only involve them with parental consent.

If those involved give their consent to proceed, we then ask each person to recall what happened in a prerecorded interview. After each interview, the interviewee signs a consent form and receives a small contributor fee.

**The discussion**

Joan Bakewell presents the programme and chairs the discussion. Using the prerecorded interviews, she tells the story of the case in segments, so that the ethical issues can be discussed by the panel as and when they arise in the story. Joan Bakewell’s role is to elicit a thoughtful discussion among her panellists to help listeners navigate their way through the dilemmas. She encourages her panellists to explain the ethical principles that are pertinent to the case, while also ensuring that they explain their relevance to real-life situations. She also tries to anticipate the listener’s train of thought in her questioning as the discussion unfolds.

The purpose of the discussion is to enable both listeners and panellists to reach their own conclusions about the course of action those involved should take. The aim is not to seek a right or wrong answer, rather to show how deliberations around ethically challenging situations are resolved.

Three or four people with a keen interest in clinical ethics, including health professionals, philosophers, lay people and lawyers, comprise the panel. One panellist is selected to summarize the ethical and, when required, legal principles, pertinent to the case. Deborah Bowman, Senior Lecturer in Medical Ethics and Law at St George’s, University of London, has done a fantastic job fulfilling this role in recent years, and now consults on the series.

The remaining panellists are chosen to provide insight into the ethical issues from different perspectives, thus providing context and enriching the ethical discussion. For example, we asked a paediatric oncologist to discuss our saviour sibling case as his experience of the family dynamics associated with treating sick children was pertinent to the ethics of this case. In another programme, when we featured the case of a woman who received a kidney from her husband despite the high risks involved, it was useful to hear a female panellist with a similar history explain the ethical issues pertinent to recipients, given that the case story was told by the donor husband.

**Conclusion**

Clinical ethics is a subject of immense relevance to all users of the health system, and we hope that this series continues to succeed in bringing this fascinating and important subject to a wider audience.

Despite the challenges involved, we have always felt that there are strong editorial reasons for featuring real cases. We think that it is more compelling to hear an ethical discussion about a dilemma that has actually affected a patient, their family and the medical staff involved. Hearing the process the individuals themselves went through to resolve a seemingly insurmountable situation really brings the ethical dilemmas to life, and facilitates the ethical discussion in the most effective way possible.

Obviously, by their very nature, the cases we feature are very sensitive. So it is perhaps surprising that so many people have agreed to take part and tell us, in their own words, what happened to them. Patients have a variety of reasons for doing this, from wanting others to learn from what happened to them, to one memorable case when the patient wanted to express profound personal gratitude to his doctor.

**Contact the series about a case**

We have broadcast 17 cases over the last five series, and we are now looking for cases for series 6 which will broadcast in July and August. If you know about a case that you think might be interesting for the series, please contact me. Any information you give about a particular case is confidential, and will only be considered for broadcast in the series if, and when, the key people involved have given their consent.

Beth Eastwood, Producer, Inside the Ethics Committee
BBC Radio Science Unit
beth.eastwood@bbc.co.uk

You can listen to, and read transcripts of, any of the programmes from Inside the Ethics Committee at: http://www.bbc.co.uk/programmes/b007xbtd

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