The structure, function and deliberative processes of Australasian clinical ethics committees

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The Structure, Function and Deliberative Processes of Australasian Clinical Ethics Committees

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Since the mid 20th century, healthcare delivery expanded from a service largely provided by individual practitioners to a complex system of services provided by multidisciplinary teams of professionals. This changing structure of healthcare delivery brought about a complex array of ethical issues in helthcare. As the ethical questions posed became increasingly complex, Clinical Ethics Committees (CECs) emerged as mechanisms to review ethical dilemmas and provide assistance and safeguards for patients and providers. In Australasia there is no apparent consensus on the method required for CECs to competently deal with ethical issues, thus indicating a need for some form of 'quality assurance' that the moral reasoning of CECs meets society's expectations. This study undertakes an analysis of CECs from Australia and New Zealand. In addition, CECs from the United Kingdom were invited to participate in order to provide some international comparison. The aims of this thesis are to 1. Describe the characteristics of participating CECs. 2. Identify the principal activities that CECs are currently engaged in. 3. Understand the processes by which CECs come to believe they are making good decisions/ recommendations. A central aim of the thesis is to provide recommendations designed to aid CECs in the assessment of their performance in order to ensure that their moral reasoning meets society's expectations. Two study instruments were specifically designed to achieve the aims of the thesis. The first instrument provides a structural analysis of participating committees, including committee activities and evaluative processes in place. The second instrument provides individual CEC members' views on a range of issues pertaining to the strucure, activities and deliberative processes of their committee. I believe that this type of approach, not previously undertaken, can, by examining areas of dissonance between what currently obtains for CECs and what committee members consider to be best practice, enhance our understanding of the processes of CECs. Following critical evaluation of the findings, the thesis provides a number of recommendations pertaining to the structure, activities, and, the evaluative and deliberative processes of CECs, culminating in the formulation of a set of guidelines, designed to assist CECs operate at their optimum level.

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Chapter 1

Introduction

Clinical Ethics Committees (CECs) are becoming increasingly important for aiding decision making on ethical issues in healthcare institutions. This chapter will provide an introduction to the relevance of health and healthcare for contemporary society, before tracing the history and evolution of CECs. The chapter will conclude with a statement of the objectives of the study.

1.1. Health and Healthcare

It is widely accepted that human beings hold good health and a long life free from pain and disability to be of fundamental value. The importance derives from the fact that, in most cultures, good health is central to the projects of every person and that impairment of 'normal' functioning due to disease, disability or injury may cause disadvantage and significant reduction in a person's opportunities in life (Denier, 2005).

Aristotle, in Book I of 'The Ethics', said that every action and pursuit is considered to aim at some good.' For Aristotle, 'the end of medical science is health.' Denier (2005), elaborating on this idea, states that healthcare is considered to be special because of its instrumental power derived from the capacity it has to affect our chances of leading a full, active, and morally fulfilling life by preventing disease and disability, restoring health where possible and providing personal and social support for the long term ill or disabled.

Further, Emanuel sees the professional purpose of healthcare to be understood to derive from a devotion to service to the ill and the protection of the health of those who are well. Since patients are vulnerable to exploitation, healthcare professionals, as part of a contract with society, must meet rigorous standards of accountability and trustworthiness (Emanuel, 2000). At the core is that the ethics of professionals should allow patients to trust that health professionals make judgments with the patient's health chiefly in mind.(Ozar, Berg, Werhane, and Emanuel, 2000).

In the wider sense, a healthcare system must ensure that appropriate treatment should be delivered in a timely manner by suitably qualified personnel in the appropriate setting (Rorty, 2000).

Up until the mid 20th century there was what Paris and Post described as the 'simple era' in healthcare, when the great majority of patients received treatments which were contained in 'the physician's little black bag' (Paris and Post, 2000) . During this era any ethical problems that arose in the delivery of healthcare were usually solved easily and often paternalistically by individual physicians and their patients and/or families (Peirce, 2004).

However, healthcare delivery expanded from what was largely a social service provided by individual practitioners, often in the home, to a complex system of services provided by multidisciplinary teams of professionals, usually within institutions, and using sophisticated technology, which allowed hitherto undreamed of diagnostic and therapeutic interventions (Dwyer, 2004; Smith, Hiatt, Berwick, and Tavistock,1999). Modern healthcare became focused on the care of populations and not only the patient before the physician. For Wildes (1997), viewing healthcare as addressing the needs of particular patients is an incomplete reading of the modern context.

The physician, although retaining the primary responsibility for patient care, often became only one of several clinicians involved in patient care. Therefore, many treatment decisions could be influenced by other healthcare professionals. Furthermore, institutional constraints were often seen to influence care decisions. For example, physicians, nurses, patient care representatives, lawyers, and administrators may be simultaneously pursuing such divergent objectives as individual patient care, public health, and resource allocation (Rorty, Werhane, and Mills, 2004). This changing structure of healthcare delivery brought about a complex array of ethical issues in healthcare and within society at large (Gallacher and Goodstein, 2002).

Changes also took place during the latter half of the 20th century in the perception of professional roles and the expectations of society. These changes led to unprecedented demand that healthcare professionals become more heavily involved in the identification, confrontation and attempted resolution of ethical issues in healthcare

(Mitchell, Kerridge, and Lovat, 1996). These changes also saw society give the value of autonomy a high priority. In fact, Charlesworth considered personal autonomy to be the 'supreme value' in a liberal society (Charlesworth, 1993, p1). This required healthcare professionals to accept the patient as the primary decision maker in terms of their health (Ozar et al., 2000).

Healthcare provider organizations were increasingly required to interact with a number of different groups of stakeholders, including patients and their families, healthcare professionals, other professional and non-professional employees, regulators, and the community at large (Ozar et al., 2000). This resulted in healthcare delivery systems struggling to manage their duties to an ever expanding array of stakeholders (Gallacher and Goodstein, 2002).

As the ethical questions posed became increasingly complex it became clear that the individual decision maker was no longer enough. Hospital committees emerged as a mechanism to review the individual circumstances of ethical dilemmas and provide assistance and safeguards for patients and providers (Peirce, 2004).

The following section traces with the history and evolution of Clinical Ethics Committees.

1.2. History of Clinical Ethics Committees

Most published data on Clinical Ethics Committees (CECs) comes from North America, where such committees have been a prominent feature of hospitals since the early 1980s (Doyal, 2001; Slowther and Hope, 2000). These CECs influence the patterns of care and have been seen as an aid to ensuring that the moral and legal standards of hospitals are of the highest level (Doyal, 2001). CECs evolved from the need to provide consultative help to physicians and patients (and their families) faced with ethical decisions (Harding, 1994). They are also seen as having a role in minimizing the risks of litigation or running foul of State or Federal authority (Doyal, 2001).

McGee et al suggest that CECs have three progenitors. These are kidney dialysis committees in the 1960s, abortion review committees in the 1970s and, in the 1980s,

infant case review committees (McGee, Spnogle, Caplan, Penny, and Asch, 2002). Ethics committees in hospitals are a relatively new phenomenon. Such bodies have been in existence for less than 40 years worldwide and precise roles and methods of functioning continue to evolve (Wenger, Golan, Shalev, and Glick, 2002).

In 1992 the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) in the USA passed a mandate that all of its approved hospitals put in place a mechanism for addressing ethical concerns (McGee et al., 2002). Although JCAHO recommends a multidisciplinary ethics committee JCAHO regulations do not require an ethics committee, but only a process by which the hospital addresses ethical issues (Slowther and Hope, 2000). Many hospitals have felt that the way to meet this requirement has been to establish an ethics committee and they are now generally expected, if not in accreditation at least in pursuit of quality assurance (Self and Skeel, 1998). Since this mandate, the percentage of US hospitals with CECs increased from 1% in 1983 to over 90% in 1998 (Guo and Schick, 2003).

In contrast to the development of CECs in the USA, CECs in Australasia and the U.K. have developed in a somewhat different manner. Since CECs are not mandated as they are in the USA, many CECs have arisen out of a perceived need by relevant stakeholders, to have a mechanism for dealing with clinical ethical issues, which is separate from HRECs. Prior to CECs, Human Research Ethics Committees (HRECs), were, in some cases, mechanisms for dealing with clinical ethical issues. According to Slowther and Hope, in Australia many HRECs report that they also provide ethics advice on clinical issues.

It has not always been apparent how clinical ethics issues have been dealt with in Australasia. Between 1991 and 1994 McNeill and colleagues conducted a series of studies of Australian hospital ethics committees. In these studies 148 (20%) of 739 hospitals surveyed, indicated that CECs were referred to in order to resolve ethical issues (Mc Neill, Walters, and Webster,1994a; Mc Neill, Walters, and Webster,1994b). However, in a more recent paper, McNeill reported that anomalies were found in these earlier studies. There was a tendency to inflate the number of CECs and to ‘over report’ their functions. The study identified 120 clinical ethics committees, which included 94 that served both as HRECs and CECs. However, on further investigation the number of

committees which were deemed to function as CECs was reduced to 79 (Mc Neill, 2001). As recently as 2011, Gold et al (2011), assert that this claim should be regarded as optimistic and difficult to confirm.

1.2.1. Human Research Ethics Committees and Clinical Ethics Committees in Australasia and the United Kingdom.

The following provides a more detailed background and makes highlights similarities and differences between HRECs and CECs in Australasia and in the U.K.

In Australia, Human Research Ethics Committees (HRECs) are constituted to review research proposals which involve human participants to ensure that they are ethically acceptable and that they comply with the relevant standards and guidelines. HRECs are guided by relevant standards, including those set out in the National Statement on Ethical Conduct in Human Research (2007) (updated 2013) (the National Statement) issued by the National health and Medical research Council (NHMRC).

Compliance with the National Statement is a prerequisite for an HREC to receive funding from the NHMRC. HRECs are required to report their compliance with the National Statement on an annual basis. This annual report has to include, the composition of the committee; the processes for the consideration of research proposals; and mechanisms for handling complaints.

An article published in the HREC Bulletin, published by the Australian Healthcare Ethics Committee (AHEC), acknowledges that some institutions combine the work of CECs with the work of their HREC. This article points out that HRECs have a defined role under the *National Statement on Ethical Conduct in Research Involving Humans,* and that the work which is characteristically undertaken by CECs is different to the defined role of the HREC. One specific difficulty in combining committees with different responsibilities is seen by AHEC as achieving an appropriate balance in committee membership such that all aspects of issues for consideration by the committee are adequately addressed. Unlike HRECs, where the membership of the committee is prescribed by the National statement, CECs have no such requirement, and have considerable latitude in the appointment of members. In addition, unlike HRECs,

there is no requirement for non-research ethics committees to register with AHEC (AHEC, 2003).

Gold et al (2011), provides a nuanced summary of the position of CECs in Australia. They state, that in Victoria, CECs are not mandated by government accreditation processes. In contrast to HRECs, in Victoria, there are no national or State-directed guidelines specifying membership categories or functions for CECs. The committees or their hospital executives decide how they will operate. This differs slightly in New South Wales where NSW Health has issued a policy directive that provides guidance and a mandated structure of governance and operation for CECs – although the establishment of CECs in NSW is not mandatory.'

In New Zealand, according to Pinnock and Crosthwaite (2004), 'Clinical ethics committees have developed in response to doctors and other health professionals becoming increasingly aware of the ethical decisions they are required to make. These committees differ in function and constitution from Research Ethics Committees the purpose of which is the ethical review of research on human subjects. While these committees can and do address clinical issues, the public nature of their deliberation and their identification as primarily research-oriented has appeared to leave an unmet need for clinical ethics advice.' It should be noted, however, that there may well be areas of similarity and overlap in the deliberative processes for CECs and HRECs. These areas will be highlighted where appropriate throughout this study.

In the U.K., according to Slowther, Johnston, and Goodall (2007), ' Research Ethics Committees (RECs) were set up to review the ethical issues arising from research within the National Health Service (NHS). It is a requirement under the governance arrangements for NHS research ethics committees issued by the Department of Health that research involving NHS patients or NHS resources receives approval from a REC prior to commencement of the research. The role and conduct of RECs is closely regulated, and is the responsibility of the relevant Strategic Health Authority. There is a central co-ordinating office for RECs that issue guidance and facilitates provision of training of REC members. In contrast to RECs, CECs are advisory and are not governed by government regulation. They sit within individual NHS Trusts and often develop as a result of clinician concern rather than managerial directive. There is no

requirement for training of members of CECs.' Slowther et al do not believe that RECs provide a helpful model for CECs since they work to a fairly rigid protocol for consideration of research projects. Clinical ethics situations are not so easily circumscribed (Slowther et al., 2002).

Table 1.1, presented by Slowther et al (2007), provides a comparison of CECs and HRECs, highlighting major areas of difference between them. Although, the table refers specifically to the U.K., it may also be considered representative of Australasian committees.

Table 1.1. Comparison of Clinical and Research Ethics Committees

Comparison of Clinical and Research Ethics Committees	
Clinical Ethics Committees	Research Ethics Committees
Advisory	Decision-making
Ethics of clinical care	Ethics of medical research involving human participants
Not regulated	Regulated
Situated within healthcare institution	Required to be outside the Trust
Training not compulsory	Compulsory training for members
No central funding	Funding for training of members and administrative support

This study aims to focus on CECs, rather than HRECs, with particular regard to issues highlighted in the CEC column of table 1.1.

In the U.K. and Europe, CECs have become much more common since the mid 1990s (Slowther, 2002). For example, all major hospitals in Norway are now required to have an ethics committee and institutional ethics committees have also been present in the Netherlands for many years (Slowther, Johnston, Goodall, and Hope, 2004). However, in the Netherlands, except for Research Ethics Committees (RECs), there are no recent figures on the numbers of ethics committees. In a 1992 survey of Dutch federal healthcare organizations 234 (33.7%) of all hospitals were reported to have an institutional ethics committee (van der Kloot Meijburg and ter Meulen, 2001).

In 2001 the Nuffield Trust in the U.K. published a survey of all National Health Service (NHS) Trusts that identified 20 CECs. By early 2003, a survey conducted by the U.K. Clinical Ethics Network (UKCEN) showed that 60 of the 315 acute NHS Trusts had a CEC (Slowther et al., 2004). There is no such network for clinical ethics committees

currently operational in Australasia. Clinical ethics committees have developed independently, often on an ad hoc basis.

According to Slowther, Hill, and McMillan,(2002), CECs in the U.K. would seem to be developing in much the same way as they have in North America, albeit at a much slower rate. Doyal also notes that there has been a slower development of CECs in Australia, U.K. and Europe compared with North America, and suggests several possibilities why this might be the case (Doyal, 2001).

In North America there has been

1. A longer tradition of federal/ state regulation of ethicolegal aspects of clinical activity.
2. Less tolerance of overt paternalism in medicine, along with a greater desire for transparency and accountability in decision making.
3. A system of statute and common law which more actively supports patient rights.
4. More willingness of patients and relatives to litigate or to make formal complaints over perceived breaches of professional duty.
5. More authority vested in adults as legal proxies for treatment decisions concerning other adults
   (Doyal, 2001, p44).

Whilst acknowledging that different healthcare systems may differ in their requirements for providing specific solutions to issues in clinical ethics, Slowther maintains that there are enough similarities to allow meaningful dialogue between and within countries. This could result in a basis for comparative evaluation of different systems. Two important questions that need to be addressed in all countries are a) Are CECs achieving their goals? and b) Are their goals worth achieving? (Slowther, 2002). These questions will be discussed more fully in the section discussing evaluation of CECs.

According to Slowther et al, the methodology for the assessment of clinical ethics support services is poorly developed. A few studies have tackled this issue, primarily focusing on process rather than outcome measures (Slowther et al., 2001b) .

As stated above, the literature concerning Australasian CECs reveals that there is currently no agreed set of guidelines concerning the structure of a CEC in Australasia. This derives importance since structural issues arise that may be seen as possible sources of shortcomings for committee decisions/outcomes. Further, there is no

apparent consensus on the method required for CECs to competently deal with ethical issues, thus indicating there is a need for some form of 'quality assurance' that the moral reasoning of CECs meets society's expectations. This study seeks to examine the nature of the moral reasoning of CECs and explore aspects of their deliberative processes. It is recognised, that while the focus of this study is on CECs, there may well be areas of overlap with HRECs and other healthcare ethics committees, particularly with respect to the structure of committees and the deliberative processes of these committees.

1.3. Study Objectives

Since there is no apparent consensus on the method required for CECs in Australasia to competently deal with ethical issues, there is a need for some form of 'quality assurance' that the moral reasoning of CECs meets society's expectations. The specific objectives of the study are to

1. Describe the characteristics of Clinical Ethics Committees.
2. Identify the principal activities that CECs are currently engaged in.
3. Understand the processes by which CECs come to believe they are making good decisions/ recommendations.
4. Formulate recommendations which might aid CECs in the evaluation of their performance and ensure that their moral reasoning meets society's expectations.

The following provides an outline of the structure of the thesis, including the specific questions investigated by the study in order to achieve the stated objectives of the study.

Chapter 2. Methodology in Bioethics

This chapter provides a discussion on methodology in bioethics, which serves to provide the theoretical underpinnings for the study in general, and in particular for the exploration of the deliberative processes of participating CECs, analysed in chapter 7.

Chapter 3. Method

This chapter describes: the study participants; the research procedure; the study instruments; protection of human subjects: and, limitations of the study methodology. The design and content of the survey questionnaires are also described in detail.

Chapter 4. Structure

It is believed that by addressing structural questions concerning clinical ethics committees (CECs), it may be possible to shed valuable light on which characteristics produce a useful committee and those which tend to impair a committee's functioning.

The questions addressed in this section of the study derive from the overall study aims and questions of the study, as stated above. Specifically, the questions investigated with respect to CEC structure are stated below.

1. The appropriate membership for a CEC:
    a. The appropriate size of a CEC
    b. The appropriate composition of a CEC
    c. Appropriate qualification for membership of a CEC
    d. Who should be the committee chairperson?
    e. The selection process for selecting committee members.

2. How long the committee has been in existence.

3. The frequency of meetings scheduled.

4. Whether a committee receives administrative support from its organisation.

5. The nature of any funding received by a committee from its organisation.

Chapter 5. Function

The study undertook to identify and describe the activities of participating committees. In addition to investigating the activities of committees, the study also undertook to gather information on individual committee members' views regarding how successful they belied their committee to be regarding its activities. By adopting this approach it is believed that it may be possible to highlight areas where committees might be lacking in the performance of their activities and, provide some recommendations as to how committee performance might be improved in these areas.

Analysis for this section of the study was undertaken to determine whether there was any statistically significant difference between responses for participants from Australasian and UK CECs. In addition, analysis of responses from CEC chairpersons and committee members was undertaken to investigate any differences between these groups of study participants.

After determining that there is a consensus in the literature concerning CECs, both in the U.S.A and elsewhere that the main functions of a CEC are; 1. Policy & Guideline Development/Review; 2. Education; 3. Case Consultation, the study examined each of these functions in depth.

The specific areas investigated in each area are given below.

1. Policy and Guidelines

The study was designed to gather information on,

1. The issues discussed by committees on policies and guidelines.

2. The amount of time spent by committees dealing with policy and guideline issues.

3. The viewpoint of individual committee members participating in the study regarding their beliefs on how successful their committees are in dealing with policy and guideline matters.

2. Education

The study was designed to gather information on,

1. The recipients of committee educational offerings.

2. The amount of time spent by committees on providing education activities.

3. The viewpoint of individual committee members participating in the study regarding how successful they believed their committees to be in providing education.

4. Factors contributing to success of the committee in providing education.

3. Case Consultation

The study was designed to gather information on,

1. The methods and volume of case consultation.

2. The amount of time spent by committees undertaking case consultation.

3. Issues arising in case consultation undertaken by committees.

4. Who can request case consultation by the committee.

5. The outcome of case consultation.

6. The viewpoint of individual committee members participating in the study regarding how successful their committees are in providing case consultation.

7. Factors contributing to the success of committees in providing case consultation.

Chapter 6. Evaluation

The study undertook to identify those participating committees which have a formal evaluation process in place. Where this was found to be the case, a number of key areas concerning the nature of this evaluative process were investigated in order to provide some insight on the effectiveness of such processes.

For the purposes of the study, sections regarding committee evaluation were included in both questionnaires 1 and 2. Questionnaire 1 was completed by individual study participants and solicited the views of individual participants on a number of areas concerning committee evaluation. Questionnaire 2 was completed by the Chairperson (or other nominated individual) of each committee, and wherever reference is made to the views of the committee this should be understood to refer to the views presented by the chairperson (or other nominated individual). The responses to questionnaire 2 were taken to represent what actually obtains for participating committees.

It is believed that by drawing comparisons between responses obtained from questionnaires 1 and 2 that it will be possible to gather information regarding what committees are currently doing and what individual committee members believe their committees should be doing in key areas regarding committee evaluation. This information may prove useful in guiding the future development of CEC evaluation processes.

The questions addressed in this section of the study derive from the overall study aims and questions of the study, as stated earlier in this chapter. Specifically, the areas investigated with respect to CEC evaluation are stated below.

1. Who evaluates committees?

2. Effective means of gathering information for evaluating of committees.

3. Effective indicators of committee success.

4. Obstacles to successful committee development.

5. Committee members' viewpoints regarding their perception of committee success

Chapter 7. Deliberative Process

The study undertook to investigate the deliberative processes of participating clinical ethics committees (CECs). Participants were requested to assess twenty-nine statements pertaining to the deliberative process of their committee. For the purposes of analysis the statements were divided into 3 broad areas,

1. The Clinical Ethics Committee meeting as a forum for discussing bioethical issues,
    a. Committee member representation from the professional disciplines.
    b. Committee membership represents diverse bioethical perspectives.
    c. Committee meetings as a useful forum for discussing bioethical issues.

    In this area, the study also investigated measures implemented by participating CECs to help avoid the potential dangers of Groupthink.

2. Procedural characteristics of the deliberative process.

In this area of the study the views of participants concerning a number of aspects of their committee's deliberative process were examined. To facilitate analysis of the results obtained from the study, the area was sub-divided into 3 sections.

a) Section a, was designed to investigate whether moral principles and value conflicts are explicitly articulated during committee deliberation on an issue.

b) Section b, examined respondents' beliefs concerning a number of procedural characteristics of a committee's deliberative process pertaining to a Perspectives approach to deliberation.

c) Section c, sought to determine the beliefs of study participants regarding aspects of their participation in committee deliberations.

3. Committee deliberation outcome

The third major area relating to the deliberative process of participating CECs, considered in depth by the study, concerned the outcome of committee deliberations. In this area of the study, participants were asked to indicate their view on statements. relating to 3 major categories of outcomes of their committee's deliberations

1. Consensus
2. Compromise
3. Majority

Statistical analysis was undertaken to determine whether there was any significant difference between responses for participants from Australasian and UK CECs. In addition, analysis of responses from CEC chairpersons and committee members was undertaken to investigate any differences between these groups of study participants.

Chapter 8. Discussion

In this chapter the results of the study are discussed and a set of guidelines for Clinical Ethics Committees (CECs), derived from the study results is presented.

1.4. Chapter Summary

This Chapter provided an introduction to the relevance of health and healthcare for contemporary society, before tracing the history and evolution of CECs. The study objectives and main study questions were articulated. Specifically, the study is designed to investigate the structural characteristics of the Clinical Ethics Committees participating in the study and identify current issues these committees are dealing with. The nature of the deliberative process of participating CECs is also investigated in order to provide some understanding of the processes by which CECs come to believe they are making good decisions/ recommendations. In addition the study will analyse the opinions of committee members regarding factors relating to their perceived success of their committees. I believe that this type of approach, not previously undertaken, can, by examining areas of dissonance between what currently obtains for CECs and what committee members consider to be best practice, enhance our understanding of the processes of CECs. One of the fundamental objectives of the study is the formulation of recommendations which might aid CECs in the evaluation of their performance and ensure that their moral reasoning meets society's expectations.

Chapter 2

Methodology in Bioethics

This chapter provides a discussion on methodology in bioethics, which serves to provide the theoretical underpinnings for the study, and in particular, for the exploration of the evaluative processes and deliberative processes of participating CECs, analysed in chapters 6 and 7, pertaining to CEC Evaluation and the Deliberative Processes of CECs. .

In chapter 7 (Deliberative Process), for example, the following areas specifically link to theoretical underpinnings described in this chapter;

7.3. Area 2. Procedural Characteristics of a Deliberative Process.
7.3.1 Moral Principles and Value Conflicts.
7.3.2 Procedural Characteristics of a Perspectives Approach to Deliberation.
7.3.3 Participation in Committee Deliberations.

2.1. Introduction

According to Kevin Wildes, bioethics should be seen, at least in part, as a form of social philosophy and, as such, gives us a lens through which we may examine secular societies. Bioethics can provide 'insight into issues of moral community, and to how a society understands political authority and its appropriate exercise'(Wildes,2002, p.125).

Comparing the functions of law and ethics in society, Melnick, Kaplowitz, Lopez, Murphy, and Bernheim express the view that, although both may be considered key institutions, they are somewhat different. While law is a formal institution which includes statutes, regulations, and public proceedings, ethics may be seen as being less formal. For example, in public policy ethics, the objective is public justification (Melnick, Kaplowitz, Lopez, Murphy, and Bernheim, 2005, p.102). Melnick et al. describe ethics as a 'process that involves exploring, analysing, and presenting

sufficient grounds or reasons for a course of action, especially when the law does not tell you what to do' (Melnick et al., 2005, p.102).

For Mitchell, Kerridge, and Lovat, when we deliberate on an ethical issue in healthcare, 'our actions and our decisions may embody an unstated theory of ethics' (Mitchell, Kerridge & Lovat, 1996, p.21) . This comes about as a result of our consideration of experiences, attitudes, beliefs, and emotions of the issue. Further, our 'process of moral reasoning,' is influenced by our fundamental beliefs concerning the structure, justification, and function of morality (Mitchell et al, 1996, p.21).

The impression in contemporary society is that medical values are of public concern and not, just a matter of professional interest. Therefore it has increasingly been understood that the moral authority in the patient-physician relationship is based in 'moral communities that link both parties with higher social orders,' rather than with the medical profession or in the 'singular will of the patient' (Trotter, 2002a, p.37).

A number of authors have expressed the view that, particularly over the last thirty years or so, advances in scientific and medical technology, and practice, have outpaced our ethical resources . Therefore bioethics has emerged, at least in part, as a mechanism to help provide ethical restraints on those innovations and practices (Tollefsen, 2000; Durante, 2008).

These advances have raised an abundance of controversial ethical and conceptually nebulous issues. These bioethical issues oscillate, according to Tollefsen, 'between the boundaries of the political, legal, and social; the scientific and the entrepreneurial; and the religious.' They also involve the personal ideals, commitments, and values, of individuals (Tollefsen, 2000, p.87). According to Tollefsen, 'a broad anticipation and approval of a steady and progressive dialectic between scientific advancement and human well-being sets the framework within which consensus is sought as the impetus for specific decisions and policies' (Tollefsen, 2000, p.87).

For Martin Benjamin, on occasion, these advances in scientific and medical technology, and practice, have created possibilities and choices that are so complex or novel, that we have been unable to decide what to think or do about them. In such cases, our particular world views and abstract general principles have been unable to offer firm guidance on

how to deal with them (Benjamin, 1995, p.252). On the other hand, there are instances where new technologies and practices have brought about definite responses which are anchored in different world views. Such issues include, for example, those regarding beginning and end of life, and procreation (Benjamin, 1995, p252). On such issues, people often have deeply held ethical positions and convictions. However, these positions may conflict with other ethical positions held within equally reasonable world views. The difficulty then becomes that, although we consider as individuals we believe we have the right solution, we are uncertain what should be done by a healthcare institution or a society 'when those directly affected hold conflicting, yet not unreasonable positions' (Benjamin, 1995, p.252).

In such situations we are required to provide moral justification and reasoning for our views. According to Beauchamp and Childress, when considering ethical issues in healthcare, 'the objective is to establish one's case by presenting sufficient grounds for it' (Beauchamp and Childress, 2001, p.384). They state that simply compiling a list of reasons is not sufficient, since those reasons may not support the conclusion. Further, not all reasons are necessarily good reasons, and not all good reasons are sufficient for justification. Therefore, according to Beauchamp and Childress, it is necessary to differentiate between a 'reason's relevance to a moral judgment" and "its final adequacy for that judgment.' They further assert that it is also required to distinguish an attempted justification from a successful justification, since a successful requires a sufficient reason (Beauchamp and Childress, 2001, pp.384-5).

However, although there is broad agreement that we can engage in bioethics, there appears to be little agreement about the methods to be utilised in achieving justification of our moral conclusions (Beauchamp and Childress, 2001, p.384).

There are many perceptions about what constitute moral problems and how these problems might be resolved. This is true both within a particular culture or worldview and between cultures. The ramifications of such cultural diversity and value pluralism will be discussed more later in this section.

A substantial number of schools of thought exist regarding what might be the best description of what constitutes the 'moral good.' For example, utilitarianism and

deontology aim to provide guidance in this matter, as do principlism, feminism, casuistry, and various forms of bioethical theory influenced by political liberalism (Tollefsen, 2000, p.77).

In the following section a number of approaches to moral reasoning will be discussed.

2.2. Moral Reasoning

When deliberating on issues that involve moral conflict or moral perplexity, there is a requirement for us to be able to justify our moral conclusions. Since there is considerable disagreement about how to justify such conclusions, it is possible to reflect on second-order problems of whether there is method in bioethics and, if we conclude that there is, how we might assess which methods are most effective (Beauchamp and Childress, 2001, p.384). This study investigates aspects of the moral reasoning approaches employed by participating committees in order to say something regarding the methodologies employed, and, whether a particular approach is dominant.

Four central approaches to moral reasoning identified in the literature were considered

The first approach involves deductive reasoning, working from the more general to the more specific. This approach is also known as the ‘top-down’ model.

The second approach utilises inductive reasoning, moving from specific observations and particular circumstances to broader generalisations and theories. This approach is sometimes called the ‘bottom-up’ model.

The third approach is an integrated approach, which does not give precedence to either the top-down or bottom-up approaches. This approach has been termed the ‘reflective equilibrium’ model (Beauchamp and Childress, 2001, p.385).

The fourth approach is one in which making moral decisions takes into account emotions, values, and beliefs, in addition to principles and ideas. This approach is sometimes termed the ‘perspectives approach’.

The theoretical background of each of these three approaches to moral reasoning, together with examples of methodologies derived from each approach is considered in detail below.

2.2.1. The Top-Down Model

In the top-down approach, we begin by adopting a theory (or a group of theories) about our topic of interest and apply them systematically to the case in hand. The next step is to narrow that down into a more specific hypothesis that we could test (Cotton, 2006).

Richard Posner describes this process of hypothesis testing. He states that the analyst uses the adopted theory to:

> *Organise, criticise, accept or reject, explain or explain away, distinguish or amplify the existing decisions to make them conform to the theory and generate an outcome in each new case as it arises that will be consistent with the theory and with the canonical cases, that is, the cases accepted as authoritative within the theory* (Posner, 1992, p.433).

In other words, according to Beauchamp and Childress, justification of the conclusion reached occurs if and only if 'general principles and rules, together with the relevant facts of a situation, support an inference to the correct or justified judgment(s)' (Beauchamp and Childress, 2001, p.385). For the top-down approach, moral reasoning involves the application of general rules or principles to the situation in question and then overlaying those principles onto particular situations as they arise (Grace and Cohen, 1998, p.7). According to Beauchamp and Childress, this approach corresponds to the way that most people learn to think morally (Beauchamp and Childress, 2001, p.385).

Using a top-down approach we are able to justify a particular judgment by bringing it under one or more moral rules. We can also justify rules by bringing them under general principles. Finally, we can defend both rules and principles by a full ethical theory (Beauchamp and Childress, 2001, p.386). However, there are several problems with the top-down approach, particularly if we adopt it uncritically (Cotton, 2006,

p.183). First, when adopting a theory to apply, the model suggests that the chosen theory presumes to have the correct 'moral rules' to guide behaviour (Cotton, 2006, p.184). In fact, many different theories exist, and each of these is able to put forward a good case in its defence as to why it can provide the correct guidance. However, as Beauchamp and Childress claim, 'there is no authoritative or even dominant theory' (Beauchamp and Childress, 2001, p.387). According to Cotton, the adoption of a top-down approach reduces the possibility for truly creative or innovative ethical problem solving (Cotton, 2006, p.184).

Second, if the top-down model is portrayed as being the single correct approach for solving problems in bioethics, there is the suggestion that principles, rules, and theories take precedence over case judgments and traditional practices. In reality, this does not seem to be the case. For example, often in difficult cases abstract rules and principles are too abstract to give guidance on the action required in the case. In such difficult cases, it is not unusual for there to be a requirement to take into account precedents, cultural expectations and factual beliefs about the world in order to help provide a richer and fuller justification than might have arisen from merely mechanically applying rules, principles, and theories (Beauchamp and Childress, 2001, pp.386-7).

Third, it may be the case that, in a given situation, no principle or rule is clearly applicable. There may be instances where the different rules or principles that might be applied to the case yield either inconclusive or contradictory results. An example of this type of situation might be found in some of the novel therapies being introduced as a result of advances made in the field of gene therapy. The problem here is in the selection of the 'right set of facts' and 'bringing the right set of rules' to bear on the situation. For Beauchamp and Childress, this is 'not reducible to a deductive form of judgment or to the resources of a general ethical theory' (Beauchamp and Childress, 2001, p.387).

In Western societies, there is a commitment to incorporating the cultural diversity, and corresponding diverse range of ethical positions, into our ethical decision-making (Cotton, 2006, p.184).

An example of a methodology which employs a top-down approach is principlism, which is discussed in detail below.

2.2.1.1. Principlism

In the 1970's there was a shift in medical practice away from paternalism, however beneficent the intent, toward patient autonomy. As a result of this, there was a distinct movement in bioethics methodology toward 'principlism.'

According to Boyd, the central question for a 'principles' based approach is 'whether a particular act or course of action is morally right' (Boyd, 2005, p.482). If the particular act or course of action obeys an agreed moral rule, or respects an agreed moral principle, then, according to Boyd, it can be considered to be morally right. For Boyd, the feature that all principles based approaches share is that an action or course of action conforms to an agreed moral rule or principle, which may be either deontological or consequentialist in origin (Boyd, 2005, p.482).

Inspired by the synthesis of rule-based utilitarianism and deontological thought, Beauchamp and Childress formulated what they termed the 'four principles approach' to biomedical ethics. Through time, this approach has widely become known as 'principlism,' and arguably became the dominant methodological approach in bioethics during the later part of the 20th century. According to Beauchamp and Childress, 'the four principles derive from considered judgments in the common morality and medical traditions' (Beauchamp and Childress, 2001, p23). The choice of principles and the content ascribed to the principles derive from Beauchamp and Childress's attempt to put the common morality and medical traditions into a 'coherent package' (Beauchamp and Childress, 2001, p.23).

At the core of this approach, Beauchamp and Childress assert, is that 'a set of principles in a moral account should function as an analytical framework that expresses the general values underlying rules in the common morality. These principles can then function as guidelines for professional ethics' (Beauchamp and Childress, 2001, p.12).

Beauchamp and Childress specify what they term as 'four clusters of moral principles' which fulfil this purpose.

The four clusters are:

1. *Respect for autonomy- a norm of respecting the decision-making capacity of autonomous persons.*
2. *Nonmaleficence- a norm of avoiding the causation of harm.*
3. *Beneficence- a group of norms for providing benefits and balancing benefits against risks and costs.*
4. *Justice- a group of norms for distributing benefits, risks, and costs fairly* (Beauchamp and Childress, 2001, p.12).

Beauchamp and Childress maintain that by examining 'considered moral judgments' and the way 'moral beliefs cohere,' they were able to conclude that the four clusters of moral principles are central to biomedical ethics. They believe that, although their framework embraces numerous types of moral norms, including principles, rules, rights, and virtues, that principles provide the 'most general and comprehensive norms' (Beauchamp and Childress, 2001, p.13).

According to Beauchamp and Childress, principles do not serve as specific guides to action, but rather leave ample room for judgment in many cases (Beauchamp and Childress, 2001, p.13). Further, their 'four principles' approach to biomedical ethical problems provides only a framework for identifying and reflecting on moral problems, rather than amounting to a general moral theory, according to Beauchamp and Childress. The main reason for this, they contend, is because 'prima facie moral principles do not contain sufficient content to address the nuances of many moral circumstances' (Beauchamp and Childress, 2001, p.13).

Although the principles approach promulgated by Beauchamp and Childress has been, possibly, the dominant methodology in bioethics over the latter decades of the 20th century, other principlist approaches have been proffered. For example, Tristan Engelhardt's 'ethical formalism,' which is based on two a priori principles. The first of these principles, the 'principle of permission,' may be understood as being a necessary condition for morality among moral strangers in a secular society in which no common morality exists. The second principle, of ethical formalism is the 'principle of

beneficence,' also seen as a necessary condition for morality, is given specific content by individual communities that are populated by moral friends who share similar values and worldviews (Bauer, 2004, p.62).

The consensus that has formed around this approach to bioethical problems has intellectual and sociological sources of legitimacy, according to Jonathan Moreno. The intellectual legitimacy derives from history, in the shape of the Hippocratic value of 'doing no harm'; from philosophical ideas, such as justice as fairness; and from legal notions, like the 'concept of bodily integrity.' From a sociological perspective, Moreno asserts that "in a pluralistic society with a powerful medical profession, a conceptual scheme that strives to 'balance' personal autonomy with professional beneficence is quite desirable" (Moreno, 1995, p.20).

In recent years, however, the dominance of the principlist approach in bioethics has been under intense scrutiny, and has received increasing criticism. This criticism has come from a variety of sources, including other universal-oriented schools of thought such as Kantians, virtue theorists, and Christian ethicists.

The main criticisms of the principlist approach are as follows:

1. In practice, the four principles used in the approach are not generally susceptible to a great deal of scrutiny, apart from among abstract theorists. Rather, these principles are often used in a deductive and mechanical fashion, providing a handy checklist of ethical perspectives to consider when deliberating on morally problematic issues (Boyd, 2005; Moreno, 1995; Fins et al., 1997). By using principles in such a deductive and mechanical manner in attempting to solve moral problems, the approach could lead to premature moral judgment. According to Fins et al., 'Such a mechanical approach could lead to orchestrated outcomes in which the selected ethical principle predetermines what counts as an important fact or reasonable question' (Fins, Bacchetta, and Miller, 1997, p.141).

2. In Beauchamp and Childress's version of principlism, each of the four principles is prima facie. This leads to the problem that the approach does not provide a

decision-making procedure for resolving conflicts or reaching practical conclusions (Boyd, 2005, p.482).

3. There is no philosophical agreement on either which principle or type of principle might be the correct one. There is no known deontological principle that can be said with absolute certainty to admit no exceptions. Although there have been compelling arguments offered by both consequentialists and deontologists in defence of their respective theories, no theory is immune from counterargument (Boyd, 2005; Gracia, 2003).

4. Arguments have been put forward that principles are either too broad or too narrow. According to Jonathan Moreno, those who subscribe to a casuistic or case-based approach regard the principles to be too broad in scope, while those who argue for a unified theoretical approach believe principles to be too narrow. In general, proponents of both argue that simply recounting these principles in isolation from actual cases and not conceived by a moral theory is both arid and useless, according to Moreno (Moreno, 1995, p.20).

5. For Chris Durante, the application of principles which strive to adhere to the claims of all groups in a diverse and pluralistic society will either fail to attain their intended objective, or they will be too vague to realise any substantive outcomes. Therefore, they possess no practical usefulness (Durante, 2008).

One further concern is that, in practice, the principles used in the approach are not generally susceptible to a great deal of scrutiny, apart from among the abstract theorists. Rather, these principles are often used in a deductive and mechanical fashion, providing a handy checklist of ethical perspectives to consider when deliberating on morally problematic issues (Boyd, 2005; Moreno, 1995; Fins et al., 1997).

Issues relating to Principlism are considered in the study. In particular, chapter 7, which is concerned with the Deliberative Processes of participating CECs, utilises the theoretical underpinnings described in this section, in the analysis of factors relating to Moral Principles and Value Conflicts (7.3.1)

2.2.2. The Bottom-Up Model

The bottom-up approach starts with a specific case or mass of cases, looks to detect patterns and regularities, and then moves to formulate a tentative hypothesis that can be explored further. The aim is to end by developing some general conclusions or theories. The emphasis for the bottom-up approach is to begin with judgments which might be intuitions or feelings about an issue, rather than some abstract rule or principle. In other words, the first principles of moral reasoning are the judgments we make (Grace and Cohen, 1998, p.7). According to Stephen Cohen, it is these ground level 'judgments that serve to generate principles, and thus a fit between principles and judgments' (Cohen, 2004, p.62). The bottom-up approach, being inductivist in nature, regards rules and principles as 'derivative in the order of knowledge, not primary' (Beauchamp and Childress, 2001, p.392).

Stephen Cohen describes what a bottom-up approach to moral reasoning would look like,

> *Generalisation from specific judgments; that is, attempts to articulate general principles that would accommodate and offer an account of specific judgments. Throughout though, the judgments themselves are not open to alteration* ***because*** *of a principle. It is, rather, the other way around. Principles are framed to accommodate judgments. With the appearance of an errant judgment, the appropriate principle or principles must change* (Cohen, 2004, p.62).

Beauchamp and Childress make the point that all moral rules are refined over time, and never become more than 'provisionally secure points in a cultural matrix of judgments' (Beauchamp and Childress, 2001, p.392). Further, 'a society's moral views find their warrant through an embedded moral tradition and a set of procedures that often permit and even foster new insights and judgments' (Beauchamp and Childress, 2001, p.392). Therefore, bottom-up theorists place emphasis on the fact that moral life evolves and reflects narratives, experience with difficult cases, and analogy from practice (Beauchamp and Childress, 2001, pp.391-2).

One example of a bottom-up methodology utilised in bioethical reasoning is casuistry, which is discussed in detail below.

2.2.2.1. Casuistry

Casuistry re-emerged during the latter part of the 20th century in bioethical reasoning. According to Annette Braunack-Mayer, the 'modern' form of casuistry has been influential in the development of contemporary bioethical theory (Braunack-Mayer, 2001, p.71) .

At least in part, the re-emergence of casuistry has occurred as a challenge to the hegemony of approaches based on principles. Casuistry denies the primacy of ethical theory or universal ethical principles or rules. Rather, it claims that specific judgments are sometimes foundational since they are self-evident or self-justifying. Therefore, they may be used as reliable guidelines for other moral judgments (Kopelman, 2006, p.606) .

For casuists, ethical decision-making results from a comprehensive examination of particular cases and is based upon maxims grounded in clinical experience, practical wisdom, and medical tradition (Mitchell et al., 1996, pp.38-39). As a result, casuists claim that the method is closer to practical and everyday moral reasoning since it attempts to resolve new problematic situations by re-applying the outcome of previous experience to them (Braunack-Mayer, 2001, p.72). According to Mitchell et al., 'For modern day casuists, moral authority and ethical norms develop from a social and medical consensus formed around consideration of specific cases and generalised analogy to other cases' (Mitchell et al., 1996, p.39).

Albert Jonsen and Stephen Toulmin wrote what has come to be widely regarded as the seminal text on contemporary casuistry. In 'The Abuse of Casuistry,' they aimed to demonstrate the relevance of casuistry for the present day. Jonsen and Toulmin defined casuistry as follows:

> *The analysis of moral issues, using procedures of reasoning based on paradigms and analogies, leading to the formulation of expert opinions about the existence and stringency of particular moral obligations, framed in terms of rules or*

> *maxims that are general but not universal or invariable, since they hold good with certainty only in the typical conditions of the agent and circumstances of action* (Jonsen and Toulmin, 1988, p.257).

A central feature of casuistry is its focus on the particular. According to Jonsen and Toulmin, 'moral knowledge is particular, so that sound resolution of moral problems must always be rooted in a concrete understanding of cases and circumstances' (Jonsen and Toulmin, 1988, p.331). According to Jonsen and Toulmin, it is first of all necessary to establish a paradigm, maxim, or type that is similar to the case at hand (Kopelman, 2006, p.607).

To demonstrate that a case is of a certain type, it is necessary to argue from analogy or identify relevant similarities and differences among cases (Kopelman, 2006, p.607). This might, for example, mean that the casuist constructs a case in terms of time, place, person, actions, and affairs. These details would be central to the case (Braunack-Mayer, 2001, p.73). According to Kopelman, 'the facts of the case, together with the maxims (rules, norms, mid-level principles, or definitions), enable us to frame practical solutions for moral problems' (Kopelman, 2006, p.607). Further, according to Kopelman, 'the solutions are contingent, but cumulative, and this accounts for why we can usefully compare parallel cases, re-evaluate maxims, and gain more confidence in maxims as they are tested over time' (Kopelman, 2006, p.607) .

In comparing cases with other cases it is necessary to identify 'paradigm cases.' Jonsen defines a paradigm case as:

> *A case in which the circumstances were clear, the relevant maxim unambiguous and the rebuttals weak, in the minds of almost any observer. The claim that this action is wrong (or right) is widely persuasive. There is little need to present arguments for the rightness (or wrongness) of the case and it is very hard to argue against its rightness or (wrongness)* (Jonsen, 1991, p.301).

Kopelman asserts that casuistry is able to avoid both dogmatism and relativism. It does so because it depends on institutions, traditions, and practices to set standards for informed debates and critical methods for dealing with problems, rather than merely

depending on individuals' liberty of conscience. Since there is significant overlap among methods of self-criticism and the ideas of different cultures, casuistry avoids the problem of being merely local or personal (Kopelman, 2006, p.607).

However, despite its attractiveness to many bioethicists, casuistry has been criticised on a number of counts.

1. The ethical aspects of individual cases may be interpreted in different ways by different persons. It is quite conceivable that, for example, ethics committee members might interpret cases and make moral judgments that reflect their own biases, value systems, or ignorance (Mitchell et al., 1996, p.39).
2. 'The argument for epistemic privilege of certain judgments relies upon an appeal to intuitions. But if our intuitions differ and there are no ways to test our different intuitions about cases, then our claims will not convince others' (Kopelman, 2006, p.607).
3. 'We disagree about who have privileged intuitions; even members of traditions and institutions often disagree among themselves about who have good intuitions' (Kopelman, 2006, p.607).

John Arras also points out the ambiguous role played by theory in casuistry. He notes that the 'new casuists,' on occasion, appear to be quite 'prepared to latch on to any source eof moral guidance that happens to be lying around, while on other occasions they defer to moral theories devised by moral philosophers.' Arras concludes that casuistry is a method that is possibly modest in its theoretical commitments (Arras, 1991).

Although the re-emergence of casuistry might be seen as a reaction against normative ethics, nonetheless it can be seen as a reminder of the importance of clinical context and practical considerations to ethical judgment (Mitchell et al., 1996, p.39).

2.2.3. The Reflective Equilibrium Model

As we have seen, when we attempt to analyse a problem in bioethics we may use a top-down or bottom-up model to justify our moral reasoning. However, 'a working moral

framework is enormously complex; more complex than anyone currently understands', according to Martin Benjamin (Benjamin, 2002, p.113). When we deliberate on problems we are required to analyse them in all their complexity. This entails the weighing up of all the principles, rules, and values involved, as well as the circumstances and consequences of each case. The result hoped for is that this will enable us to determine all, or at least most, of the possible courses of action possible (Gracia, 2003, p.230) .

A third approach to moral reasoning is that of 'reflective equilibrium.' The term 'reflective equilibrium' in moral theory was introduced by John Rawls in his seminal text 'A Theory of Justice.' (Rawls, 1971)

According to Matthew Cotton:

> *The method of reflective equilibrium involves an iterative process of moral reasoning, working back and forth between our affective 'bottom-up' moral judgments and intuitions about specific instances or particular cases, the more abstract normative principles or moral rules that govern them, and the theoretical considerations that we believe have bearing among them* (Cotton, 2006, p.186).

For Cotton, the key factor in the reflective equilibrium method is the revision of any elements in the approach wherever necessary, in order that an acceptable 'coherence' among them is achieved Cotton, 2006, p.186). According to Cotton, 'reflective equilibrium is the end-point of a deliberative process in which we reflect on and revise our beliefs about an area of moral inquiry' (Cotton, 2006, p.186).

According to Martin Benjamin, 'general rules and principles and particular moral judgments are in *equilibrium* if they are mutually supportive. The *equilibrium* is *reflective* if it is based on a continuous dialectical interplay between the two' (Benjamin, 2002, p.115). The strength of the reflective equilibrium method, according to Benjamin, is that it can provide guidance in problematic cases, where we have a lack of conviction about the best course of action. Reflective equilibrium accomplishes this by reinforcing the presumptive validity of both particular judgments and, general rules and principles (Benjamin, 2002, p.115). In practical terms, this involves the 'specification,

reciprocal weighting, testing, revising, and balancing of principles, rules, background theories, and particular judgments' (Cotton, 206, p.186).

There is, however, a criticism of reflective equilibrium which has been voiced by numerous authors. For example, Martin Benjamin states that 'so long as we restrict ourselves to achieving coherence between particular moral judgments and general rules and principles, we run the risk of simply rationalising pre-existing prejudices' (Benjamin, 2002, p.115). Allen Buchanan, along similar lines, states 'critics of the reflective equilibrium method have often complained that the method is not reliable because our intuitions are 'culturally bound'- the implication being that 'our' reflective equilibrium may well be parochial, at best a coherent representation of the views of the particular group we happen to belong to' (Buchanan, 2002, p.145) .

Reflective equilibrium thus stated, does not provide a check for the likelihood of establishing a 'narrowly coherent, but more broadly unacceptable, fit between pre-existing judgments and principles' (Benjamin, 2002, p.116).

For Benjamin, the response to this criticism is to draw a distinction between what he labels *wide* reflective equilibrium and *narrow* reflective equilibrium.

In defining *wide* reflective equilibrium, Benjamin states, that in order to achieve a semi-independent constraint on particular judgments and general rules and principles, we are required to add a third element to the equation- background beliefs and theories (Benjamin, 2002, p.116). These background beliefs and theories include beliefs about human nature; the nature of the world according to science and metaphysics; psychology, sociology, and political and economic behaviour (Benjamin, 2002, p.116).

Therefore, a *wide* reflective equilibrium, according to Benjamin, 'requires a consistent and coherent fit among particular moral judgments, general rules and principles, *and background beliefs and theories*' (Benjamin, 2002, p.116). In order to achieve a *wide* reflective equilibrium, we are required to go back and forth among the three elements, in order to find the most coherent and complete fit we can (Benjamin, 2002, p.116).

A serious challenge the reflective equilibrium method must meet, according to Buchanan, is whether the social practices and intuitions that influence one's moral intuitions are epistemically reliable, insofar as the beliefs that influence those intuitions are concerned (Buchanan, 2002, p.145). The examination of the manner in which different cultures or traditions expedite or hinder the formation, preservation, and transmission of morally relevant beliefs can provide a judicious instrument for increasing the reliability of the reflective equilibrium approach. At the same time, it should be recognised that a 'defective social framework,' may be impossible for anyone working within it to identify its defects (Buchanan, 2002, p.149).

An example of a methodology employing reflective equilibrium is one way in which 'prinicplism has evolved over the latter part of the 20th century. As previously stated, principlism was considered to be the dominant approach to deliberation in bioethics in the mid to late twentieth century. However, over the last twenty years or so, principlism has continued to evolve from a largely 'deductivist' approach that 'relies upon deontological and utilitarian moral theories to a 'dialectical' approach that draws upon both principles and 'cases,' and relies upon the notion of a 'common morality'' (Turner, 2003, p.110). It should be noted in particular, that Beauchamp and Childress make this explicit in later versions of their text, 'Principles of Biomedical Ethics'. In the fifth edition of this text, for example, they state that instead of supporting a top-down or bottom-up model, they favour 'a version of another model, variously referred to as 'reflective equilibrium' and coherence theory' (Beauchamp and Childress, 2001, p.397). They believe that 'moral justification proceeds from an expansive coherent framework of norms that originate at 'all levels'. They further state that such norms 'emerge from institutions, individuals, and, cultures, and no norm is immune to revision' (Beauchamp and Childress, 2001, p. 408).

2.2.4. The Perspectives Approach

In recent years, a number of alternative methodologies have gained prominence in the literature concerning contemporary bioethics. Several notable examples of these methodologies embrace Diego Gracia's conception of deliberation in which he asserts 'deliberation is the cornerstone of any adequate methodology'. Gracia believes this yo be the case because moral decisions are required to take into account emotions, values ,

and beliefs, in addition to principles and ideas (Gracia, 2003,p227). Gutman and Thompson (1997,p40), elaborate on the nature of this process by contending that 'the number or diversity of voices heard and arguments made is not the only or even most important factor in making deliberations work: the character and will of the deliberators themselves are critical. They must be willing to try and broaden their own perspective in light of what they hear in the deliberative process. They must come to the forum open to changing their own minds as well as to changing the minds of their opponents'. Approaches based on this type of methodology have been termed 'perspectives' approaches by Boyd (2005). Whilst proponents of a perspectives-based approach do not dispute the relevance that approaches based on principles have when undertaking deliberation on bioethical issues, they contend that these approaches only partially account for the ethical story (Boyd, 2005, p483). The theoretical background for examples of such perspective approaches is presented below. In particular, the sections on clinical pragmatism, hermeneutics, and the ethics of care provide, at least in part, the theoretical basis for the inclusion of statements in Section 7.3.2 of chapter 7 (Deliberative Process).

2.2.4.1. Clinical Pragmatism

One approach, which has come to prominence as a result of the dissatisfaction with ethical analysis that seems far removed from empirical realities and health care, and the trend for bioethics to accentuate autonomy, abstract reasoning, and an approach which undermines a theoretical generic subject neglectful of race and gender, is, what Mitchell et al. term 'new pragmatism' (Mitchell et al., 1996, p.38). According to Mitchell et al., this pragmatic approach is 'characterised by inductivism, the recognition of the importance of feminist moral philosophy, psychology, sociology, social anthropology, and attention to context, empirical research, and differences of race, ethnicity, and gender'(Mitchell et al., 1996, p.38). In spite of the fact the contemporary pragmatists in bioethics have postulated a myriad of theories that reflect the tradition of pragmatist philosophy, the common thread amongst these contemporary theories is the importance of usefulness, consensus, and the application of scientific methods for testing claims. These contemporary theories also seek to promote democratic dialogue, and avoid universal 'truth' claims (Durante, 2008).

Since ethical pragmatism involves a practical, rather than a distinctly theoretical approach, and is concerned with contributing a 'method of justification' for ethical ideas, rather than a specific theory with fixed content, it should be considered to be a 'meta-ethical' approach to bioethics (Cotton, 2006, p.185). Further, instead of offering a theory for universally deciding 'right from wrong,' pragmatism supplies a method which can be used to assess the validity of ethical claims. Consequently, pragmatism is at variance with 'normative' models of ethics (Cotton, 2006, p.185).

According to Chris Durante, there are two main groups responsible for implementing the pragmatic approach. The first group are those such as Glen McGee and Jonathan Moreno, 'whose concern is more theoretical, dealing with principles and analysing the state of bioethics in general.' The second group includes those such as Matthew Bacchetta and Joseph Fins, 'whose concerns are case-based, addressing ways of bringing about resolution to moral dilemmas in particular instances of moral conflict in clinical settings.' Durante labels the former group 'pragmatic bioethicists,' and the latter group 'clinical pragmatists' (Durante, 2008).

However, according to Durante, the 'pragmatic bioethicists' and the 'clinical pragmatists' have sufficient similarities for us to be able to regard them as being representative of a single movement within contemporary bioethics (Durante, 2008). This point is expanded upon by Micah Hester, who states that bioethical pragmatism, which emphasises intelligent, purposeful inquiry, and free and flexible habits of deliberation, is primarily methodological, rather than metaphysical. This methodological emphasis is clearly upheld in what has come to be known as 'clinical pragmatism' (Hester, 2003, p.552).

Fins et al.(1997), assert, because of the negative connotations often associated with pragmatism, at the outset it is necessary to emphasise that 'clinical pragmatism' is not meant to 'promote whatever works' to serve the agenda of those involved in the inquiry. Rather, according to Fins et al (1997, pp. 129-130), 'Clinical pragmatism integrates clinical and ethical decision-making'. In addition to the ethical analysis of relevant moral considerations, the method concentrates on the interpersonal processes of assessment and consensus formation. For Fins et al., 'clinical pragmatism adopts a democratic model of moral problem solving' (Fins et al., 1997, p.131). Rather than

solving bioethical problems by 'expert' judgment in the form of ethical expertise of bioethicists or the clinical expertise of healthcare professionals, the solutions to such problems lie with the context of reciprocity, 'in which all concerned parties are entitled to be heard and work together to arrive at a mutually satisfactory solution' (Fins et al., 1997, p.131).

Clinical pragmatism may be viewed an inductive approach to moral deliberation. The process requires diligent deliberation on the clinical and narrative details of the issue at hand. For example, such deliberation might include comparing the situation at hand with other similar cases. This type of comparison integrates an element of casuistry into the process. In addition, by reaching an agreement on possible options for an issue, through a partnership of all parties involved, the process can be considered democratic, and experimental. Further, by recognition of the fact that the process may or may not guide the resolution of the problem involved, the attempt to make decisions in the full recognition of the need to act in the face of uncertainty, highlights that clinical pragmatism also acknowledges the fallibility of the process (Steinkamp and Gordijn, 2003; Fins, Miller, and Bacchetta, 1998; Hester, 2003).

Thus, clinical pragmatism is based on the premise 'that a thorough process of inquiry and deliberation is likely to yield a satisfactory decision' (Fins et al., 1998, p40). On such occasions, a methodical approach produces the expected result, but in a manner that encourages the parties involved that there was no undue haste to reach any moral judgment. For Fins et al., arriving at a consensus among those taking part in the deliberation 'is the best means of avoiding idiosyncrasy, absolutism, and unilateral judgment, which threaten shared decision-making' (Fins et al., 1998, p.40).

Pragmatists are satisfied to aim for sensible, practical solutions to important moral issues without any certainty of being 'right.' For Fins et al., 'the guiding light of pragmatic moral inquiry is not *a priori* reason, with the power to intuit the 'right,' but experimental intelligence in search of more judgments on matters of substance and procedure that can be endorsed by fellow problem solvers through consensus' (Fins et al., 1998, p.40).

One of the ways in which pragmatism differs from various traditional approaches to moral problem solving is in its rejection of the notion that moral principles are 'absolute' and 'fixed.' Rather, moral principles should be considered as 'tools' for guiding conduct (Jansen, 1998, p.24).

However, despite the fact that pragmatists do not view principles as absolute and fixed, moral rules and principles do in fact inform pragmatism. Fins et al. assert that 'pragmatists simply resist ascribing fixity and timeless validity to moral principles because they reject the spectator theory of knowledge underwriting appeal to such principles. And they also perceive such fixed, absolute principles as unsuitable to a dynamic world' (Fins et al., 1998, p.40).

Hester states that we are not able to move from general principles if we are not first acquainted with the specific features of the problem at hand, and any appropriate ethical principle must arise out of the context, if it is to have any meaning to the given situation (Hester, 2003, p.554). As circumstances of social existence change, some of these principles may require to be modified, or even discarded, depending on their functional fitness in the process of moral problem solving (Fins et al., 1998, p.40). As Hester succinctly states, 'Principles must be developed from the features and specifics of the problematic situation that we are attempting to make satisfactory' (Hester, 2003, p554).

Steinkamp and Gordijn assert that, 'in clinical pragmatism it is taken for granted that there is no agreed upon order of moral values and norms available' (Steinkamp and Gordijn, 2003, p.236). Consequently, it is accepted that in order for there to be the possibility for a well founded solution in moral conflict, there must be detailed and substantial deliberation. According to Steinkamp and Gordijn, 'with this presupposition clinical pragmatism is based upon similar assumptions as the 'principles of biomedical ethics' by Beauchamp and Childress' (Steinkamp and Gordijn, 2003, p.236).

However, an important difference between the approaches, 'which makes clinical pragmatism appear more radical in taking seriously the lack of an *a priori* orientation,' is highlighted by Steinkamp and Gordijn. This difference being that Beauchamp and Childress's principlism gives the impression that the principles of 'autonomy,' 'beneficence,' 'nonmaleficence,' and 'justice,' have a defined content. It is the

theoretical importance of specification and balancing in the application of the principles that is left open (Steinkamp and Gordijn, 2003, p.236). As noted previously, in practice this may lead to principles being used in a deductive and mechanical way in the attempt to solve moral problems. At worst this can lead to premature moral judgment (Fins et al., 119, p.141).

In the clinical pragmatism's approach, in contrast, principles themselves are seen to be 'even more tentative orientation marks of moral content' (Steinkamp and Gordijn, 2003, p.236). Steinkamp and Gordijn, highlight an important point, which they state is inspired by the philosophy of John Dewey:

> *Principles are to be understood in analogy to scientific hypotheses. Principles do have moral content and can give orientation, but they have to be evaluated during the decision-making process itself* (Steinkamp and Gordijn, 2003, p.36).

For clinical pragmatists, the importance of not being committed to predetermined convictions regarding principles or other morally pertinent aspects of an issue, is that issues hitherto appearing to pose an intractable dilemma can be recreated 'by a process of creative problem solving that arrives at a plan of action satisfactory to all of the stakeholders' (Fins et al., 1997, p.141).

In summary, clinical pragmatism has a number of desirable characteristics which make it worthy of consideration as an approach to moral problem solving in bioethics

1. An emphasis on dialogue.
2. A commitment to consensus.
3. A focus on particular individuals rather than persons in general.
4. A strong interest in the process as well as the product of moral decision-making (Tong, 1997, p.147).

According to Rosemary Tong, 'clinical pragmatism promises more than most other methods of moral problem solving, to help increasingly diverse individuals make 'good' moral decisions under conditions of enormous uncertainty' (Tong, 1997, p.147).

Despite the appeal for many of adopting pragmatic bioethics as an approach for dealing with morally problematic situations, the method has attracted a considerable amount of criticism on a number of points. While some of these criticisms are of a similar nature to criticisms of other bioethical approaches, others are specific to pragmatism.

According to Elizabeth Cooke (2003), and Christopher Tollefsen (2000), pragmatic bioethics is to be criticised for not being firm enough nor conclusive enough about fundamental questions of normativity, which these authors claim are crucial to a field like bioethics. Cooke maintains that this is due to 'the excessively fuzzy nature of pragmatism's goal.' According to Cooke, normative questions require answers and sometimes consensus is not sufficient (Cooke, 2003, p.635).

Lynn Jansen elaborates on this point by highlighting that, since not every consensus warrants respect, consensus can not be taken to be a criterion of success in moral problem solving. Jansen sees this to be the case because, on occasions, consensus may be reached owing to the fact that critical aspects of the issue have been neglected or because the interested parties have failed to give all the pertinent factors the weight they deserve (Jansen, 1998, pp.26-27). According to Jansen, clinical pragmatists have not overlooked this crucial argument. They have pronounced that it is not a consensus per se that is the measure of success in moral problem solving, but rather a consensus that 'can withstand moral scrutiny.' However, for Jansen, 'this just raises the question of how we are to distinguish a morally suspect consensus from one that can withstand moral scrutiny' (Jansen, 1998, p.27).

Jansen states that, at this point, clinical pragmatists might possibly want to argue that we can make this distinction by appealing to procedural conditions alone. For example, was everyone given an equal opportunity to participate in deliberation, were participants sufficiently informed in the issues involved, and did the participants involved in the deliberation fully comprehend the nature of the problem being discussed. However, according to Jansen (1998, pp.27-28), even although it may be the case that these procedural criteria provide some form of justification for discriminating between a doubtful moral consensus and one that warrants respect, it is still not sufficient justification. For it is still possible in some circumstances that even if these criteria are

met, that there can still be errors made in resolving a moral problem that arises (Jansen, 1998, pp.27-28).

Another reason why consensus might not be considered a criterion of success in moral problem solving, according to Chris Durante, is that it is possible that a group of decision-makers may reach agreement by virtue of the fact that some of its members are passive. It could also be the case that, for example, a strong-willed chair or member unduly influences the group, or that group members become so relaxed and understanding with each other that they start to think alike (Jansen, 1998, pp.27-28).

These, along with other issues regarding consensus in bioethics, will be discussed in more fully in chapter 7 (Deliberative Process).

A further concern posed for clinical pragmatism, is that it expresses a contentious version of the role that moral principles should play in moral problem solving (Jansen, 1998, p.23). As discussed earlier, clinical pragmatists assert that moral principles are to be understood as 'hypothetical guides.' Lynn Jansen articulates a problem with this view when she states:

> *If we think that moral principles are only hypothetical guides in particular cases, how are we to decide when they should be followed and when they should not? Thus, it is unclear how moral principles as the clinical pragmatists conceive them, are to provide any guidance at all* (Jansen, 1998, p.34).

According to Cotton, although pragmatism offers the essence of how a deliberative approach to the analysis of bioethical issues might evolve, it is unable to offer a specific procedure for expounding a viable balance between 'top-down' and 'bottom-up' approaches in bioethics. Cotton suggests that the concept of 'reflective equilibrium' is of more value in bioethics (Cotton, 2006, pp.185-186).

Other criticisms of pragmatism, those which concentrate on the philosophical aspects of pragmatism (in particular, classical American pragmatism) are beyond the scope of this paper. These criticisms include debate on the realist versus anti-realist conception of truth.

Issues relating to Clinical Pragmatism are considered in the study. In particular, chapter 7, which is concerned with the Deliberative Processes of participating CECs, utilises the theoretical underpinnings described in this section, in the analysis of factors relating to Procedural Characteristics of a Perspectives Approach to Deliberation (7.3.2)

2.2.4.2. Hermeneutics

'Hermeneutics is a philosophical method of understanding and interpretation' (Steinkamp and Gordijn, 2003, p.241). It was originally the art of interpreting ancient texts, but has widened, under the influence of German philosophers Hans-Georg Gadamer, Martin Heidegger, and Wilhelm Dilthey, to become interested in the interpretation of behaviour, speech, and institutions. According to Steinkamp and Gordijn, 'hermeneutics can be understood as a paradigm to comprehend phenomena of human existence in general' (Steinkamp and Gordijn, 2003, p.241). In the second half of the 20th century, approaches of hermeneutic reflection on morality were conceived both in general ethics and in bioethics.

A hermeneutics approach contends that a moral problem is not something simply 'out there,' or given, like a natural object. Rather, it should be seen as a 'construction put on events seen from a perspective shaped by history and tradition' (Boyd, 2005, p.485). It has become widely recognised that cultures vary in what they recognise to be moral problems, and also about the proper manner to deal with those that they do recognise. According to Boyd (2005, p.483), all of us , conditioned by our history, tradition, and experience of life, have our own moral perspectives, which differ, in more or less significant ways, from the perspectives of others. From this, Boyd asserts that 'all of us are prejudiced in one way or another' (Boyd, 2005, p.483). Boyd goes on to state that 'hermeneutics,' which is to be considered a perspectives approach, questions whether prejudice is to be considered a 'bad thing' (Boyd, 2005, p.483). H-G Gadamer, one of the 20th century's most influential figures in hermeneutics, argued for a constructive stance on prejudice. According to Gadamer, without a positive view of prejudice, we would be unable to ever make sense of anything at all (Gadamer, 2004).

According to Boyd, when we start to take into consideration what someone is saying, our prejudices are already moving forward, second-guessing the meaning of what we are being told. For Boyd, if we do not make that preliminary forecast of the meaning of what we are being told, we would be unable to make a start, or become engaged with that person. The crucial point is that once we become engaged we are 'really listening.' If that is the case, then according to Boyd, 'we will soon find that the meaning we are anticipating is either confirmed, or corrected, by what we hear the other person actually saying. As further anticipations of meaning in turn are corrected or confirmed, understanding of what is being said to us grows' (Boyd, 2005, p.483). However, what we have to be careful about, is not allowing our prejudices to run too far ahead, thereby engulfing what the other person is saying. According to Gadamer, this could possibly occur if we believe that we are not prejudiced, while remaining 'under the tyranny of hidden prejudices' (Gadamer, 2004, p.272).

Drew Leder asserts that hermeneutics gets under way with a 'spirit of dialogic openness.' 'One approaches another person with the sense that they have something to teach, a perspective capable of transcending, overturning, or revising one's own in a productive way' (Leder, 1994, p.255). While this process does not guarantee arrival at the 'absolute truth,' it might however, advance richer interpretations of the issue being deliberated upon. By careful, self-reflection about one's prejudices, and openness to others, it is possible to attain a comprehension which is likely to be more responsive to more features of the situation at hand (Leder, 1994, p.255). Thus, when persons with differing perspectives on a subject have a conversation about it, it is possible for them to finish with a new, shared perspective on the subject, one which is more acceptable to each of them than any of the original perspectives. Gadamer terms this shared perspective a 'fusion of horizons' (Gadamer, 2004).

In practical terms, central to the hermeneutic process is the requirement of listening to the different 'narratives' told by others involved in what has been perceived as the issue at hand. Boyd asserts, that 'for the process to be productive, those involved in the situation need to listen to one another, so that they can work out among themselves what is going on ethically and, if possible, reach some new and more productive shared understanding of the situation' (Boyd, 2005, p.484).

According to Steinkamp and Gordijn, ‘a strong point of hermeneutic deliberation is that it explicitly takes into account moral uneasiness, moral remorse, and moral residue’ (Steinkamp and Gordijn, 2003, pp.242-43). Further, rather than being decision-oriented, hermeneutic deliberation embodies an interpretative and more reflective approach to issues in bioethics (Steinkamp and Gordijn, 2003, pp.242-43). In doing so, rather than specifically looking for solutions to a single case, understanding can be attained, and interpretation can come out on top. Whilst hermeneutic deliberation is unable to achieve the kind of moral certainty to which some principles based approaches aspire, it is able to create a realm of reflection within the practice of bioethics (Steinkamp and Gordijn, 2003; Boyd, 2005).

However, as Steinkamp and Gordijn point out, ‘confining oneself in ethical deliberation to understanding and interpretation may prove incomplete. After all, it may amount to blinding out the need to get answers to the questions as to what should be done’ (Steinkamp and Gordijn, 2003, p.243). They conclude that ‘the hermeneutic method should probably be complemented by normative considerations related to the case itself’ (Steinkamp and Gordijn, 2003, p.243).

In summary, the hermeneutic approach highlights the fact that interpretative methods of deliberation are not immediately intended to discover answers to moral questions as to what should be done. Rather, for Steinkamp and Gordijn (2003, p.241), ‘they are applied to explore the meaning and content of a moral intuition when there is no or limited clarity about the moral problem.’ For Steinkamp and Gordijn, in such cases, ‘a method of interpretation and understanding may fit better than the stepwise development of a moral judgment’ (Steinkamp and Gordijn, 2003, p.241).

Issues relating to Hermeneutics are considered in the study. In particular, chapter 7, which is concerned with the Deliberative Processes of participating CECs, utilises the theoretical underpinnings described in this section, in the analysis of factors relating to Procedural Characteristics of a Perspectives Approach to Deliberation (7.3.2)

2.2.4.3. The Ethics of Care

'Contemporary feminist philosophers have challenged the rationality, validity, practicality, and inherent sexism of Western moral philosophy' (Mitchell et al., 1996, p.36). According to Noel Preston, at the core of the feminist approach to normative ethics is an emphasis on care, compassion, and relationships. This approach has come to be known as the 'ethics of care' (Preston, 2007, p.48).

Mitchell et al., identify a number of features that are associated with an 'ethics of care,' namely

1. The rejection of overemphasis on individual rights, autonomy, and rationality in bioethics.
2. The denial of the requirement for value-neutral philosophies or abstract ethical principles.
3. The rejection of the adversarial nature of moral conflict as a means for resolving ethical issues in clinical practice.
4. The stressing of the significance of values such as empathy, interdependence and caring, and also the importance of the shared responsibility all members of society have to each other.
5. The emphasis on the importance of context and the relevance of politics and power to understanding ethics and healthcare (Mitchell et al., 1996, pp.36-37).

The 'ethics of care' and 'situation ethics' have a lot in common, according to Preston. Both approaches promote the injunction to care to the level of a duty (Preston, 2007, p.48).

In general, those who support the 'ethics of care' repudiate the emphasis on universal moral rules, individual rights, law, objectivity, and autonomy. Rather, proponents of the 'ethics of care' emphasise the significance of personal responsibility, love, trust, and caring (Mitchell et al., 1996, p.37). However, this does not inevitably entail the total rejection of consequentialist or deontological theories. What is required though is a re-evaluation of these approaches as to whether they exemplify the male perspective to the exclusion of the care perspective Preston, 2007, p.48).

The significance, for many, of the 'ethics of care' has been in focusing awareness on how problems arise in specific social and personal contexts. In doing so, by highlighting the importance of caring, tolerance, and humanity, the 'ethics of care' has been influential in returning beneficence to a more central place in bioethics (Kopelman, 2006; Mitchell et al., 1996).

However, the 'ethics of care' has attracted various criticisms. For some, the 'ethics of care' does not fulfil the requirements of a normative theory, since it appears to critically underrate the significance of justice, rights, and the universalisability of moral rules. Further, it cannot be demonstrated that traditional theories inevitably preclude the values and considerations important to the 'ethics of care' (Preston, 2007; Mitchell et al., 1996).

One further difficulty with this approach, according to Kopelman, is 'that our experiences and feelings may be unreliable guides for action because of bias, prejudice, ambivalence, or ignorance' (Kopelman, 2006, p.610).

2.2.4.4. Virtue Ethics

According to Damian Grace and Stephen Cohen, there has been a revival of 'virtue ethics' since the 1970's (Grace and Cohen, 1998, p.16).

This has come about, at least in part, as a challenge by many ethicists to the primacy of deontological and utilitarian philosophy and the emphasis on rights, rules, and ethical principles. Virtue ethicists reject the notion of dealing with moral problems by applying the 'correct theory,' or rigid schema, in a mechanical fashion (Grace and Cohen, 1998, p16; Mitchell et al., 1996, p.32).

One of the leading contemporary exponents of virtue theory has been Alasdair MacIntyre. In his seminal text 'After Virtue,' MacIntyre (1984) analyses the ethical chaos in post-modern secular societies. He concludes that a duty-based ethic will not work and that a consequence-based ethic is fraught with too many dangers. MacIntyre sees a virtue-based ethics as a viable alternative (Preston, 2007, p.51) .

The concept of virtue ethics derives from ancient philosophical traditions e.g. Aristotle and Plato. 'Virtue ethics stresses the kind of moral abilities that put us in a position to act morally, whether after weighty deliberation or quick reaction'(Cohen, 2004, p.48) .

According to Mitchell et al., Aristotle did not see virtue to be an innate capacity. Rather, he regarded it to be a disposition acquired by proper training, experience, and the acquisition of practical wisdom (Mitchell et al., 1996, p.33).

For Alasdair MacIntyre, virtue is something that is shaped by a social vision of the good as much as by internal personal determinants (MacIntyre, 1984). Rather than accepting that someone who follows certain moral rules and ethical obligations is to be automatically considered virtuous, virtue ethics holds the conviction that the rightness or wrongness, of an action is rooted in the intrinsic 'motive' for the action. Therefore, virtue ethics inquires into what are considered to be the attributes of someone we consider 'virtuous' (Mitchell et al., 1996, p.32).

In this sense, 'virtue refers to competence in the pursuit of moral excellence and character traits that are morally valuable, such as honesty, gentleness, integrity, and discernment. Thus, the model of the moral person is one who is disposed by character to have the right motives and desires' (Mitchell et al., 1996, p.32).

According to Preston, virtue theory has two particularly worthwhile features. The first being that it provides a 'check on the excessively cognitive style of other approaches, allowing a place for feelings, roles and relationships in line with an ethic of care.' The second is that it provides us with a 'tool to assist identifying core community values in pluralistic societies' (Preston, 2007, p.31). However, while agreeing that virtue theory does indeed have an important place in practical ethics, Mitchell et al., are not convinced that virtues are a sufficient basis for determining the moral basis of behaviour. They also doubt that there is an adequate rationale for virtue theory to take precedence over theories that place emphasis on principles, rights, or duties. In addition, it may be the case that virtue theory is too simplistic and imprecise to sufficiently account for, or justify, 'the rightness' or 'wrongness' of actions (Mitchell et al., 1996, p.33).

At the same time, despite these apparent deficiencies in virtue theory, virtue ethics highlights the fact that when deliberating on problematic bioethical issues, we should not ignore the moral characteristics of the individuals involved, or the process of practical reasoning that constitutes the grounds for their decisions (Mitchell et al., 1996, p.34).

2.3. Pluralism in Bioethics

Having considered approaches to moral reasoning and specific methodologies that have been employed in contemporary bioethics, it is also important to consider the reasons why issues in bioethics have become matters of such importance. Much of this importance derives from the fact that, in Western societies, secularism and pluralism has led to a multitude of positions being adopted on bioethical issues.

One particular focus of the study involves the outcome of a committee's deliberative process and in particular, the moral authority of any outcomes of a committee's deliberation. Sections 7.2.2 Committee Membership Represents Diverse Bioethical Perspectives and 7.2.3 Committee Meetings as a Useful Forum for Discussing Bioethical Issues, in chapter 7(Deliberative Process), explicitly link to this section. Similarly, chapter 6 (Evaluation), utilizes concepts from this section to provide some theoretical background for CECs having a formal evaluation process in place.

Agreement among members of clinical ethics committees can take a variety of shapes. For example, at one end of the range is complete agreement on both the substance of a recommendation and its supporting arguments. At the opposite end of the range is vote-taking, and the committee's sanctioning the will of the majority. Between these two extremes, according to Benjamin, are overlapping consensus and compromise (Benjamin, 1995, p.242). It will be identified in the analysis of the outcomes of the deliberative processes of participating CECs (chapter 7), that consensus is widely considered the theoretically most important outcome of a committee's deliberative process.

The word 'consensus' equates to 'an agreement in opinion: the collective unanimous opinion of a number of persons' (Engelhardt, 2002, p.10). Originating from the Latin *consensus*, meaning to feel together, to agree, or to unite in a common purpose,

consensus conveys the impression of unanimous consent (Engelhardt, 2002, pp.10-11). However, as a number of authors point out, consensus need not mean that every person in the field of inquiry agrees on every point. Rather than reaching unanimity on a single conclusion to a debate, consensus can be viewed as arriving at an outcome everyone can live with after full discussion by all parties involved (Hester, 2002, p.22; Spike, 2006, pp.247-8).

In bioethics, the problem is that there is no unanimous consent with regard to most bioethical issues. This can be seen to come about, at least in part, from the fact that there exists a pluralism of values within society. This value pluralism holds that there can be different rankings of human goods, understandings of right-making principles, and in their ordering. Further, there exist different perceptions of moral evidence and of the deep metaphysical significance and meaning of existence (Engelhardt, 2002, pp.10-11). According to Susan Kelly, 'the rise of interest in consensus tends to be linked to the value pluralism which is often attributed to the emergence of bioethics itself' (Kelly, 2003, p.348). Kelly also believes that, more than at any time in the past, society is less unified by a set of core values (Kelly, 2003, p.348).

Important aspects relating to the deliberative process of a CEC are those of cultural diversity and value pluralism. The following section elaborates on the theoretical relevance of cultural diversity for a CEC's deliberative process, before drawing a distinction between cultural diversity and value pluralism. The discussion concludes by considering the notion of 'pluralist 'friendly' theories in bioethics.'

2.3.1. Cultural Diversity

A great number of the issues that are pre-eminent in contemporary bioethics express the perspective of the Western philosophical and scientific tradition in which they are grounded. During the 20th century it became progressively acknowledged that this philosophical and epistemological tradition is neither universal nor of overriding importance, and that moral values are historically and culturally contingent, and therefore irremediably plural (Trotter, 2002b; Mitchell et al., 1996).

Whilst acknowledging the complexities of the concept of 'culture', Mitchell et al., consider culture to be 'a major determinant of customs and social norms,' and that it

'plays a central role in shaping people's values, beliefs, knowledge, behaviour, and social interaction' (Mitchell et al., 1996, p.40). For Mitchell et al., this suggests that in multicultural societies like Australia and the United Kingdom, it is possible for 'culturally-related moral values which influence decisions and behaviours in certain situations' to exist (Mitchell et al., 1996, p.40).

According to Leigh Turner, until around the mid-1990's, cultural norms, rooted within the structures of 'local knowledge,' were not of any great significance for most moral philosophers. Rather, the mission of moral philosophy was customarily regarded to be involved with "cleaning or removing the 'distorting lens' of culture to more clearly see more clearly the moral point of view" (Turner, 2003, p.100).

Turner states that this situation started to change in the late 1990's, when social science research started to secure a more important position within the discipline of bioethics (Turner, 2003). The recognition of the moral diversity that exists in multicultural societies has led to many different positions on certain biomedical developments being embraced. This has, in turn, led to conflict of opinion as to the relative benefits and harms of such developments. Bioethicists find themselves on the position of having to establish meaningful responses to cultural pluralism, religious diversity, and norm conflicts, while at the same time striving to respect the diverse views of the population they are trying to protect and represent (Durante, 2008).

An outline of this position is given by Daniel Callahan:

> *How are we as a community, dedicated to pluralism, to find room for the different values and moral perspectives of different people and different groups? How are we to respect particularism? How as a community made up of diverse individuals and groups to find a way to transcend differences in order to reach a consensus on some matters of common human welfare? How, that is, are we to respect universalism? There can be no culturally and psychologically perceptive ethics without taking into account the diversity of moral lives, but there can be no ethics at all without universals* (Callahan, 2000, pp.37-38).

Arising from this widespread view of the relationship between ethics and universals and secularism's dominance in bioethical theory, is the widely accepted approach for

bioethicists to develop normative claims built on the supposition that there is a shared 'common morality' and 'universal' moral intuitions. In other words, practical moral reasoning in bioethics 'proceeds from a shared body of widely accepted, self-evident, uncontroversial norms that are affirmed by all 'reasonable' people' (Turner, 2003, p.109).

Examples of approaches that incorporate this viewpoint are to be seen in the version of principlism developed by Beauchamp and Childress (2001), and in the approach to casuistry as postulated by Jonsen and Toulmin (1988). The principlist approach in bioethics developed by Beauchamp and Childress postulated that the four moral principles, 'autonomy,' 'beneficence,' 'nonmaleficence,' and 'justice,' could provide a comprehensive moral foundation for addressing practical issues in bioethics. The assumption was that these four principles were able to provide incontestable 'common ground' as prima facie principles for normative analysis (Turner, 2003, p.100).

However, according to Turner, this view did not acknowledge that different cultures and traditions of moral inquiry might uphold unique substantive principles, or advance resources for giving a significantly different interpretation of the four 'core' principles (Turner, 2003, p.100).

For Chris Durante, addressing moral diversity and pluralism in bioethics creates the danger that 'any principles which attempt to respect the claims of all groups will either not succeed in achieving their intended goal or they will be too vague to accomplish any substantive results, possessing no practical usefulness or applicable proposals' (Durante, 2008).

2.3.2. Cultural Diversity and Value Pluralism

It is worthwhile to note that a distinction that can be made between pluralism, in the sense of cultural diversity, and value pluralism.

According to John Kekes:

> *Pluralism is not merely the thesis that there is a diversity of moral traditions. Pluralists also hold that there is diversity within a moral tradition and that this is good. For it is a condition of a moral tradition successfully fostering human welfare that it should embody a multiplicity of equally important and yet irreducibly different goods which can be ordered and balanced in many different ways* (Kekes, 1992, p.39).

Pluralists maintain that there are varying kinds of claims made by morality on moral agents. The force of such claims, for example, claims based on duties, rights, virtues, and the conception of the good life, is recognised because moral agents consider them to be 'goods.' According to Kekes, 'pluralism is the view that there are qualitatively different types of goods; they are sources of different types of moral claims, and they are not reducible to each other, because they are incommensurable' (Kekes, 1992, p.37). Kekes stresses that this does not mean that 'pluralists are committed to denying that morality makes some claims equally binding on all moral agents' (Kekes, 1992, p.38). In this sense, pluralists differ from moral relativists and various forms of subjectivism.

This notion of pluralism derives its importance from the fact that pluralism encompasses diversity, not only between cultures and traditions, but also diversity within a given culture or tradition. From this, it can be seen that pluralism may be seen present as a problem for ethics in general, and bioethics in particular. There have been various theoretical and methodological efforts to find some kind of solution to this problem (Durante, 2008). Examples of such an approach in bioethics can be seen in the employment of Clinical Pragmatism and Contract Theory methods of 'responding to pluralism and overcoming the relativistic tendencies which may emerge in the pluralist-friendly theory of biomedical morality' (Durante, 2008).

According to Durante, the contract theorists

> *Have a critical attitude toward moral absolutism, ethical realism, and the inherent universalistic agenda of the moral theories espoused by various sorts of principlism. By seriously taking moral pluralism into consideration, contract theory relies on neither moral absolutism nor a set of universal principles* (Durante, 2008).

Durante describes the contract theory approach to be a method for

1. ‘Discerning those terms of cooperation that rational, self-interested agents would agree are morally advantageous to all parties participating in the cooperative endeavour.
2. Implementing such agreed upon terms in an objective structure for moral systems’ (Durante, 2008).

Therefore, the contractarians, instead of putting forward a definite set of universal principles, have offered a method whereby groups of individuals are able to formulate a set of rules which is based on those shared moral values they recognise as taking precedence in the midst of a profusion of wide-ranging values. One of the motivations for this approach is to be found in what John Rawls referred to as ‘reasonable pluralism.’ This is to be understood as ‘the idea that those individuals possessing conflicting, yet reasonable, moral doctrines are able to come over to the bargaining table and negotiate rationally with one another’ (Durante, 2008).

However, the contractarians approach, while it undertakes to establish a middle ground between particularism and pluralism, does present some problems in terms of its methodology, according to Chris Durante. The two most pressing problems of the approach are firstly, in similar fashion to the principlists, contractarians depend on ethnocentric values and a Westernised perception of rationality to effect the establishment of cross-cultural norms. Secondly, the whole contractarian approach not only assumes, but is based on a perception of human nature which may be found to be unacceptable by the prospective parties, yet which is essential for the functionality of the contractarian methodology (Durante, 2008).

In similar fashion, clinical pragmatism recognises the significance of moral diversity. In their approach, the pragmatists pay particular attention to the role of consensus and processes for arriving at it. Rather than focusing on an approach’s ability to produce or discover truthfulness, the pragmatist focus is on the usefulness of the theories. Pragmatism, as methodology in bioethics, has already been discussed in some detail.

2.4. Summary of Methodology in Bioethics

In this section the theoretical underpinnings of methodological approaches in contemporary bioethics were examined. After a general introduction to methodology in bioethics, the chapter focused on four approaches to moral reasoning in bioethics, before discussing the significance of cultural diversity and value pluralism.

1. The first section considered approaches to moral reasoning. After highlighting that deliberation on complex moral issues requires us to be able to justify our conclusions, there followed an examination of four approaches to moral reasoning. The 'top-down,' bottom-up', 'reflective equilibrium', and 'perspectives' models were discussed, along with discussion on examples of specific methodologies associated with each approach.

2. The second section discussed cultural diversity and value pluralism. This derives significance from recognition of the fact the moral diversity that exists in a multicultural society has led to many different positions in bioethical issues. Kekesian value pluralism, which postulates that pluralism encompasses diversity, not only between cultures, but also diversity within a given culture, was also discussed.

Chapter 3

Methodology

3.1. Introduction

This was an exploratory study designed to address the study questions stated in chapter 1.

The research design was a descriptive correlational retrospective survey. The study was descriptive since it sought to obtain information concerning the current status of a phenomenon of interest which in this case, was clinical ethics committees and their activities. The study was correlational because it sought to describe the relationship among variables without inferring a cause-and-effect relationship. It was recognised that the results of the study might not guide, but rather, may serve to enlighten and inform about the activities and processes of participating committees. It was a retrospective study since it asked participants to consider past experience in answering the questions related to the activities of their clinical ethics committee (Polit and Hungler, 1991).

3.2. Study Overview

The study utilised a cross-sectional design, using self-administered questionnaires.

Copies of two self-administered questionnaires were distributed to the chairperson (or other nominated contact person) of clinical ethics committees identified in Australia, the United Kingdom and New Zealand.

The chair of each committee was invited to complete and return questionnaires 1 and 2. The chair of each committee was also asked to distribute copies of questionnaire 1 to all other members of their respective committees.

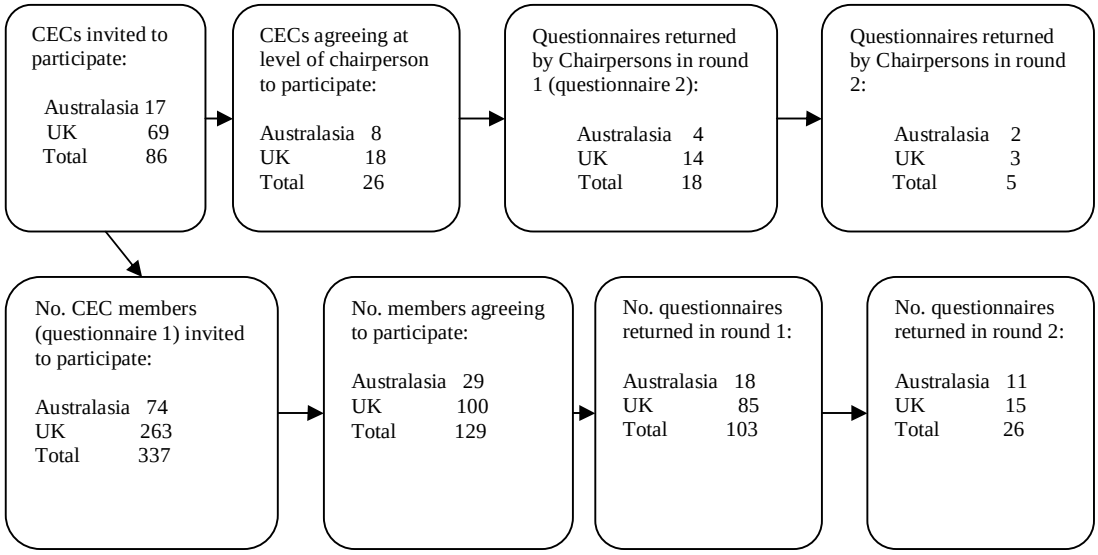
The design and content of the survey questionnaires are described in detail at section 3.4 of this chapter.

The following sections describe: the study participants; the research procedure; the study instruments; protection of human subjects: and, limitations of the study methodology.

3.2.1. Participants

The participants for the study were members of Clinical Ethics Committees (CECs) identified in Australia, New Zealand, and the United Kingdom (UK). A flowchart showing an overview of the study design, with regard to participants, is shown in figure 3.1.

Figure 3.1. Study Participants



Details of participating committees and individual participants are discussed below.

3.2.1.1. Committees

The study population was derived from information provided by the U.K. Clinical Ethics Network (UKCEN), New South Wales Health (NSW Health, 2006), and information determined by the researcher from contacting individual hospitals in Australia and New Zealand. In each instance, information was verified by letters, telephone calls, and emails by the researcher to each of the hospitals.

The total number of CECs is unknown, although there have been estimates of the number of committees that currently exist, for example, in the UK by UKCEN, and in New South Wales by NSW Health. Under the terms of a policy directive on 'Clinical Ethics Processes in NSW Health,' public health organisations, although not required to establish a CEC, must notify the Department of Health of the establishment of a 'clinical ethics capacity or service (including terms of reference and membership)' (NSW Health, 2006).

Therefore, the size of the sample for the study was based on the factors of available knowledge of the population, and recommendations from the literature.

The main obstacle in identifying participants from Australasia for the study was that there is no national mailing list for CECs in Australia or New Zealand. This meant that the task of identifying the committees in Australia (apart from NSW) and New Zealand was lengthy and tedious. When hospital central switchboards or administrative officers were contacted, many were not aware of the existence of a CEC or did not know the name of the committee chairperson. On many occasions the enquiry resulted in referral to the hospital Human Research Ethics Committee (HREC). On occasions, subsequent contact with a different person within a given hospital, for example, the Chief Medical Officer rather than switchboard resulted in a different response regarding the existence of a CEC.

One other factor hindering this process was the change in the number of CECs over a relatively short period of time. For example, in New South Wales, the number of operational CECs reduced from 8 in September 2005 to 3 in March 2006. This was due to the restructuring of Health Divisions in NSW during this period.

Potential participants from CECs in the UK were somewhat easier to identify. For the purposes of the study, participants were identified from the membership of the United Kingdom Clinical Ethics Network (UKCEN). UKCEN was established in 2001 to provide support for the growing number of clinical ethics committees and groups that were developing in National Health Service Trusts and some private hospital in the U.K. Administrative support for UKCEN is provided by the Ethox Centre, University of Oxford. In 2006, UKCEN identified 69 CECs known to operational in Acute, and

Primary Care National Health Service (NHS) Trusts, and provided contact details for each committee.

As shown in figure 3.1, 86 CECs were invited to participate in the study: 16 in Australia; 1 in New Zealand; and, 69 in the U.K.

Of the CECs identified in Australia, one committee responded saying that it had only recently been formed, and therefore did not feel that it should be included. One other Australian 'CEC' responded, saying that in fact Clinical ethics matters were dealt with by an ethicist, rather than a CEC. Two of the CECs contacted individually in Victoria, had amalgamated.

From figure 3.1, it can be seen that initially, 26 CECs agreed, at the level of the chairperson, to participate in the study. However, two Australasian and one U.K. committee did not participate. In the case of the Australasian committees, this was due to the restructuring of Health Divisions in NSW during this period. The U.K. committee was lost to follow-up.

A total of 23 CECs participated in the study. Six of these committees were from Australasia and the remaining 17 committees were from the U.K. In terms of response rates, overall 27% of invited CECs participated in the study, with 35% of Australasian CECs and 25% of U.K. CECs participating.

The participating Australasian committees included two from Children's hospitals (located in Queensland and Victoria), and, four committees from major hospitals in New South Wales, Victoria (2) and Auckland (New Zealand). The U.K. committees included two from Children's hospitals. The other 15 committees were from hospitals managed by National Health Service (NHS) Trusts. UKCEN publishes a regional list of CECs in the U.K. In total, the U.K. is divided into 13 regions. Table 3.1, shows a list of these regions and the location of participating CECs.

Table 3.1. U.K. Participating CECs by Region

U.K. Regions	No. CECs participating
Scotland	0
North East	1
North West	0
Yorkshire and Humberside	1
Northern Ireland	0
Wales	1
West Midlands	2
East Midlands	3
Eastern England	2
London	3
South East	2
Southern England	1
South West	1

It can be seen from table 3.1, that CECs from 10 of the 13 regions participated in the study. The exceptions were Scotland, Northern Ireland and the North West. London and the East Midlands each provided 3 of the participating CECs.

One factor, in the consideration of issues concerning potential selection bias, is to examine some characteristics of committees which declined to participate in the study.

In Australasia, 11 committees declined to participate in the study. These included committees from 6 public hospitals located in major cities in Victoria (3), New South Wales (2) and South Australia (1), 3 private hospitals, 1 Children's hospital and 1 Women's hospital.

In the U.K., 52 committees declined to participate in the study. These included committees from 38 public hospitals managed by NHS Trusts. Four of these committees were from hospitals located in major cities (3 from London and one from Manchester). The other non-participating committees in this category were from regional centres. None of the committees invited from Northern Ireland (2) or Scotland (1) agreed to participate in the study. The remaining 14 U.K. committees which declined to participate in the study included committees from 7 teaching hospitals affiliated to universities, 3 Private hospitals, 2 Children's hospitals, 1 Women's hospital and one committee from a NHS Ambulance Trust.

Notably, from the above, none of the private hospitals invited to participate in the study (3 from the U.K. and 3 from Australasia) agreed to participate. This may possibly considered a source of selection bias.

3.2.1.2. Individual Study Participants

With regard to individual study participants, from figure 3.1, it can be seen that a total of 129 members from participating committees agreed to participate in the questionnaire section of the study. This represented an overall response rate of 38%, with similar response rates of 39% and 38% respectively for Australasian and U.K. participants.

100 (78%) participants were members of the U.K. committees and 29 (22%) participants were members of the Australasian committees.

Information regarding individual participants in terms of a. status of committee membership; b. gender; and c. age, is presented below.

a. Status of committee membership. Participants were requested to indicate their membership status of the committee.

Table 3.2. Committee Membership Status

			Committee membership status		
			member	chair	Total
Country	Australasia	Count	23	6	29
	UK	Count	86	14	100
Total		Count	109	20	129
		% of Total	84.5	15.5	100.0

Table 3.2, shows that 15.5% of all participants were committee chairpersons and 84.5% were other committee members. 14 (14%) of U.K. participants were chairpersons of their committee. Therefore, 86 (86%) of U.K. participants were committee members other than the chair of the committee. For Australasia participants, 6 (21%) of participants indicated they were the committee chairperson and 24 (79%) of participants indicated they were committee members other than the chair of the committee.

Three chairpersons from U.K. CECs who completed questionnaire 2 did not complete questionnaire 1. There were no instances of CEC chairpersons completing questionnaire 1 but declining to forward copies of the questionnaire to their committee members.

b. Gender of Participants.

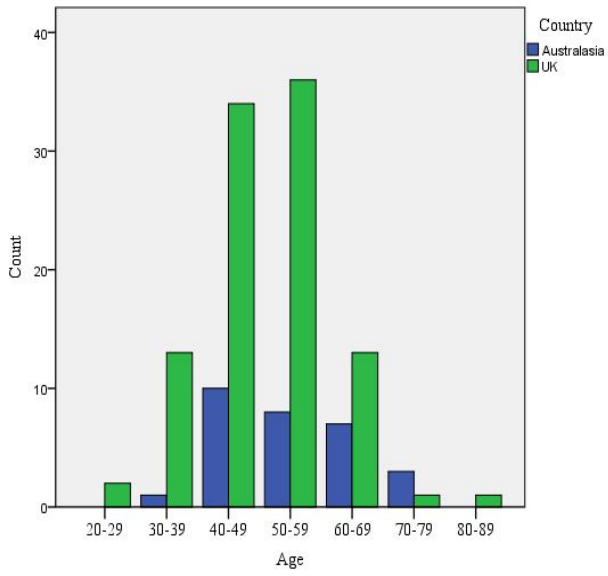
Table 3.3. Gender of Participants

			Country		Total
			Australasia	UK	
Gender	male	Count (%)	15 (52%)	40 (40%)	55 (43%)
	female	Count (%)	14 (48%)	60 (60%)	74 (57%)

Table 3.3, shows that 74 (57%) of all study participants were female and 55 (43%) of participants were male. Sixty (60%) U.K. participants compared with 14 (48%) Australasian participants were female and 40 (40%) U.K. participants compared with 15 (52%) Australasian participants were male.

c. Age of Participants.

Figure 3.2. Age of study participants



From figure 3.2, it can be seen that overall the ages of study participants ranged from the 20-29 to the 80-89 age groups. It can also be noted that the U.K. participants showed

a greater variation of age groups than their Australian counterparts. This may be due, at least in part, to the greater number of U.K. participants.

Table 3.4. Age of Study Participants

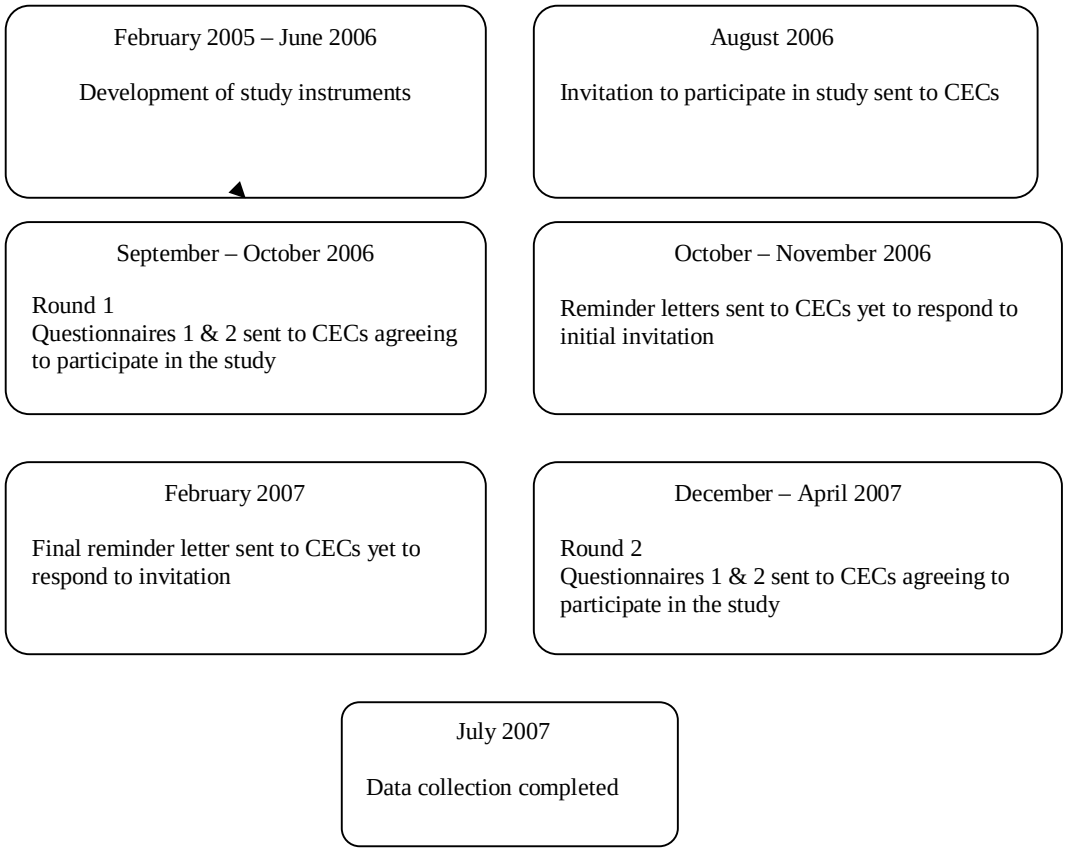
Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p
Age of participants	Australasia	29	4	77.09		
	UK	100	4	61.50		
	Total	129	4		1099.50	.039

As shown in table 3.4, a Mann-Whitney U test was used to compare the distributions of the age of study participants from Australasia (n=29) and the U.K. (n=100). This test revealed a statistically significant group difference (Mann-Whitney U= 1099.50, p= .039, sig < .05, 2-tailed. Although the median values were the same for U.K. (Mdn= 4) and Australasian (Mdn= 4) participants, the mean rank for Australasian participants (77.09) was greater than that for U.K. participants (61.50).

3.3. Research Procedure

The research procedure utilised for the study is described below**.** Figure 3.3**,** provides an overview and timeline for the study.

Figure 3.3. Study Timeline



3.3.1. Initial Invitation

During August 2006, an invitation to participate in the study was sent to the chair (or other nominated contact) of each Clinical Ethics Committee (CEC) identified in Australia, New Zealand, and the United Kingdom (appendix 1).

The invitation informed participants that they had been selected on the basis that their institution had been identified as having an operational CEC. The aims of the study were outlined.

An explanation of the requirements for participation in the study was given, which included the completion of the self-administered questionnaires, and the distribution of questionnaires to other members of the committee.

The invitation also provided explanation of the protocols to maintain anonymity of participants. Details of the ethics approval for the study by the 'Arts, Humanities & Law Human Research Advisory Panel' of the University of New South Wales (UNSW) were provided, along with the contact details of the Ethics Secretariat in case of complaint.

Participants were informed that the results of the study would be used to form the basis of a PhD thesis, and that in any publication, information would be provided in such a way that participants could not be identified. Participants were informed that their decision whether or not to participate in the study would not prejudice their future relations with UNSW, and that they were free to withdraw their consent and to discontinue participation in the study at any time.

Participants were invited to direct any further questions regarding the study to either the investigator or the study supervisor. Contact details for both persons were provided.

At the end of the invitation, a cut-off consent section was included. Participants were asked to sign a declaration which stated that, having read the information contained in the invitation, they had decided to take part in the study. It was clearly stated that participants were free to withdraw their consent and to discontinue participation in the study at any time.

In addition to providing contact details, respondents were requested to indicate the number of members serving on their committee. This was asked in order to determine the number of questionnaires to be sent to each participating committee.

Respondents were asked to return the consent form directly to the investigator, in the reply paid envelope provided. Respondents who had decided against participating in the study were also asked to return the consent form, left blank. This served to confirm receipt of the invitation, and prevent follow-up reminders.

A letter of introduction from the study supervisor was included with the initial invitation to participate in the study. In addition to introducing the investigator, this letter requested participation in the study, and offered to provide further information on request (appendix 2).

3.3.2. Recruitment of Individual Participants

Chairpersons responding that their committee was willing to participate in the study were sent a pack that included the appropriate number of questionnaires, and a covering letter (appendix 3). All packs were mailed using registered mail.

The covering letter, after thanking respondents for agreeing to participate in the study, provided instructions to the committee chair. These instructions included: the request for the chair to complete and return questionnaires 1 and 2 (questionnaires 1 and 2 were printed on different coloured paper to simplify identification); the committee chair was also asked to distribute the provided copies of questionnaire number 1 to all other members of their committee. The questionnaires to be returned directly to the investigator using the enclosed reply paid envelopes.

In addition, there was a request for completed questionnaires to be returned to the investigator by 31 December 2006, if possible.

Along with a copy of questionnaire number 1, and a reply paid envelope, committee members were provided with an invitation to participate in the study (appendix 4). This invitation was identical to that sent to committee chairpersons other than it did not provide a cut-off consent form. The consent form was omitted on the grounds that questionnaires completed by committee members were done so anonymously, and consent is implied by respondents returning the self-administered questionnaire.

In cases where no reply had been received, a reminder letter was sent to the committee chair (appendix 5). For CECs in Australia and New Zealand the reminder was sent four weeks after the initial invitation. Reminders to committees in the United Kingdom were sent six weeks after the original invitation, to allow for the potentially longer delivery time.

The reminder letter highlighted the fact that there are relatively few CECs in existence, and therefore the importance of obtaining input from as many committees as possible in order for the study to be able to accurately represent the practice of CECs.

In addition, a number of committees that had indicated their willingness to participate in the study by returning completed consent forms did not respond. A follow-up letter or e-mail was sent to such committees, in case the questionnaires for the study had not been received (appendix 6).

3.3.3. Completed Questionnaires

The questionnaires sent to each institution were marked with a code which identified the institution. When copies of questionnaire 1 were returned they were further coded to differentiate individual respondents. In addition, any questionnaire number 1 returned by a committee chairperson was further coded to indicate the respondent's position on the committee. This was done in order to be able to make a comparison between the responses of committee chairpersons and other committee members.

The information collected from the responses to questionnaires 1 and 2 was coded, and inputted in to a standard statistical software package, SPSS.

It was noted that a number of committee chairpersons had expressed the wish for their committee's participation in the study be formally acknowledged in any publication of results. Therefore, the final letter included the opportunity for each chairperson to express their committee's preference regarding this matter (appendix 7).

3.3.4. Protection of Human Subjects

There was no potential for harm, physical, psychological, social, cultural or financial, to the participants or investigator during the study.

The measures taken to protect human subjects participating in the study are summarised as follows:

1. Informed Consent

Written informed consent was obtained from chairpersons of committees willing to participate in the study.

Since questionnaires completed and returned by committee members were done so anonymously, consent was implied by respondents returning the self- administered questionnaire.

2. Confidentiality, Privacy, Anonymity

1. To preserve confidentiality, questionnaires were identified by institution only, by means of a code.

2. Questionnaires were returned directly to the investigator to ensure privacy.

3. Data obtained during the initial 'collection phase' of the study was stored securely by the investigator. Subsequently, the data will be stored securely at the School of Philosophy, UNSW for a period of seven years.

4. Access to data obtained is limited to the investigator and supervisors.

3. Deception

It was not be necessary during the research to deceive participants.

4. Conflict of Interest, including Financial Involvement

The research is not being funded by any agency outside the UNSW.

There is no conflict of interest, including financial gain, likely to result from the project.

3.3.5. Ethics Approval

The study was granted approval to proceed by the 'Arts, Humanities and Law Human Research Advisory Panel' of the University of New South Wales (approval number: 05 2 162).

Two participating committees from the UK required the study protocols to be ratified by their respective Human Research Ethics Committees.

3.4. Instruments

The following section describes the instruments used in the study: The survey questionnaires; and the semi-structured interview.

3.4.1. Survey Questionnaires

According to Kumar, the use of a questionnaire as a means of collecting primary data has several advantages: It is less expensive, and therefore saves human and financial resources; and, it offers greater anonymity since there is no face-to-face interaction between respondents and interviewer (Kumar, 1996, p114).

One of the most important factors to be considered in the construction of a survey questionnaire is the development of the attitudinal scale to be employed. This derives importance since the strength of the attitudinal scale "lies in its ability to combine attitudes towards different aspects of an issue and to provide an indicator that is reflective of an overall attitude" (Kumar, 1996, p135).

The development of the attitudinal scale used in Sections A and C of Questionnaire 1 is discussed below.

Attitudinal Scale

For Sections A and C of Questionnaire 1, a Likert type scale was selected to measure respondents' attitudes. The Likert type scale was selected because it allows for a wider

range of responses than simply asking respondents whether they agree or disagree with a statement. As a result of this wider range of possible scores, there is an increase in the number of statistical analyses that are available (Pallant, 2005).

A further reason for selecting a Likert type scale is that it is the most common scale in use, and, when compared with other attitudinal scales, for example, the Thurstone scale, or the Guttman scale, it is relatively easy to construct (Kumar, 1996).

A seven point scale was selected, with number one on the scale corresponding with 'strongly disagree', and number seven corresponding with 'strongly agree.' There is considerable debate in the literature about the number of choices that should be offered. For example, Burton (2004), states that it is preferable to include more categories than fewer, because if a scale is too broad it is usually possible to combine categories at a later date. However, if the scale contains too few categories, it may not be possible to do anything to rectify it after the data has been collected.

A seven-point scale, rather than a five-point scale was also selected for this study on the basis that, there are those who do not like making extreme choices, since this might make them look as if they are completely certain when they, in fact, recognise there are always valid opposing views to many questions. In addition, some people may also prefer to be thought of as moderate rather than extremist (Kumar, 1996).

Another point of debate concerns whether the scale should have an odd, or an even number of responses. An odd-numbered scale has a middle value which may be interpreted as either 'neutral' or 'undecided'. On the other hand, a scale with an even number of responses is a 'forced-choice' scale in which the respondent is forced to decide whether they lean more towards the agree or disagree end of the scale for each item (Kumar, 1996).

An odd-numbered scale was selected on the basis that, an even-numbered scale may force respondents to make a choice which may not necessarily reflect their true position.

A problem that can occur is where people could possibly become influenced by the way they have answered previous questions. For example, if they have agreed several times

in a row, they might carry on agreeing. It is also possible that they could intentionally break the pattern by disagreeing with a statement with which they may possibly otherwise have agreed. In order to circumvent this potential problem, a number of *reversal items* were introduced in each section. In reversal items the sense of the item is reversed. For example, in section A, the fourth statement relating to education is worded 'I do not feel sufficiently prepared for my role on this ethics committee."

These reversal items are also significant since there is the requirement to reverse the response value for each of these items before summing for the total.

3.4.2. Questionnaire 1

Questionnaire 1 contained measures designed to examine clinical ethics committee members' responses to the following: beliefs about the success of their committee with regard to its various activities; views on the relative importance of factors which contribute to a successful committee; and, involvement in the deliberative process of their committee.

To investigate these issues, the fifteen-page questionnaire was designed with four sections: A. Principal Activities of the committee; B. Success factors; C. Deliberative process; D. Respondent characteristics (Appendix 8).

Section A. Committee Activities

Section A. contained four parts: 1. Education; 2. Policy/Guidelines; 3. Case Consultation; 4. Evaluation of Committee Activities.

The statements contained in Sections; A.1. Education; A.2. Policy/ Guidelines; and A.3. Case Consultation, derive from a survey instrument utilised by Rebecca Dobbs, in a study of Clinical Ethics Committees in New Mexico (Dobbs, 2000). In addition, statements in Section A.4 and Section C (Deliberative Process), were derived from Dobbs. Information from Dobbs's study was also used in the formulation of statements for Section B (Committee Activities) of questionnaire 2. The instrument used by Dobbs

was chosen for direct use and development of statements to be included in the current study as it closely aligned with many of the aims and objectives of the current study.

1. Education

Participants were asked to respond to seven statements relating to their beliefs about their committee's success in its role of education provider. Participants were required to respond to these statements using a 7-point Likert style scale on which 1 corresponded with 'strongly disagree' and 7 corresponded with 'strongly agree.' In addition, participants could respond 'n/a' (not applicable) where their committee did not participate in that particular activity, for example, in the education of the community at large.

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At the end of this section, participants were invited to make any comments they wished on their committee's role of providing education.

2. Policy/ Guidelines

Participants were requested to respond to seven statements relating to their beliefs about their committee's success in its role of developing and/or reviewing policies and guidelines. Participants were required to respond to these statements using a 7-point Likert style scale on which 1 corresponded with 'strongly disagree' and 7 corresponded with 'strongly agree.' In addition, participants could respond 'n/a' (not applicable) where their committee did not participate in that particular activity.

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Space was left at the end of this part for participants to make any comments they wished on their committee's role on policy/ guidelines.

3. Case Review/ Consultation

Participants were requested to respond to six statements relating to their beliefs about their committee's success in its activities relating to case consultation. Participants were required to respond to these statements using a 7-point Likert style scale on which 1 corresponded with 'strongly disagree' and 7 corresponded with 'strongly agree.' In addition, participants could respond 'n/a' (not applicable) where their committee did not participate in that particular activity, for example, acute case consultation.

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Space was left at the end of this part for participants to make any comments they wished on their committee's case consultation/ review activities.

Sections 1-3 above were concerned with respondent's beliefs about their committee's role in particular activities. Part 4 of Section A. was concerned with participants' beliefs about the overall success of their committee.

4. Evaluation of Committee Activities

Part 4 sought to establish participants' beliefs about the overall success of their committees.

To this end, participant's beliefs on four distinct areas were investigated: a. the overall success of their committee; b. obstacles to the successful development and effectiveness of their committee; c. effective means of gathering information to evaluate the success of their committee; d. measures which would be effective indicators of the success of their committee.

In each area, participants were required to respond to the statements using a 7-point Likert style scale on which 1 corresponded with 'strongly disagree' and 7 corresponded with 'strongly agree.

a. Overall Success.

Participants were asked to respond to six statements concerning their beliefs about the overall success of their committee.

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b. Obstacles to the Successful Development of the Committee.

Participants were asked to respond to five statements which were identified from the literature as being potential obstacles to the successful development, or hindrances to the effectiveness of a clinical ethics committee.

Statements for this section were developed from a survey instrument used by Slowther et al (2001), which was used to identify and describe the state of clinical ethics support services in the UK. The study surveyed NHS Trusts in operation during 2000. The study also provided information for developing statements pertaining to the issues which arise for CECs in discussions relating to policies and guidelines (Questionnaire 2, Section B.3: Committee Activities). In addition, information from Slowther's study provided information in the development of statements for Section D of questionnaire 1 (Respondent Characteristics) and Section A of questionnaire 2 (Committee Activities).

Statement	Source
1. Lack of resources (financial and human)	Developed from Slowther et al, (2001b)
2. Lack of training available for committee members	Developed from Slowther et al, (2001b)
3. Lack of appropriate expertise on the committee	Developed from Slowther et al, (2001b)
4. Reluctance of clinicians (particularly doctors) to recognise and use the committee.	Developed from Slowther et al, (2001b)
5. Difficulties in raising the profile of the committee within the hospital community.	Developed from Slowther et al, (2001b)

Space was provided at the end of this part for respondents to specify other obstacles to the successful development of a clinical ethics committee.

c. Effective Means of Gathering Information to Evaluate the Success of a Committee.

The statements for this section and Section d, effective indicators of success of a committee, derived directly from a study by Moore (2005), which investigated how CECs measure outcomes, success or value in hospitals in the UK. Moore's study also provided the source of information for the formulation of the statements for Section C. Committee Evaluation, of Questionnaire 2. This study was selected as it provided an organised and comprehensive overview of two of the areas of CEC evaluation to be investigated by this study.

Participants were asked to respond to five statements which were identified from the literature as being means of gathering information to evaluate the success of a clinical ethics committee.

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pace was provided at the end for respondents to specify other effective means of gathering information to evaluate the success of a clinical ethics committee.

d. Measures: Effective Indicators of Success of a Committee.

Participants were asked to respond to six statements which might be seen as measures that would be effective indicators of the success of a clinical ethics committee.

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Space was provided at the end for respondents to specify other measures they believe to be effective indicators of the success of a clinical ethics committee.

Section B. Success Factors

This section utilised a survey instrument described in a study by Guo and Schick (2003), which sought to identify factors considered by U.S.A. healthcare ethics committee chairpersons and members to be essential to the success of an ethics committee. The study analysed results obtained a survey instrument returned by 294 chairpersons and 223 members of 334 ethics committees from acute care hospitals across the United States in the calendar year 2000. The instrument utilised by Guo and Schick was included in the current study since it was envisaged it would provide useful data concerning the functions and evaluation of participating CECs.

Respondents were asked to indicate the degree to which they agreed or disagreed with statements about factors which contributed to the 'success' of their ethics committee. Four sub-categories were included: 1. Leadership: 2. Participation, Communication, Skills: 3. Administrative Support; 4. Structure, Function and Process.

In addition, respondents were asked to rank each of these sub-categories in order of importance in contributing to the 'success of a Clinical Ethics Committee.

In each part, participants were required to assess the factors using a 5-point Likert style scale on which 1 corresponded with 'unimportant' and 5 corresponded with 'essential'. The 5 point scale used in this section was identical to the scale used in Schick and Guo's study, to allow for more accurate comparison of results.

1. Leadership

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2. Participation, Communication, Skills

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3. Administrative Support

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4. Structure, Function, Process

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Overall Assessment

Section B. concluded with a request for participants to assess the relative importance of each of the above four areas in their overall importance to the success of their committee: 1. leadership; 2. participation, communication, skills; administrative support; structure, function, process.

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Section C. Deliberative Process

Section C. was constructed following an extensive search of the literature on deliberative processes in clinical ethics committees.

Section C. was designed to investigate participants' attitudes toward the deliberative process of their committees. Participants were requested to assess twenty-nine statements pertaining to the deliberative processes of their clinical ethics committee.

Participants were required to respond to these statements using a 7-point Likert style scale on which 1 corresponded with 'strongly disagree' and 7 corresponded with 'strongly agree.' In addition, participants could respond 'n/a' (not applicable) where their committee did not participate in that particular activity.

The first two statements sought the respondent's beliefs concerning the diversity of professional disciplines, and diversity of bioethical perspectives represented on the committee.

Statement	Source
1. Our committee has sufficient member representation from the professional disciplines	Direct from Dobbs (2000)
2. Our committee's membership represents diverse bioethical perspectives.	Direct from Dobbs (2000)

Statements 3 to 11 were concerned with eliciting the participant's beliefs about their committee's process of deliberating on an issue. Statements, 3-6, and statement 11 were taken directly from an instrument developed by Jurchak (1996), for a study which examined the process of ethics case consultation in end-of-life decisions in the USA. The participants in this study were members of the Society for Bioethics Consultation (SBC), cited as being a primary growth indicator of the growth of involvement in bioethics consultation in the USA. The multidisciplinary membership of the SBC includes philosophers, physicians, nurses, clergy, lawyers, and social workers. In

addition, information from Jurchak's study was used in the development of statements 7-10, and 12-16 of this section of the current study.

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There followed five statements (12, 13, 14, 15, and 16) relating to the participant's personal experience of the committee's process.

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Statements 17 to 27 concerned the participant's assessment of the outcome of their committee's deliberations. These statements were formulated from a chapter by Benjamin (2005) entitled 'The Value of Consensus' in 'Society's Choices: Social and Ethical Decision Making in Biomedicine'. This paper by Benjamin provided an in-depth discussion on the various forms of agreement arising from ethics committee deliberations. These forms of agreement ranged from full agreement to vote taking. Benjamin's paper also provided the source for statements 28 and 29, relating to sources of error in committees.

The first five statements in this group of statements (17-21) sought information regarding consensus as an outcome of clinical ethics committee's deliberative processes. Statements 22, 23, and 24 relate to 'compromise' as an outcome of committee deliberation. Statements 25 and 26 relate to 'majority rule' as an outcome of committee deliberation. Statement 27 concerns the authority of any consensus reached by the committee.

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The final two statements in Section C (28 and 29), were designed to assess whether the participant's committee had measures in place that might help avoid commonly identified sources of error for a committee

Statement	Source
28. The chairperson appoints member(s) to make the case against the majority	Newly developed from Literature (Benjamin, 1995)
29. Committee members have sufficient opportunity to scrutinise any second-hand information they receive on issues to be discussed at meetings.	Newly developed from Literature (Benjamin, 1995)

Section D. Respondent Characteristics

Section D. represented a two page demographics questionnaire designed to collect the following data on clinical ethics committee members.

Statement	Source
How long has the committee been in operation?	Newly developed from literature
How many members does the committee have?	Newly developed from literature
The number of committee members in each category Provider/ Medical staff (Medical graduate) Nursing Law Ethics Non-medical administrator Lay/ Community representative Social services Clergy/ Pastoral care Board member Other (please specify)	Newly developed from literature
Who selects members of the committee?	Newly developed from literature
How many committee meetings are scheduled for 2006?	Newly developed from literature
What is the occupation of the committee chairperson?	Newly developed from literature
How long has the current chairperson been in the chair?	Newly developed from literature
Does the committee receive administrative support from the hospital?	Newly developed from literature
Does the committee receive funding from the hospital for- Education/ training? Ethicist/ Ethics consultant? Administration? Other? (please specify)	Newly developed from literature

As indicated above, questions in this section were developed from the literature concerning CECs. In particular, studies by McGee, Spanogle, Caplan, and Asch (2002); Slowther, Bunch, Woolnough, and Hope (2001b); Wenger, Golan, Shalev, and Glick (2002); Gill, Saul, McPhee, and Kerridge (2004); and Hurst, Hull, DuVal, and Danis (2005), provided much of the information for the items included in this section.

3.4.3. Questionnaire 2

Questionnaire 2 (appendix 9), contained measures designed to examine the structure, activities, and evaluation processes of clinical ethics committees. The items of the questionnaire reflected aspects of the process of ethics case consultation, education, and policy development/ review identified in the literature.

To investigate these issues, the nine-page questionnaire was designed with three sections: A. Committee structure; B. Committee activities; and C. Committee evaluation.

Section A. Committee Structure

Section A. contained nine questions relating to the structure of the committee.

Statement	Source
1. How long has the committee been in operation?	Newly developed from literature
2. How many members does the committee have?	Newly developed from literature
3. Please indicate the number of committee members in each category Provider/ Medical staff (Medical graduate) Nursing Law Ethics Non-medical administrator Lay/ Community representative Social services Clergy/ Pastoral care Board member Other (please specify)	Newly developed from literature
4. Who selects members of the committee?	Newly developed from literature
5. How many committee meetings are scheduled for 2006?	Newly developed from literature
6. What is the occupation of the committee chairperson?	Newly developed from literature
7. How long has the current chairperson been in the chair?	Newly developed from literature
8. Does the committee receive administrative support from the hospital?	Newly developed from literature
9. Does the committee receive funding from the hospital for- Education/ training? An Ethicist/ Ethics consultant? Administration? Other? (please specify)	Newly developed from literature

As indicated, the questions were constructed following a review of the literature concerning the structure of clinical ethics committees. In particular, studies by McGee, Spanogle, Caplan, and Asch (2002); Slowther, Bunch, Woolnough, and Hope (2001b); Wenger, Golan, Shalev, and Glick (2002); Gill, Saul, McPhee, and Kerridge (2004); and Hurst, Hull, DuVal, and Danis (2005), provided much of the information for the items included in this section.

Section B. Committee Activities

Section B. contained 13 questions relating to the activities of the committee. From the literature on clinical ethics committees it was identified that case consultation; education; and policy/ guideline development/ review were the major areas that such committees are involved in (Adams, 1997; Dobbs, 2000; Gill, 2004; Guo and Schick, 2003; Peirce, 2004; Ross, 2000; Slowther et al., 2004; McGee et al., 2002; Szeremeta, Dawson, Manning, Watson, Wright, Northcutt, and Lancaster, 2001).

The first question in this section requested participants to respond 'yes' or 'no' to whether their committee participated in case consultation; ethics education, which was sub-divided into committee member education, hospital staff education, and community education; and policy and guidelines development/ review.

Statements for this section were developed from a study by McGee et al (2002), which conducted a national survey of ethics committee chairpersons in the USA regarding the successes and failures of the functions performed by hospital ethics committees. This study was selected as a source for developing statements for the current study as it included information from one thousand hospital ethics in the USA. In addition, information from this study was utilised in the formulation of statements for Section A of questionnaire 2 (Committee Structure) and Section D of questionnaire 1 (Respondent Characteristics).

Statement	Source
Please indicate the activities in which your committee participates 1. Case Consultation (including retrospective) 2. Ethics Education Committee member education Hospital staff education Community education 3. Policy and Guidelines development/ review 4. Other (please specify)	Developed from McGee et al (2002)

Following question 1, Section B. contained questions specifically about: 1. Case consultation; 2. Education; and 3. Policy/ Guidelines.

1. Case Consultation

Participants were asked to answer five questions regarding the nature of case consultation carried out by their committee.

Statement	Source
1. Please indicate the methods of case consultation in which your committee engages	Newly developed from literature
2. How many case consultations has your committee dealt with in the last 12 months? a) Acute b) Retrospective	Newly developed from literature
3. Who can request consultation?	Newly developed from literature
4. Issues raised in consultations	Newly developed from literature
5. Outcomes of case consultation	Newly developed from literature

As indicated above, questions in this section were developed from the literature concerning CECs. In particular, studies by McGee, Spanogle, Caplan, and Asch (2002); Wenger, Golan, Shalev, and Glick (2002); Hurst, Hull, DuVal, and Danis (2005), provided much of the information for the items included in this section.

The first question asked participants to indicate the method(s) of case consultation undertaken by their committee. This included: acute case consultation; and retrospective case consultation. In addition, participants could indicate that their committee did not participate in any form of case consultation.

Question number 2 asked respondents to indicate the number of acute case consultations and the number of retrospective case consultations their committee had dealt with in the previous 12 months, ranging from 0 to more than 13.

Question number 3 was concerned with who could request case consultation by the committee. Respondents were asked to indicate, by circling all that applied, those who were able to request case consultation. The list included: the attending physician; resident physician; family members; nursing staff; social worker; the patient or their surrogate; hospital staff; outside agencies; any committee member. In addition, space was left for participants to specify any others parties not listed above who could request case consultation by the committee.

Question number 4 in this section asked respondents to indicate all of the issues that had been raised in case consultation undertaken by their committee. From the literature regarding case consultation in clinical ethics committees, the following issues were identified: new technologies; patient autonomy/ competency; resource allocation; end of life issues; refusal of intervention; truth telling; confidentiality; problematic proxy; conflicts of interest; requests for futile treatment. Respondents were given space to specify any other issues in case consultation not listed above.

Question number 5 concerning case consultation requested participants to indicate the outcomes of case consultations that applied to their committee. The following outcomes of case consultation were identified from the literature on clinical ethics committees: recommendations to physicians and staff; consultation with risk management; communication with patient/ family; publication of case studies; binding decisions; and arbitration with third parties. In addition to indicating all of the above outcomes that applied to their committee, respondents were provided space to specify any other outcomes not listed above.

(McGee et al., 2002; Wenger et al., 2002; Hurst et al., (2005).

2. Education

Participants were asked to answer three questions on education activities undertaken by their committee. In each case participants were requested to give a 'yes' or 'no' answer. Questions for this section were developed from a study by Wenger et al (2002), which investigated the structure, function and heterogeneity of 42 hospital ethics committees in Israel. This study also provided information used in the construction of statements for Section D of questionnaire 1 (Respondent Characteristics), Section A of questionnaire 2 (Committee Structure) and Section B of questionnaire 2 (Committee Activities).

Statement	Source
Has your committee provided any bioethics education for committee members in the last 12 months?	Developed from Wenger et al (2002)
Has your committee provided any bioethics education for the hospital community in the last 12 months?	Developed from Wenger et al (2002)
Has your committee provided any bioethics education for the general community in the last 12 months?	Developed from Wenger et al (2002)

3. Policy and Guidelines

Participants were asked to indicate all of the issues from the following list that their committee had discussed. These issues were identified from the literature on clinical ethics committees as being the most commonly discussed in relation to policy/ guideline development/ review. In addition to the above, respondents were given space to specify any other issues that their committee had discussed regarding hospital policy/ guideline development/ review (Slowther et al., 2001b).

Statement	Source
Please indicate the issues your committee has discussed regarding hospital policy/ guidelines Brain death DNR orders Commercial use of tissue Withdrawal of care Consent policy Elective ventilation Advance directives Confidentiality issues Rights of relatives Consent for DNA testing Possession of illicit drugs	Developed from Slowther et al (2001b)

Section C. Committee Evaluation

Section C. contained six questions pertaining to the evaluation process of clinical ethics committees.

Statement	Source
1. Does your committee have a formal evaluation process in routine use?	Developed from Moore (2005)
2. How is information gathered to allow analysis for evaluation?	Developed from Moore (2005)
3. What outcome measures are used to indicate the 'success' of the committee?	Developed from Moore (2005)
4. Who is responsible for evaluating the committee?	Developed from Moore (2005)
5. Does your committee have any formal contact with other clinical ethics committees? (circle appropriate response)	Developed from Moore (2005)
6. In the past 12 months, please estimate the proportion of time that your committee spent performing each of the following activities. ETHICS EDUCATION Committee member education Hospital community education General community education CASE CONSULTATION Acute Retrospective POLICY/ GUIDELINES Review/ revision Development OTHER ACTIVITES	Developed from Moore (2005)

Question number 1 asked whether the respondent's committee had a formal evaluation process in routine use. If the respondent answered 'yes', they were directed to question 2. If the respondent answered 'no', they were directed to question 5.

3.5. Validity and Reliability of Instruments

The validity of an instrument is the determination of the extent to which the instrument actually reflects the abstract concept being examined. The reliability of a research instrument 'is the degree of consistency with which the instrument measures the

attribute it is supposed to be measuring. Reliability can be equated with the stability; consistency or dependability of a measuring tool' (Polit and Hungler, 1991, p242).

Due to time, cost, and sample size constraints, it was not possible to measure validity and reliability through repeated testing of the instruments.

Validity and reliability of the instruments were measured by observing the following issues:

The survey instrument content and construct validity was accomplished by submission to review by an experienced instrument developer/ methodologist, and a senior member of a clinical ethics committee. The overall reliability of the instrument was assessed by consideration of the clarity of the questions and the general format of the questionnaires.

3.6. Limitations of Method

It is recognised that there are a number of limitations and disadvantages associated with the methodology selected for the study.

Limitations and Disadvantages of Questionnaires

A number of disadvantages of using a questionnaire as a means of collecting information have been identified in the literature relating to methodology.

Questionnaires are notorious for their low response rates, which results in a reduction of the sample size. According to Kumar (1996), factors which influence the response rate include: the interest of the sample in the topic of the study; the layout and length of the questionnaire; and the quality of the letter explaining the purpose and relevance of the study.

A criticism of this nature concerning the length of the survey instrument (questionnaire 1) was made by a member of a CEC in the U.K., who responded that the questionnaire was too long, and that clinicians may not be able to find time or be willing to complete it. However, although the overall study population is small, it was believed that members of CECs were highly motivated, and sufficiently interested in their activities

associated with their CEC, and as such, would be prepared to spend more time completing the questionnaire. The decision was taken to endeavour to maximise the amount of information obtained relating to CECs in order to more fully understand the processes involved.

Since not everyone who receives a questionnaire returns it, another limitation of survey research is that of 'self-selecting bias.' It is conceivable that those respondents who return a questionnaire have attitudes, motivations, and attributes that differ from those who do not return the questionnaire (Kumar, 1996).

Two other limitations of a survey research methodology relate to the lack of opportunity to clarify issues, whereby, if different respondents interpret questions differently, the quality of the information provided will be affected, and the fact that spontaneous responses are not allowed for (Kumar, 1996). The former is circumvented to a degree by careful construction of the survey instrument.

One final limitation of a survey research methodology is that the response to a question may be influenced by the response to other questions. Since respondents can read all the questions before answering, the way in which a respondent answers a particular question could be affected by their knowledge of other questions (Kumar, 1996, p114).

3.7. Chapter Summary

This chapter described the research methodology followed in conducting the study. The research design chosen enabled the investigator to achieve the aims and objectives of the study.

Chapter 4

Clinical Ethics Committee Structure

4.1. Introduction

Addressing structural questions concerning clinical ethics committees (CECs) may be able to shed valuable light on which characteristics produce a useful committee and those which tend to impair a committee's functioning.

According to the literature concerning CECs, many of the structural questions being considered by North American CECs are now being debated in the United Kingdom (U.K.) and Australasia. Section A., of study instrument questionnaire 2 (appendix 9), was designed to gather information from participating committees on these structural questions, in order to provide a description of the structure of clinical ethics committees currently operating in Australasia and the U.K.. The questions were constructed following a review of the literature concerning the structure of clinical ethics committees, which included studies by McGee, Spanogle, Caplan, and Asch (2002); Slowther, Bunch, Woolnough, and Hope (2001); Wenger, Golan, Shalev, and Glick (2002); Gill, Saul, McPhee, and Kerridge (2004); and Hurst, Hull, DuVal, and Danis (2005); and Slowther (2002).

The questions addressed in this section of the study derive from the overall study aims and questions of the study, as stated in chapter 1. Specifically, the questions investigated with respect to CEC structure are stated below.

1. The appropriate membership for a CEC:
    a. The appropriate size of a CEC
    b. The appropriate composition of a CEC
    c. Appropriate qualification for membership of a CEC
    d. Who should be the committee chairperson?
    e. The selection process for selecting committee members.
2. How long the committee has been in existence.
3. The frequency of meetings scheduled.
4. Whether a committee receives administrative support from its organisation.

5. The nature of any funding received by a committee from its organisation.
(McGee, Spanogle, Caplan, and Asch (2002); Slowther, Bunch, Woolnough, and Hope (2001); Wenger, Golan, Shalev, and Glick (2002); Gill, Saul, McPhee, and Kerridge (2004); and Hurst, Hull, DuVal, and Danis (2005); and Slowther (2002)).

These questions, together with the results obtained, are given below.

4.2. Appropriate Membership for a Clinical Ethics Committee.

4.2.1. Committee Size

Guo and Schick found that the size of a clinical ethics committee (CEC) was a significant characteristic associated with the perceived success of committees – larger committees being perceived to be more successful. The question of what constitutes a successful committee and how this might be measured is discussed fully in chapter 6 (committee evaluation). Guo and Schick found the average size of a CEC was 20 members and suggested that this may due to the fact that large committees find it easier to form a quorum, and also that large committees find it easier to divide into sub-committees which may spread the work. They concluded that small committees need to increase their size in order to expand their expertise (Guo and Schick, 2003). In contrast, the American Medical Association (AMA) recommends that the size of any CEC should not be so large as to make it unwieldy (AMA, 2005).

In the U.K., the Royal College of Physicians (RCP) Working Party Report (2005), suggested that in most instances membership of a CEC would be between eight and fourteen members, depending on the proposed function of the committee (RCP, 2005). A 2002 study on U.K. CECs noted that the size of the CECs investigated ranged from 11-17 members (Szeremeta et al., 2001).

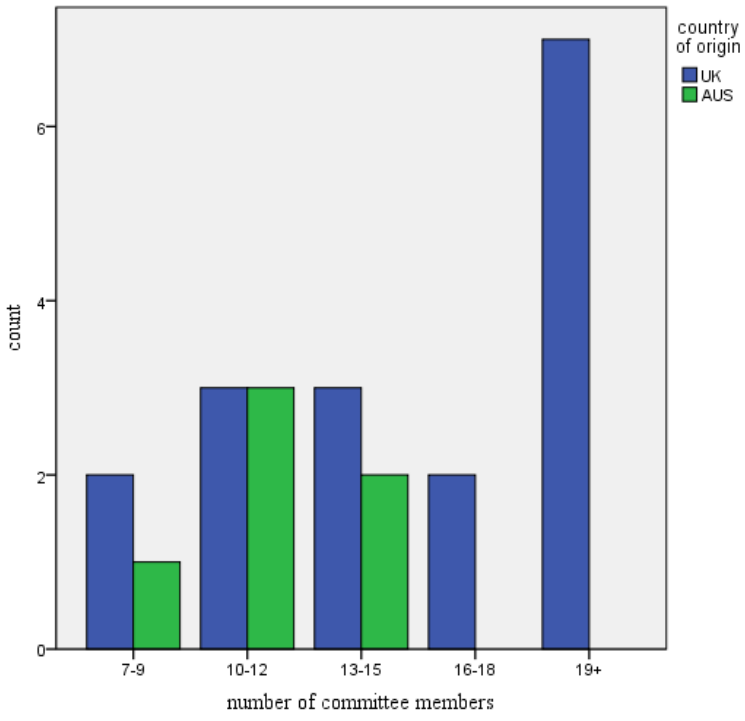
In Australia, during 2006, the New South Wales Government Department of Health initiated ‘The New South Wales Ethics Advisory Panel (NSW CEAP)’. The CEAP is NSW Health’s peak advisory group on clinical ethics issues, and was constituted to provide a forum through which a diverse and knowledgeable group of individuals could advise NSW Health on clinical ethics issues of State wide relevance, review policies

that raise ethical issues, identify emerging clinical ethical issues and trends. The 15-member CEAP is intended to bring together wide-ranging expertise in clinical ethics, clinical practice, law, philosophy, and community and consumer issues (NSW Health, 2006). It should be noted that the CEAP in NSW has a different charter than that of an individual hospital's CEC, since it has a whole of state and population focus which a local CEC does not require to have. Thus, it might reasonably be expected to be constituted differently than a hospital CEC. It follows, therefore, that while structural elements of the CEAP may provide some insight for hospital CECs, it should not necessarily be regarded as a model for these committees.

Study Findings

The results for this section, regarding the number of members serving on participating committees, are derived from responses obtained from Section A of Questionnaire 2. Questionnaire 2 was completed by the Chairperson (or other nominated individual) of each committee, and, wherever reference is made to views of the Committee this should be understood to refer to the views presented by the Chairperson (or other nominated individual).

Figure 4.1 Numbers of Members Serving on Participating Committees



It can be seen from figure 4.1, that 7 of the 23 committees participating in the study had more than nineteen members. The most notable study finding in this area was that, while 7 of the 17 committees from the U.K. had more than nineteen members and 9 had more than sixteen members, none of the Australasian committees (n=6) had more than fifteen members.

In the study, approximately one quarter 6 of participating committees had between ten and twelve members, and a further 5 committees had between thirteen and fifteen members. In other words, around one half of all committees had between ten and fifteen members. In Australasian committees, 5 out of 6 committees had between ten and fifteen members compared with 6 of the 17 U.K. committees. Exactly one-half of the Australasian committees (3) had between ten and twelve members.

It is interesting to note that only 3 committees overall, with a similar number for both U.K. (2) and Australasian committees (1), had between seven and nine members. Further, none of the participating committees had a membership of fewer than seven.

In order to determine if there was a statistically significant difference in size between participating committees from Australasia and the U.K., a Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The Mann-Whitney U test indicated no significant difference between Australasian (Mdn = 4) and U.K. (Mdn =6) committees, U= 24.50, p = .056, r = .40. According to Cohen's interpretation of effect size, there was a medium effect size (r = .40). It may be noted that the median was greater for U.K., indicating U.K. committees to be larger.

4.2.2. Appropriate Composition of a Clinical Ethics Committee

There is currently no agreed set of guidelines on the composition of a clinical ethics committee (CEC) in Australia/U.K./North America (Hollerman, 1991; Peirce, 2004; RCP, 2005). However, as noted previously, in 2006, the New South Wales Government Department of Health initiated 'The New South Wales Ethics Advisory Panel (NSW CEAP).

Regarding clinical ethics committee membership, the Policy Directive 'Clinical Ethics Processes in NSW Health', states,

In constituting a clinical ethics committee regard has to be had to the following:

a. *Collective membership must have the capacity to deal with complex clinical ethical issues and each member should make a contribution.*
b. *Membership should reflect the local context and the likely issues that will be referred to the committee for deliberation.*
c. *Functions (education, policy development, case advice) being undertaken by the committee.*
d. *The benefits of appropriate multidisciplinary and community input where the committee undertakes education and policy development roles.*
e. *Membership does not need to replicate that required by NHMRC for Human Research Ethics Committees.*
(NSW Health, 2006).

The current membership of the CEAP is:

Committee chairperson

Two members with expertise in law

Three members with knowledge and experience in research/ clinical ethics

Two members with experience in philosophy or religion

One member with experience in clinical medical practice

One member with experience in nursing or allied health practice

One member with understanding of consumer health issues

One lay woman with understanding of community issues

One lay man with understanding of community issues

(NSW Health, 2006).

It may be noted that while section e, of the NSW policy directive, states that 'Membership does not need to replicate that required by NHMRC for Human Research Ethics Committees', the composition of the CEAP closely mirrors the composition of Human Research Ethics Committees as required in section 2.6 of the National Statement on Ethical Conduct in Research Involving Humans (NHMRC, 1999). One reason for this similarity in committee composition may lie in the fact that, according to the NHMRC statement, 'The primary role of an HREC is to protect the welfare and rights of participants in research' (NHMRC, 1999). In similar fashion, a fundamental role of the CEAP may be seen as the protection of the welfare and rights of patients.

Hollerman suggested that the optimum membership for a CEC would be one third physicians, one third nurses and one third 'others'. 'Others' would include members from groups such as social workers, clergy, lawyers, ethicists, administrators, patient representative organizations and lay members (Hollerman, 1991). In one study of North American CEC characteristics in 2000 revealed that physicians (41%) and nurses (21%) dominated the composition of CEC's (Guo and Schick, 2003).

McNeill (2001), in a study of Australian CECs found the membership to include 33% medical graduates, 16% nurses and 21% administrators. McNeill also found that 84% of committees had at least one member with a degree/ diploma in theology; 35% had a member with a degree/ diploma in philosophy; and 23% had a member with a degree/ diploma in ethics. 55% of CEC's in this study were found to have at least one member who had completed a short course on ethics.

In a study which looked at the composition of a number of hospital CECs in the U.K., Szeremeta et al. (2001), found that all the committees it investigated were multidisciplinary and included 'non-medical' members. The inclusion of these 'non-medical' members aimed at providing a broader representation of views.

A Working Party Report for the Royal College of Physicians (RCP) in the U.K. (RCP, 2005), suggested that CEC membership be such that it is able to provide a 'multidisciplinary and informed forum for the discussion of ethical issues likely to arise in the healthcare setting it serves' (RCP, 2005,p38). The report emphasises the need for input from a wide range of stakeholders involved in the provision of healthcare by the institution. For example, in addition to health professionals, a CEC should involve hospital management, lay persons, ethical and legal expertise, and, where appropriate, spiritual input. The beliefs, practices and language of the population being served by a healthcare institution are also important, and ethics support will need to be sensitive to them (RCP, 2005).

While it has been acknowledged that input from a wide range of stakeholders is desirable, there have been a number of cautionary notes in the literature concerning the composition of CECs in this regard. For example, there is currently some debate on whether it would be beneficial for a CEC to have an ethicist as a member. While it

might seem desirable to have someone with this type of expertise, an objection to having an ethicist on a CEC is that many of the people with expertise in this area have theoretical rather than practical backgrounds (Slowther and Hope, 2000; Slowther, Hope, and Ashcroft, 2001a). Other concerns, regarding the inclusion of lay members on CECs have been raised. It has been recognised that lay members, by bringing a 'non-health professional' perspective, can provide a balance between the 'technical' and 'ordinary outside' worlds to committee deliberations. However, while this kind of participation may be seen to add legitimacy to any discussion on ethical issues (RCP, 2005), Hollerman expresses the concern that such lay members might increase the risk of breaking patient confidentiality (Hollerman, 1991). Further, while the inclusion of 'Spiritual input' into committee deliberations may be desirable, it is important that these members recognise the diversity of religious belief. The RCP report emphasises that it would be inappropriate for one religious faith to be designated as the sole spiritual contact (RCP, 2005).

Notwithstanding these concerns, the importance for having a diverse membership for a CEC is emphasised by a discussion on group decision making by Surowiecki in 'The Wisdom of Crowds'. For Surowiecki, 'wise' groups have four elements which help to create good decisions. These are Diversity of opinion, Independence, Decentralization, Aggregation of private judgements into group decisions (Surowiecki, 2004). A CEC, therefore, should consider the importance of each committee member in adding diversity of thought, independence, decentralization, and aggregation to the decision making process. Aggregation of information into decisions helps ensure that all relevant information is considered. CECs should be formed from not only diverse professional groups but also by individuals with diverse opinions (Peirce, 2004).

A further benefit of broadening the decision-making base is, that by making it more decentralized, it is less likely that a powerful chairman might unduly influence the results (Peirce, 2004).

Study Findings

The results for this section, regarding the composition of participating committees, are derived from responses obtained from Section A of Questionnaire 2. Questionnaire 2

was completed by the Chairperson (or other nominated individual) of each committee, and, wherever reference is made to views of the Committee this should be understood to refer to the views presented by the Chairperson (or other nominated individual).

In order to compare the composition of Australasian and U.K. committees, a Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The results are shown in table 4.1.

Table 4.1. Committee Membership

Profession / Discipline	Country of Origin	N	Median	Mann-Whitney U	p	r
Number of provider/medical staff	UK	16	5			
	Australasia	6	3			
	Total	22	4	18.00	.025	.48
Number of nursing staff	UK	16	3			
	Australasia	6	2			
	Total	22	3	15.50	.014	.11
Number from legal profession	UK	16	1			
	Australasia	6	1			
	Total	22	1	36.00	.186	.28
Number of ethicists	UK	16	1			
	Australasia	6	1			
	Total	22	1	42.00	.591	.11
Number of non-medical administrators	UK	16	1			
	Australasia	4	0.5			
	Total	20	1	28.00	.684	.09
Number of lay/community members	UK	16	2			
	Australasia	6	2			
	Total	22	2	40.50	.565	.12
Number from social services	UK	14	0			
	Australasia	5	1			
	Total	19	0	9.50	.002	.70
Number from pastoral care	UK	15	1			
	Australasia	6	1			
	Total	21	1	31.50	.226	.26
Number of board members	UK	16	1			
	Australasia	5	0			
	Total	21	1	26.50	.223	.26

Table 4.1, shows a statistically significant difference between Australasian and U.K. committees for the number of Provider/ Medical staff, with the median value for Provider/ Medical staff being greater for U.K. committees (Mdn = 5) than for Australasian committees (Mdn = 3).

Similarly, for Nursing staff, table 4.1, shows a significant difference between Australasian and U.K. committees, with the median value being greater for U.K. committees (Mdn = 3) than for Australasian committees (Mdn = 2).

In terms of Committee membership, table 4.1, shows the other significant difference between Australasian and U.K. committees was for the number of members from Social Services. In this case, the median value was greater for Australasian committees (Mdn = 1) than for U.K. committees (Mdn = 0).

Table 4.1, further shows no statistically significant difference between Australasian and U.K. committees for the numbers of committee members from the Legal profession, Ethicists, non-medical Administrators, Lay/ community members, members from Pastoral care and Board members.

In terms of median values**,** table 4.1, shows that Provider/ medical staff (Mdn = 4) and Nursing staff (Mdn = 3), as having the greatest median values. This finding is unsurprising, given the function of CECs. It may also be noted, in terms of median values, that lay/ community members had the third highest median (Mdn = 2). As noted previously, Lay Members, by bringing a 'non-health professional' perspective, can provide a balance between the 'technical' and 'ordinary outside' worlds to committee deliberations. This kind of participation may be seen to add legitimacy to any discussion on ethical issues (RCP, 2005). However, on the other hand, Hollerman expresses the concern that such lay members might increase the risk of breaking patient confidentiality (Hollerman, 1991).

A study finding of interest, in the area of committee membership, was that all 6 of the Australasian committees and 12 U.K. committees confirmed that they had an ethicist on their committee. This is of interest as there is currently some debate on whether it would be beneficial for a CEC to have an ethicist as a member. While it might seem

desirable to have someone with this type of expertise, an objection to having an ethicist on a CEC is that many of the people with expertise in this area have theoretical rather than practical backgrounds (Slowther and Hope, 2000; Slowther et al., 2001b).

One further finding of interest in this area was with regard to clergy/ pastoral care. It was found that 19 of all participating committees indicated that they had at least one such representative on their committee, with five participating committees (four from the U.K. and one from Australasia) indicating they had more than one member representing pastoral care. Once again, as previously noted, while the inclusion of 'Spiritual input' into committee deliberations may be desirable, it is important that these members recognise the diversity of religious belief. The RCP report emphasises that it would be inappropriate for one religious faith to be designated as the sole spiritual contact (RCP, 2005).

4.2.3. Appropriate Qualification for Membership of a Clinical Ethics Committee

The most common requirement for service on a clinical ethics committee (CEC) is an expressed interest. Ethics training and expertise are generally deemed to be a bonus rather than a requirement (Peirce, 2004). For example, in the development of the Peterborough Hospitals NHS Trust CEC, Szerementa noted that the committee members were a group of people who had an interest in ethics but little in the way of formal ethics training (Szeremeta et al., 2001). Committee membership can often be decided less by qualification than by the goal of having a member 'buy into' the needs for integrity (Emanuel, 2000).

McNeill (2001) expressed a concern that there is a lack of ethical expertise beyond an applied 'on the job' knowledge of ethics in Australian CECs. Similarly, Somerville, maintained merely assuming that people of good intention, acting in good faith are competent committee members was not valid. Particularly if these characteristics were taken to mean that such members are sufficiently educated in ethics (Somerville, 2004). However, for Emanuel, qualifications are acquired 'on the job' by having a critical mass or minimum number of members on the committee who are already well qualified and can set the norms for disclosure and decision making (Emanuel, 2000).

While there is little evidence in the literature of formal requirements for CEC membership, the University of Washington system, for example, requires that CEC members have some knowledge of the application of principles, such as those of autonomy, beneficence, non-maleficence and justice (Peirce, 2004). Currently, in Australia and the U.K. there is no agreement about the required educational training for members of CECs (RCP, 2005).

Hollerman lists a number of qualities which he believes to be necessary for CEC members. These include tolerance of conflict and ambiguity, being articulate and vocal, possessing analytical skills in regard to ethical alternatives, being able to think in a reflective manner, bringing an alternative perspective, and, importantly, having a genuine interest in the issues at hand (Hollerman, 1991).

Since the decision of physicians to use the committee for case consultation will be influenced by their perception of the composition of the committee, physician members should be highly qualified and highly respected members of the medical community (Hollerman, 1991). However, while experts have a role to play, this role is not more important than the roles played by other committee members. For example, a physician will bring medical expertise but not necessarily moral expertise (Peirce, 2004).

The Royal College of Physicians (RCP) recommended that all members of a CEC be provided with training which delivers what is considered 'appropriate' knowledge and skills, and awareness of ethical issues. Further to this, committee members should also have access to ongoing training (RCP, 2005). This report favoured the development of a statement of core competencies required for an effective CEC. This was seen as a way of enabling those establishing new committees to design training and education programs. It would also allow a basis for evaluating CECs and perhaps help in achieving greater consistencies between committees (RCP, 2005).

According to Slowther, in a study of clinical ethics support services in the U.K., most respondents believed some training of CEC members to be desirable. This could be in the form of training in ethical theory or training in the process of ethical deliberation (Slowther & Hope, 2000). For example, the CEC at the James Paget Hospital attended outside educational courses, developed links with a local university and debated local

case studies in order to improve their skills in the analysis and management of ethical issues (Szeremeta et al., 2001).

Others, for example, Loff and Black, believe that a week of intensive training in critical thinking may be of the most value for members of an ethics committee (Loff and Black, 2004), while Slowther maintains that skills in mediation would be an additional requirement to those of ethical analysis (Slowther et al., 2001b).

On the other hand, O'Donnell noted that there may be a danger with training of professionalisation of committee members. An important point made was that the promotion of a culture of ethical thinking which also keeps a diversity of informed opinion is a difficult task (O'Donnell, 2005).

Further, a study of ethics education and value prioritization among members of U.S. hospital ethics committees by Bardon, found no correlation between ethics education and moral decision making. This study found no evidence of any substantial correlation between ethics education- and interest- and value prioritization (Bardon, 2004). However, Bardon's study did find correlations between moral decision making and factors like age and type of institution where the committee operates. This led to the conclusion that further research on the role factors such as age, experience, or other social factors on the behaviour of decision making in a CEC context is required. Bardon also concluded that further studies are required to specifically assess the effects of ethics education on performance in a CEC context (Bardon, 2004).

According to Bardon, the absence of any measured impact of ethics education is consistent with the recent history of studies on the effects of ethics education for healthcare professionals and CEC members (Bardon, 2004). Studies by Gross and Wenger & Lieberman support Bardon's claim that there is no clear evidence of any relationship between ethics education for healthcare professionals and either moral competency , moral development, or projected behaviour in clinical ethics contexts (Bardon, 2004; Gross, 1999; Wenger and Lieberman, 1998).

Bardon posed a further difficult question – 'What is the relationship between ensuring knowledge of moral theory and methods of moral reasoning , on one hand, and ensuring

"appropriate" moral reasoning and advising on the other?'(Bardon, 2004, p396). This question will be addressed by the study in the analysis of the deliberative process of CECs.

Study Findings

In section D., of study instrument questionnaire 1, participants were asked whether they had completed any formal or informal ethics education and, if so, what was the nature of such education.

1. Formal Ethics Education

The study sought to draw some comparisons for formal education in ethics between participants from Australasian and U.K. committees. In addition, comparisons were made between committee chairpersons and other committee members.

a. Country of Origin

Table 4.2. Formal Ethics Education – Country of Origin

			yes	no	total	p
Origin	UK	Count	43	57	100	
	AUS	Count	16	13	29	
Total		Count	59	70	129	.292
		% of Total	46	54	100	

From table 4.2, it can be seen that, overall, 46% of respondents (n=129) indicated that they had completed some form of formal ethics education.

Due to small sample size, a two-sided Fisher's Exact Test (FET) test was used for statistical analysis and p value less than .05 was considered statistically significant. It can be seen from table 4.2, that there was no statistically significant difference for formal education between Australasian and U.K. participants, p = .292 (FET).

b. Committee Membership Status

Table 4.3. Formal Ethics Education – Committee Membership Status

			yes	no	total	p
CEC status	Member	Count	47	62	109	
	Chair	Count	12	8	20	
Total		Count	59	70	129	0.223
		% of Total	46	54	100	

It can be seen from the results presented in table 4.3, that there was no statistically significant difference for formal education between committee chairpersons and other committee members, p = .223 (FET).

Study participants were requested to indicate the nature of any formal ethics education completed. The formats given in this section were; a. degree course or, b. Credit course. The study sought to draw some comparisons for the type of formal education in ethics completed between participants from Australasian and U.K. committees. In addition, comparisons were made between committee chairpersons and other committee members.

Due to the small sample size, a two-sided Fisher's Exact Test (FET) test was used for statistical analysis and p value less than .05 was considered statistically significant. The results are shown in tables 4.4 and 4.5, below.

a. Country of Origin

Table 4.4. Type of Formal Ethics Education Completed – Country of Origin

Type of formal education						
Degree			yes	no	total	p
Origin	UK	Count	19	81	100	
	AUS	Count	9	20	29	
Total		Count	28	100	129	
		% of Total	22	78	100	0.202
Credit Course						
Origin	UK	Count	21	79	100	
	AUS	Count	5	24	29	
Total		Count	26	103	129	0.796
		% of Total	20	80	100	

a. Degree Course

Table 4.4, shows that overall, 22% of study participants (n=129) indicated that they had completed a degree course in ethics. There was no statistically significant difference between Australasian and U.K. participants in this category, p = .202 (FET).

b. Credit Course

Table 4.4, shows that 20% of all study participants (n=129) had completed a credit course in ethics. There was no statistically significant difference between Australasian and U.K. participants in this category, p = .202 (FET).

b. Committee Membership Status

Table 4.5. Type of Formal Ethics Education Completed – Committee Membership Status

Type of formal education						
Degree			yes	no	total	p
CEC status	Member	Count	22	87	109	
	Chair	Count	6	14	20	
Total		Count	28	101	129	0.377
		% of Total	22	78	129	
Credit Course						
CEC status	Member	Count	21	88	109	
	Chair	Count	5	15	20	
Total		Count	26	103	129	0.552
		% of Total	20	80	100%	

It can be seen from the results presented in table 4.5, that there was no statistically significant difference between committee chairpersons and other committee members for either Degree, p = .377 (FET) or for Credit Course, p = .552 (FET).

2. Informal Ethics Education

Study participants were also asked if they had attended any informal ethics training provided in the following formats; a. local conference/ seminar; b. national conference/ seminar; c. hospital in-service; d. correspondence course; e. self-study. Participants were asked to indicate all formats applicable to them. In similar fashion to the above sections regarding formal education, the study sought to draw some comparisons for the type of informal education in ethics completed between participants from Australasian

and U.K. committees. In addition, comparisons were made between committee chairpersons and other committee members.

Once more, due to the small sample size, a two-sided Fisher's Exact Test (FET) test was used for statistical analysis and p value less than .05 was considered statistically significant. The results are shown in tables 4.6 and 4.7, below.

The results obtained are given below,

a. Country of Origin

Table 4.6. Type of Informal Ethics Education Completed – Country of Origin

Type of informal education						
local conference/seminar			yes	no	total	p
Origin	UK	Count	62	38	100	
	AUS	Count	20	9	29	
Total		Count	82	47	129	0.521
		% of Total	64	36	100	
national conference/seminar						
Origin	UK	Count	50	50	100	
	AUS	Count	20	9	29	
Total		Count	70	59	129	0.091
		% of Total	54	46	100	
hospital in-service						
Origin	UK	Count	42	58	100	
	AUS	Count	15	14	29	
Total		Count	57	72	129	
		% of Total	44	56	100	0.399
correspondence course						
Origin	UK	Count	3	97	100	
	AUS	Count	0	29	29	
Total		Count	3	126	129	1.00
		% of Total	2	98	100	
self-study						
Origin	UK	Count	21	8	29	
	AUS	Count	70	30	100	
Total		Count	91	38	129	1.00
		% of Total	70	30	100	

a. Local Conference/ Seminar

Overall, 64% of all study participants (n=129) indicated that they had attended a local conference or seminar on ethics. The study findings revealed that 69% of Australasian participants (n=29) and 62% of U.K. participants (n=100) had attended this format of ethics education. There was no statistically significant difference between Australasian and U.K. participants in this category, p = .521 (FET).

b. National conference/ seminar

Overall, 54% of all respondents (n=129) stated they had attended a national conference or seminar on ethics, with 69% of Australasian respondents (n=29) and 50% of U.K. respondents (n=100) indicating that they had attended such a conference or seminar. There was no statistically significant difference between Australasian and U.K. participants in this category, p = .091 (FET).

c. Hospital in-service training

Hospital in-service training was a mode of informal ethics training for 44% of all participants (n=129), with 52% of Australasian respondents (n=29) and 42% of U.K. respondents (n=100) indicating that they had received such in-service ethics training. There was no statistically significant difference between Australasian and U.K. participants in this category, p = .399 (FET).

d. Correspondence course

Only 2% of all respondents (n=129), 3% of U.K. participants (n=100) and none of the Australasian participants (n=29), indicated that they had undertaken any ethics education by means of a correspondence course. There was no statistically significant difference between Australasian and U.K. participants in this category, p = 1.00 (FET).

e. Self-study

Overall, 70% of study participants (n=129) indicated that they had gained ethics education through informal self-study. Self-study was understood to be private reading. For this mode of informal ethics training, there was an almost identical response from U.K. (70%) and Australasian (71%) committees. There was no statistically significant difference between Australasian and U.K. participants in this category, p = 1.00 (FET).

b. Committee Membership Status

Table 4.7. Type of Informal Ethics Education Completed – Committee Membership Status

Type of informal education						
local conference/seminar			yes	no	Total	p
CEC status	Member	Count	70	39	109	
	Chair	Count	12	8	20	
Total		Count	82	47	129	0.802
		% of Total	64%	36%	100%	
national conference/seminar						
CEC status	Member	Count	53	56	109	
	Chair	Count	17	3	20	
Total		Count	70	59	129	0.003
		% of Total	54%	45%	100%	
hospital in-service						
CEC status	Member	Count	51	58	109	
	Chair	Count	6	14	20	
Total		Count	57	72	129	0.222
		% of Total	44%	56%	100%	
correspondence course						
CEC status	Member	Count	3	106	109	
	Chair	Count	0	20	20	
Total		Count	3	126	129	1.00
		% of Total	2%	98%	100%	
self-study						
CEC status	Member	Count	76	33	109	
	Chair	Count	15	5	20	
Total		Count	91	38	129	0.792
		% of Total	70%	30%	100%	

From the results presented in table 4.7, the only type of informal ethics education which showed a significant statistically significant difference between committee chairpersons and other committee members, was for the attendance at a national conference or seminar, p = .003 (FET). In this instance, 49% of committee members compared with 85% of committee chairpersons indicated they had attended a national conference or seminar. This result is unsurprising, since it could be reasonably expected that

committee chairpersons might represent their committee at such conferences, and also may be more likely to present papers.

4.2.4. Who should be the Chairperson of a Clinical Ethics Committee?

According to Hollerman, the chairperson of a CEC should possess strong leadership qualities and have an interest in bioethical issues (Hollerman, 1991). From a purely pragmatic point of view, it may be desirable to have a senior physician as chairperson. This may especially be the case in the early stages of development of a committee (Slowther and Hope, 2000).

In a 2000 study, by Slowther and Hope, which set out to identify and describe the state of CECs in the U.K., 14 out of 20 committees which took part in the interview study had a senior physician as the chairperson (Slowther and Hope, 2000). However, a problem which may arise if the chairperson is 'too strong a leader' is that others, and more specifically, lay members of the committee may feel pressured to follow the lead of the chair. The decision is then based on one person's, not the group's, judgement. This could lead to premature closure of an issue before all information is considered before reaching a decision (Peirce, 2004).

Study Findings

Chair Occupation

In the study, 15 of the 23 participating committees had a physician as chairperson. Further, 18 of the committees had either a physician or nurse as chairperson and 1 committee had a member of an allied healthcare profession as chairperson. This means that, in the study, only 4 of the participating committees had a chairperson from outwith the medical/ nursing/ allied healthcare professions. These 'other' chairpersons included 2 hospital administrators, 1 lawyer, and 1 academic. Due to the nature and function of CECs, the predominance of physicians as chairpersons is unsurprising.

Chair Experience

The study also sought to determine how long the current committee chairperson in each of the participating committees had been in office. Table 4.8, shows how long the current chairperson has been in office for Australasian and U.K. committees.

Table 4.8. Crosstabulation: Length of Time Current Chairperson has been in Office

		Country of origin						Total		
		UK			AUS					
		Count	% within origin	% of Total	Count	% within origin	% of Total	Count	% within origin	% of Total
How long has current chairperson been in office?	0-6 months	3	17.6	13.0	0	0.0	0.0	3	13.0	13.0
	7-12 months	2	11.8	8.7	1	16.7	4.3	3	13.0	13.0
	25-30 months	4	23.5	17.4	0	0.0	0.0	4	17.4	17.4
	31-36 months	2	11.8	8.7	1	16.7	4.3	3	13.0	13.0
	37-42 months	2	11.8	8.7	1	16.7	4.3	3	13.0	13.0
	43-48 months	1	5.9	4.3	0	0.0	0.0	1	4.3	4.3
	49-54 months	1	5.9	4.3	0	0.0	0.0	1	4.3	4.3
	55+ months	2	11.8	8.7	3	50.0	13.0	5	21.7	21.7
Total		17	100.0	73.9	6	100.0	26.1	23	100.0	100.0

From table 4.8, it can be seen that overall, 6 of the 23 committee chairpersons had held office for over four years, 4 for between three and four years, 7 between two and three years, and 6 for less than one year. Three of the chairpersons of Australasian committees (n=6) had been in office for over four years compared with 3 of the U.K. committee chairpersons (n=17).

In order to determine if there was a statistically significant difference in duration of committee chairperson between participating committees from Australasia and the U.K., a Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The test results are shown in table 4.9.

Table 4.9. Duration in Office of Committee Chairperson

Statement	Country of Origin	N	Median	Mann-Whitney U	p
Duration in office of committee chairperson	Australasia	6	8.5		
	UK	17	5		
	Total	23	6	28.00	0.103

From table 4.9, it can be seen that a Mann-Whitney U test indicated no significant difference in this area between Australasian (Mdn = 8.5) and U.K. (Mdn =5) committees.

4.2.5. Selection Process for Members of a Clinical Ethics Committee

In regard to the question of who selects the committee members, Hollerman found that the members would normally be appointed by the person to whom the committee reports (Hollerman, 1991). This could, however, lead to a legitimate concern, expressed by Leavitt, that committee members could be selected to serve the interests of the hospital management. He cites as an example the pursuit of liberal Do Not Resuscitate (DNR) policies to save resources (Leavitt, 2000). For this reason McNeill maintains that committees need a degree of autonomy from management. This would allow basic questions to be posed concerning the institution and to evaluate freely whether the institution is conducting itself ethically (Mc Neill, 2001).

Self & Skeel, in a 1998 study of clinical ethics committees (CECs), noted that while there appeared to be a variety of ways in which CEC members were selected, most appointments involved a degree of self-selection, or at least a willingness to accept the appointment and function in that capacity. The study considered whether the potential self-selection bias meant that CEC members were different in their moral reasoning skills from their colleagues who did not serve on such committees. The conclusion of the study was that there were significant differences among members and non-members of CECs. It was noted that whether due to the self-selection bias of CEC members, or some other factor, the composition of CECs seems to have a profound effect pulling toward homogeneity of the membership. Self& Skeel state that this may not be a bad thing if it leads to the best ethical thinking in the institution – but given the

contemporary emphasis on cultural diversity in society, they ask if this homogeneity within CECs is appropriate (Self & Skeel, 1998).

Study Findings

Table 4.10. Committee Member Selection

		Who Selects Committee Members				Total
		committee chairperson	hospital board	hospital CEO	other	
Country of origin	UK	9	2	0	6	17
	AUS	0	0	2	4	6
Total		9	2	2	10	23

From table 4.10, it can be seen that overall, in 9 of the participating committees (n=23), members of the committee were selected by the committee chairperson. In comparing Australasian and U.K. committee, whereas 9 committees from the U.K.(n=17) indicated that the committee chairperson selected committee members this was not the case in any of the committees from Australasia (n=6).

It was found that 10 of the committees indicated that members were selected by person(s) other than those listed in the questionnaire. Of this sub-group, 6 committees responded that individual committee members were selected by the committee as a whole. One other committee indicated that professional groups nominated medical, nursing, and allied health representatives, with the committee as a whole inviting lay and specialist members (such as ethicists, lawyers, and pastoral care representatives). One committee responded that the chairperson was selected by the hospital's Chief Medical Officer (CMO), and the other committee members by the committee as a whole. Further responses included one committee indicating that the hospital's Chief Executive Officer (CEO) selected committee members on the recommendation of the committee, one committee indicating that members were selected by a sub-group of the committee, and one committee responding that committee members were selected jointly by the chairperson and the hospital CRO.

The 6 of the 17 U.K. committees that indicated members were chosen by 'other' than articulated in the questionnaire all stated that the committee as a whole selected the members.

In Australasia, the 4 committees that responded members were chosen by 'other' than articulated in the questionnaire indicated that members were chosen jointly by the CEO and the committee chairperson (1 committee); by a sub-group of the committee (1 committee); by the hospital CEO on the recommendation of the committee (1 committee) and; 1 committee indicated that the committee chairperson was chosen by the hospital CEO and the other members by the committee as a whole.

4.3. Length of Time in Existence

Ascertaining the length of time a committee had been existence was seen as a factor in gauging the success of a committee. The fact that a committee had been in existence for a number of years could be interpreted as an indication that the committee had gained acceptance within the hospital community.

Figure 4.2. Length of Time in Existence

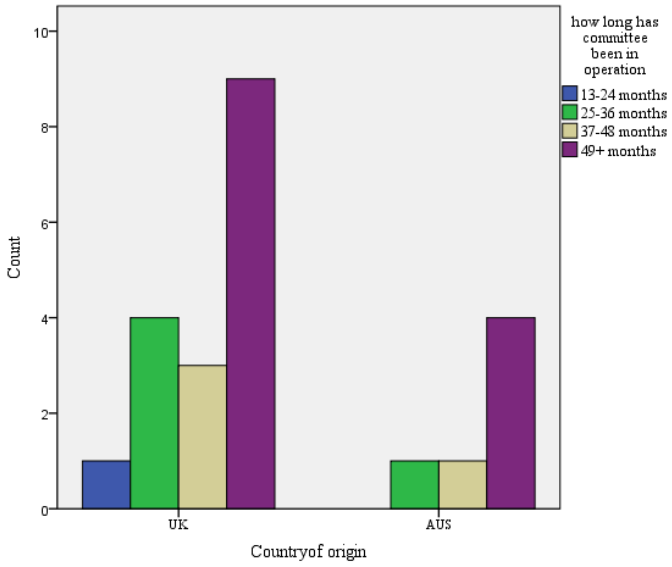


Figure 4.2, shows the length of time that participating committees have been in existence by country of origin. From figure 4.2, it can be seen that overall, 13 of the

committees (n=23) participating in the study had been in existence for over four years, 9 had been in existence for between two and four years, and, 1 had been in existence for less than two years. The comparison of the length of time committees had been in existence between committees from Australasia (n=6) and the U.K. (n=23) showed marked similarities to the overall findings, with the majority of committees having been in existence for over four years (4 of the 6 Australasian committees and 9 of the 17 U.K. committees). One notable difference is that none of the Australasian committees had been in existence for less than two years.

In order to determine if there was a statistically significant difference in the length of time committees have been in existence between participating committees from Australasia and the U.K., a Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The test results are shown in table 4.11.

Table 4.11. Length of Time in Existence

Statement	Country of Origin	N	Median	Mann-Whitney U	p
How long has committee been in operation?	Australasia	6	5		
	UK	17	5		
	Total	23	5	42.500	.507

From table 4.11, it can be seen that a Mann-Whitney U test indicated no significant difference between Australasian (Mdn = 5) and U.K. (Mdn =5) committees, for length of time in existence.

4.4. Meetings Scheduled

Determining the number of meetings scheduled by each committee over a twelve month period (2006) was included as one measure to indicate of the level of committee activity. The purpose of this measure was to investigate whether less active committees were perceived to be as successful as their more active counterparts. This question will be dealt with in the section relating to the evaluation of committees.

Figure 4.3. Meetings Scheduled for 2006

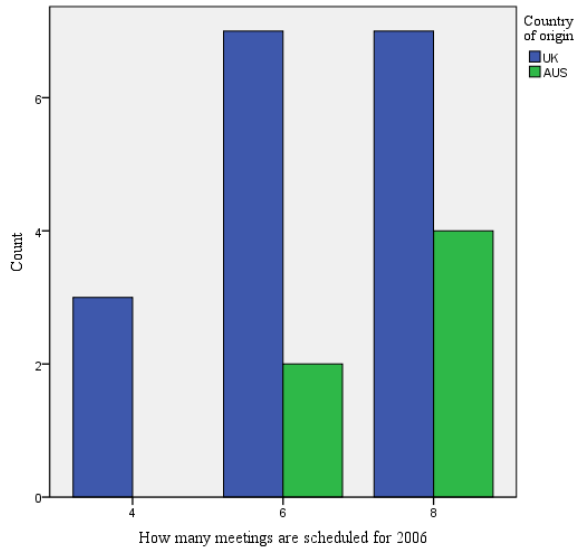


Figure 4.3, shows the number of meetings scheduled by participating committees for 2006. The results show that, overall, 3 of the 23 committees had scheduled a meeting every quarter i.e. four meetings for 2006, 9 of the committees had scheduled 6 meetings for the period, and, 11 had scheduled more than 8 meetings for 2006. A comparison of the number of meetings scheduled by committees from Australasia (n=6) with those from the U.K. (n=17) revealed that while 3 of the committees from the U.K had scheduled quarterly meetings, none of the Australasian committees had scheduled less than 6 meetings for the twelve month period. It was also noted that, while in the U.K. 7 committees had scheduled more than 8 meetings for the year and 7 committees had scheduled 6 meetings for the year, the majority of Australasian committees (4 out of 6) had scheduled more than 8 meetings for 2006.

In order to determine if there was a statistically significant difference in the number of meetings scheduled between participating committees from Australasia and the U.K., a Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The test results are shown in table 4.12.

Table 4.12. Meetings Scheduled for 2006

Statement	Country of Origin	N	Median	Mann-Whitney U	p
How many committee meetings are scheduled for 2006?	Australasia	6	8		
	UK	17	6		.219
	Total	23	6	35.00	

From table 4.12, it can be seen that a Mann-Whitney U test indicated no significant difference between Australasian (Mdn = 8) and U.K. (Mdn =6) committees, for the number of meetings scheduled for 2006. It may be noted that the median value was greater for Australasian committees.

4.5. Administrative Support

Table 4.13. Administrative Support

			yes	no	total	p
Origin	UK	Count	14	3	17	
	AUS	Count	5	1	6	
Total		Count	19	4	23	1.00
		% of Total	83%	17%	100%	

Table 4.13, shows that 19 of the 23 participating committees (83%) indicated that they received administrative support from their hospital. Comparison between Australasian (n=6) and U.K. committees (n=17) showed an almost identical incidence of committees receiving such support i.e. 14 (82%) of U.K. committees and 5 (83%) of Australasian committees.

Due to the small sample size, a two-sided Fisher's Exact Test (FET) test was used for statistical analysis and p value less than .05 was considered statistically significant. It can be seen from table 4.13, that there was no statistically significant difference for administrative support between Australasian and U.K. committees, p = 1.00 (FET).

4.6. Funding

The study also sought to identify areas where participating committees received funding from their hospital. The main areas of funding were found to be; funding for education; funding for administration, and; funding for an ethicist. The study results are presented in table 4.14. Once again, due to the small sample size, a two-sided Fisher's Exact Test (FET) test was used for statistical analysis and p value less than .05 was considered statistically significant.

Table 4.14. Type of Administrative Support

Type of Funding						
Education			yes	no	Total	p
Origin	UK	Count	10	7	17	
	AUS	Count	1	5	6	
Total		Count	11	12	23	.155
		% of Total	48	52	100	
Ethicist						
Origin	UK	Count	1	16	17	
	AUS	Count	2	4	6	
Total		Count	3	20	23	.155
		% of Total	13	87	100	
Administration						
Origin	UK	Count	11	6	17	
	AUS	Count	3	3	6	
Total		Count	14	9	23	.643
		% of Total	61	39	100	

From table 4.14, it can be seen that 14 of the 23 committees indicated that they received funding for administration. For both committees from the U.K., (11 out of 17) and from Australasia (3 out of 6) this was the main area for which funding was provided. There was no statistically significant difference for funding for administration between Australasian and U.K. committees, p = .643(FET).

11 of the committees participating in the study (n=23) indicated that they received funding from their hospital for education. There was no statistically significant

difference in funding for education between Australasian and U.K. committees, p = 0.155(FET).

Regarding funding for an ethicist, overall 3 of the 23 committees responded that they received such funding. There was no statistically significant difference for funding for an ethicist between Australasian and U.K. committees, p = .155 (FET).

One committee from the U.K. specified that no funding was made available to it for membership of the U.K. Clinical Ethics Network (UKCEN). The UKCEN was established in January 2001 to provide support for the growing number of clinical ethics committees and groups that were developing in National Health Service Trusts and some private hospitals in the U.K. The Network is made up of members of clinical ethics committees and clinical ethics groups, and individuals with an interest in clinical ethics.

The importance of whether a committee receives funding and/or administrative support is, along similar lines to those noted by McNeill (2001) regarding who selects committee members, such that committees need a degree of autonomy from management to allow fundamental questions to be posed concerning the institution.

4.7. Chapter Summary

Following an introduction which identified the structural questions being considered in the literature concerning the characteristics that might support the production of a useful CEC, and those which might impair a committee's functioning, the findings obtained by the study were presented. These findings aimed to produce a description of structural features of participating CECs from Australasia and the U.K., and where appropriate highlight key differences in committee structure between CECs from Australasia and CECs from the U.K.

The main study findings from this section of the study regarding CEC structure are summarised below.

Committee Size. There was no statistically significant difference found between participating committees from Australasia and the U.K. in terms of committee size.

Committee Composition. A statistically significant difference between Australasian and U.K. committees was found for the number of Provider/ Medical staff, and for the number of Nursing staff. In each case the median values being greater for U.K. committees. In addition, a significant difference between Australasian and U.K. committees was found for the number of members from Social Services. In this case, the median value was greater for Australasian committees.

Committee Member Qualifications. 46% of respondents (n=129) indicated that they had completed some form of formal ethics education. There was no statistically significant difference for formal education between Australasian and U.K. participants. Similarly, there was no statistically significant difference found between Australasian and U.K. participants for types informal education undertaken. However, a statistically significant difference was found between committee chairpersons and other committee members for the attendance at a national conference or seminar.

Committee Chairperson. It was found that 15 of the 23 participating CECs had a physician as chairperson. Further, 18 of the committees had either a physician or nurse as chairperson. In terms of chairperson experience, there was no statistically significant difference found between Australasian and U.K. committees for the duration in office of the committee chairperson.

Length of Time in Existence. No statistically significant difference was found for length of time in existence between Australasian and U.K. CECs. 13 of the participating committees (n=23) had been in existence for over four years.

It was also found that for the categories of number of meetings scheduled, administrative support, and committee funding, there was no statistically significant difference between Australasian and U.K. CECs.

Structural questions are important as they concern ideas that may be possible sources of shortcomings for committee decisions/outcomes. By addressing such issues, it is hoped

that it might be possible to shed light on which characteristics are desirable for optimum committee functioning.

In conjunction with the findings obtained from the study regarding the functions, deliberative processes, and evaluation of CECs, the results obtained from this section, regarding the structure of CECs may enhance our understanding of the processes by which CECs arrive at their outcomes.

Chapter 5

Clinical Ethics Committee Functions

5.1. Introduction

'A clinical ethics committee's (CEC) work should be closely allied to, and justified by, the mission of the institution it serves' (Ross, 2000, p5). Therefore CECs should pose fundamental questions in relation to the ethical norms of the services their institution provides (Campbell, 2001).

To be effective, a CEC should be able to provide support to health professionals who are involved with difficult ethical issues. Many ethical issues which arise in healthcare institutions are more likely to be concerned with normative choices than with the science of healthcare (Peirce, 2004). A CEC should also be seen to provide such support. A CEC may be seen as aiding the establishment and communication of values and may also be seen to be instrumental in articulating the boundaries of conduct which are perceived to determine the 'moral character' of the institution (Gillon, 1997; Harding, 1994).

Since the patient-physician relationship is at the core of high quality healthcare, healthcare institutions must strive to preserve this relationship. However, in doing so, the institution has to also ensure that the interests of all other stakeholders are not compromised (Rorty et al., 2004).

The fundamental importance of healthcare in contemporary society means that there is a need to extend compliance 'beyond the lowest common denominator of regulatory compliance'(Batts, 1998, p39). This also has the effect of reducing the possibility of audit, investigation or litigation (Batts, 1998; Gillon, 1997).

An important point, made by Raven, is that 'even the most ethical practitioner will struggle to make good health care ethics decisions in the corrupt or unethical organization'(Raven, 2002, p7).

A central goal for a CEC would be to establish what the RCP Report calls an 'organizational ethics memory'. This would be achieved by ensuring consistency in decision-making (RCP, 2005).

There is some debate about where a CEC should be located within an institution. On one hand, it may be advantageous for a CEC to be located within the governance structure of the organization, since this would allow for greater potential to influence practice, and to have better access to resources. On the other hand, being located outside of the formal governance structure might allow greater degree of independence and transparency in committee deliberations, and provide a forum for discussion seen to be outside of the management structure (RCP, 2005).

There is widespread consensus in the literature concerning CECs, both in the U.S.A and elsewhere that the main functions of a CEC are-

1. Policy & Guideline development/review

2. Education

3. Case consultation

(Adams, 1997; Csikai, 1995; Cushman, 1990; Dobbs, 2000; Gill et al., 2004; Guo and Schick, 2003; McGee et al., 2002; Peirce, 2004; Ross, 2000; Rudd, 2002; Slowther et al., 2004; Szeremeta et al., 2001)

4. In addition to the above articulated functions, a number of 'other' functions can be identified. In particular, a function of a CEC worthy of consideration is that of resource allocation. However there are very few reports of instances where a CEC has developed or advised on policies for resource allocation decisions (Slowther and Hope, 2002).

The study undertook to identify and describe the activities of participating committees. In addition to investigating the activities of committees, the study also undertook to gather information on individual committee members' views regarding how successful they believed their committee to be regarding its activities. By adopting this approach it

is hoped that it may be possible to highlight areas where committees might be lacking in the performance of their activities and, provide some recommendations as to how committee performance might be improved in these areas.

A discussion on these activities, along with the findings of the study, is now presented.

5.2. Policies and Guidelines

5.2.1. Introduction

'Bioethics policies document an organisation's values'(Harding, 1994, p2).

According to Rorty (2000), institutional guidelines and policies provide means to achieving the goals of the institution. An organization's moral integrity is in evidence in its policies and practices. In other words, it transcends individuals' moral agency (Giganti, 2004).

A number of authors have described that Clinical Ethics Committees (CECs) develop institutional policies on a variety of issues. For example, do not resuscitate orders (DNR), informed consent, refusal of lifesaving / sustaining treatment, disclosure of medical errors, and rights and duties of relatives (Gillon, 1997; Harding, 1994; Slowther et al., 2001b).

A more controversial role for a CEC might be in quality assurance, assessing compliance with established institutional policies and guidelines, particularly if this entails designing corrective procedures in cases of noncompliance (Harding, 1994).

Slowther et al considered that a CEC's role in policy development should include the identification of areas of concern and then input into the development of any policies or guidelines deemed necessary. They should also consider existing policies and be able to advise on ethical issues that may arise from them. Issues arising from retrospective case discussion may also highlight areas where there might be a need for the development of policy/ guidelines (Slowther et al., 2001b).

It has been suggested that contact between CECs is important in order to avoid 'reinventing the wheel' (Slowther et al., 2001b). This raises the issue of the possibility of a national set of guidelines for CECs which will be discussed under evaluation.

Rigorous evaluation of both process and outcome is required during policy development (Slowther et al., 2001b).

According to Doyal, the success of a CEC in formulating local policy is dependent on several key factors. These include the extent to which clinical staff actually implements the policies – this can be seen as a key indicator for measuring the success of a CEC. Doyal also believes that there have to be supportive institutional structures and mechanisms for monitoring the degree to which staff conform to the published policies. Otherwise the success of the CEC's work it is impossible to judge (Doyal, 2001).

5.2.2. Study Findings

Participating CECs were asked, in Questionnaire 2, to indicate whether they undertook Policy and Guidelines development /review. Questionnaire 2 was completed by the Chairperson (or other nominated individual) of each committee, and, wherever reference is made to views of the Committee this should be understood to refer to the views presented by the Chairperson (or other nominated individual). Due to the small sample size, a two-sided Fisher's Exact Test (FET) test was used for statistical analysis and p value less than .05 was considered statistically significant.

The results regarding CEC participation in Policy and Guidelines development/ review are shown in table 5.1, below.

Table 5.1 Committee Activities - Policy/ Guidelines

			Policy/guidelines		Total	p
			yes	no		
Origin	UK	Count	16	1	17	
	AUS	Count	6	0	6	
Total		Count	22	1	23	1.00
		% of Total	96	4	100	

From table 5.1, it can be seen that only one of the committees participating in the study indicated they did not undertake Policy and Guidelines development/ review. It can be seen from table 5.1, that there was no statistically significant difference between Australasian and U.K. committees for participation in undertaking Policy and Guidelines development/ review , p = 1.00 (FET).

The study gathered information on:

1. The issues discussed by committees on policies and guidelines

2. The amount of time spent by committees dealing with policy and guideline issues

3. The viewpoint of individual committee members participating in the study regarding how successful their committees are in dealing with policy and guideline matters.

The study findings are given below:

5.2.2.1. Issues Discussed

Participating committees were asked, in questionnaire 2, to indicate issues that their committee had discussed regarding hospital policy/ guidelines. These issues are listed below.

a. Brain death, b. DNR orders, c. Commercial use of tissue, d. Withdrawal of care, e. Consent, f. Elective ventilation, g. Advance directives, h. Confidentiality, i. Rights of relatives, j. Consent for DNA testing, k. Possession of illicit drugs, l. Other issues.

The study results regarding issues discussed by participating CECs are given as follows.

a. Brain Death

			Brain death		Total	p
			yes	no		
Origin	UK	Count	1	16	17	
	AUS	Count	3	3	6	
Total		Count	4	19	23	.04
		% of Total	17	83	100	

The above table shows that 17% of all participating CECs had discussed issues surrounding Brain death. Statistical analysis confirmed a significant difference between UK and Australasian CECs (p = .04, FET), with 1 of 17 UK committees compared with 3 of 6 Australasian committees indicating they had discussed issues concerning Brain death.

b. DNR Orders

			DNR orders		Total	p
			yes	no		
Origin	UK	Count	12	5	17	
	AUS	Count	3	3	6	
Total		Count	15	8	23	.621
		% of Total	65	35	100	

Regarding the discussion of issues concerning DNR orders, there was no significant difference between UK and Australasian committees (p = .621, FET). It can be seen from the above table that 65% of CECs had discussed Policy issues concerning DNR orders.

c. Commercial Use of Tissue

			Commercial use of tissue		Total	p
			yes	no		
Origin	UK	Count	2	15	17	
	AUS	Count	1	5	6	
Total		Count	3	20	23	1.00
		% of Total	13	87	100	

87% of CECs indicated that they had not discussed issues relating to the Commercial use of tissue. There was no statistically significant difference between UK and Australasian committees for this issue (p = 1.00, FET).

d. Withdrawal of Care

			Withdrawal of care		Total	p
			yes	no		
Origin	UK	Count	9	8	17	
	AUS	Count	4	2	6	
Total		Count	13	10	23	.66
		% of Total	56	44	100	

57% of CECs indicated they had discussed matters concerning withdrawal of care. There was no statistically significant difference between UK and Australasian committees for this issue (p = .66, FET).

e. Consent

			Consent		Total	p
			yes	no		
Origin	UK	Count	11	6	17	
	AUS	Count	6	0	6	
Total		Count	17	6	23	.144
		% of Total	74	26	100	

74% of participating CECs indicated they had discussed issues concerning consent.
There was no statistically significant difference between UK and Australasian committees for this issue (p = .144, FET).

f. Elective Ventilation

			Elective ventilation		Total	p
			yes	no		
Origin	UK	Count	2	15	17	
	AUS	Count	0	6	6	
Total		Count	2	21	23	1.00
		% of Total	9	91	100	

9% of participating committees had discussed issues concerning elective ventilation, indicating that this issue. There was no statistically significant difference between UK and Australasian committees for this issue (p = 1.00, FET).

g. Advance Directives

			Advance directives		Total	p
			yes	no		
Origin	UK	Count	10	7	17	
	AUS	Count	3	3	6	
Total		Count	13	10	23	1.00
		% of Total	56	44	100	

56% of committees indicated they had discussed issues concerning advance directives. There was no statistically significant difference between UK and Australasian committees for this issue (p = 1.00, FET).

h. Confidentiality

			Confidentiality		Total	p
			yes	no		
Origin	UK	Count	7	10	17	
	AUS	Count	4	2	6	
Total		Count	11	12	23	.371
		% of Total	48	52	100	

Almost one-half of participating committees (48%) indicated they had discussed issues concerning confidentiality. There was no statistically significant difference between UK and Australasian committees for this issue (p = .371, FET).

i. Rights of Relatives

			Rights of relatives		Total	p
			yes	no		
Origin	UK	Count	4	13	17	
	AUS	Count	2	4	6	
Total		Count	6	17	23	.632
		% of Total	26	74	100	

Around one-quarter (26%) of CECs indicated they had discussed issues regarding the rights of relatives. There was no statistically significant difference between UK and Australasian committees for this issue (p = .632, FET).

j. Consent for DNA Testing

			Consent for DNA testing		Total	p
			yes	no		
Origin	UK	Count	1	16	17	
	AUS	Count	3	3	6	
Total		Count	4	19	23	.04
		% of Total	17	83	100	

83% of all participating CECs indicated they had not discussed issues surrounding consent for DNA testing. However, in this regard, there was a significant difference between UK and Australasian committees (p = 0.04, FET), with 3 of the 6 Australasian committees compared with 1 of the 17 UK committees indicating they had discussed issues concerning consent for DNA testing.

k. Possession of Illicit Drugs

			Possession of illicit drugs		Total	p
			yes	no		
Origin	UK	Count	0	17	17	
	AUS	Count	1	5	6	
Total		Count	1	22	23	.262
		% of Total	4	96	100	

The large majority of participating committees indicated they had not discussed issues concerning the possession of illicit drugs. There was no statistically significant difference between UK and Australasian committees for this issue (p = .262, FET).

l. Other Issues

			Other issues		Total	p
			yes	no		
Origin	UK	Count	6	11	17	
	AUS	Count	3	3	6	
Total		Count	9	14	23	.643
		% of Total	39	61	100	

39% of committees indicated they had discussed issues of policy and guidelines, other than those described above. There was no statistically significant difference between UK and Australasian committees for this issue (p = .643, FET).

The 'other' issues included; flu pandemic; hydration and nutrition at end of life; restraint; organ donation after death; rights of children; and PEG feeding.

From the results given above, it can be seen that the policy/ guideline issues most discussed by committees participating in the study were Consent (74%), DNR orders (65%) and Advance directives (56%). In each of these cases, statistical analysis using Fisher's exact test, showed no significant difference between UK and Australasian committees.

For two of the issues discussed by CECs i.e. brain death, and, consent for DNA testing, there was a statistically significant difference between UK and Australasian committees. In each of these cases, a greater proportion of Australasian CECs had discussed these issues.

5.2.2.2. Time spent on Policy Issues

In addition to identifying the policy/ guidelines issues that the clinical ethics committees participating in the study had been discussing, responding committees were asked, in questionnaire 2, to estimate the proportion of time that they had spent dealing with such policy issues. The question regarding time spent dealing with policy issues was divided into a. time spent dealing with policy review or revision and, b. time spent dealing with policy development.

a. Policy Review/ Revision.

CECs were asked to indicate how much of their time was spent on conducting review or revision of policies/ guidelines. The responses given are summarised in table 5.2, below.

Table 5.2. Time Spent on Policy Review/Revision

			Time spent on policy review/ revision				Total
			none	little	some	most	
Origin	UK	Count	1	4	10	2	17
	AUS	Count	0	2	3	1	6
Total		Count	1	6	13	3	23
		% of Total	4	26	57	13	100

It can be seen from table 5.2, that only one of the CECs participating in the study indicated that it did not spend any time on policy review/ revision, while 57% of participating CECs indicated that they spent 'some' time on policy review/ revision.

b. Policy Development

CECs were asked to indicate how much of their time was spent on policy/ guidelines development. The responses given are summarised in table 5.3, below.

Table 5.3. Time Spent on Policy Development

			Time spent on policy development				Total
			none	little	some	most	
Origin	UK	Count		3	9	0	15
	AUS	Count	1	2	1	1	5
Total		Count	4	5	10	1	20
		% of Total	20	25	50	5	100

Table 5.3, shows that 50% of participating committees spent 'some' time on policy development.

In order to determine if there is a significant difference between UK and Australasian CECs in regard to time spent on policy/ guidelines issues, non-parametric statistical analysis was undertaken. The results are given in tables 5.4, below.

Table 5.4. Analysis of Time Spent on Policy Development/ Review

Statement	Country of Origin	N	Median	Mann-Whitney U	p	r
Time spent on policy review/revision	Australasia	17	3			
	UK	6	3			
	Total	23	3	50.000	.938	.16
Time spent on policy development	Australasia	15	2			
	UK	5	3			
	Total	20	3	36.000	.887	.03

From table 5.4, it can be seen that a Mann-Whitney U test indicated no significant difference between Australasian (Mdn = 3) and U.K. (Mdn =3) committees, U= 50.00, p = .938, r = .16, for time spent on policy review/ revision. Similarly, for time spent on policy development, a Mann-Whitney U test indicated no significant difference between Australasian (Mdn = 2) and U.K. (Mdn =3) committees, U= 36.00, p = .887.

It can be noted from table 5.4, that the median was greater for U.K committees (Mdn = 3) compared with Australasian committees (Mdn = 2), indicating U.K. committees spent more time on policy development than did Australasian committees.

5.2.2.3. Committee Member Viewpoint

One of the study instruments, Questionnaire 1, was designed to gather information on individual committee members' perceptions of the success of their committee regarding its activities concerning policies and guidelines.

Participants were requested to respond, using a 7-point Likert Scale, to a number of statements concerning their committee's handling of issues regarding policies and guidelines.

Analysis for this section was undertaken to determine whether there was any statistically significant difference between responses for participants from Australasian and UK CECs. In addition, analysis of responses from CEC chairpersons and committee members was undertaken to investigate any differences between these groups of study participants.

1. Country of Origin

Table 5.5. Committee Member Viewpoint: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Our CEC adequately deals with policy review	Australasia	28	6	82.84			
	UK	97	5	57.27			
	Total	125	5		802.50	.001	.30
Our CEC adequately identifies areas policy required	Australasia	28	6	77.25			
	UK	97	5	58.89			
	Total	125	5		959.00	.015	.21
Our CEC's current policy consistent with hospital mission	Australasia	28	6	78.63			
	UK	88	5	52.10			
	Total	116	6		668.50	.000	.34
Policy developments are made in consultation with affected stakeholders	Australasia	28	5	73.77			
	UK	90	4	55.06			
	Total	118	4.5		860.50	.010	.24
Policy revisions are made in consultation with affected stakeholders	Australasia	28	5.5	74.14			
	UK	91	5	55.65			
	Total	119	5		878.00	.011	.24
Our CEC effectively communicates information on policy to stakeholders	Australasia	28	5.5	74.30			
	UK	91	4	55.60			
	Total	119	4		873.50	.011	.23
Our CEC assesses the impact of revised policy	Australasia	27	5	75.78			
	UK	92	3	55.37			
	Total	119	4		816.00	.006	.25

Table 5.5, shows there to be a significant difference between Australasian and U.K. participants for each of the statements. For each statement, the median value shows Australasian respondents having greater agreement than their U.K. counterparts.

Table 5.6 below, summarises the median values for each of the statements in this section pertaining to policy and guidelines.

Table 5.6. Policy/ Guidelines Median Values

Statement	n	Median
Our CECs current policy consistent with hospital mission	116	6
Our CEC adequately deals with policy review	125	5
Our CEC adequately identifies areas policy required	125	5
Policy revisions are made in consultation with affected stakeholders	119	5
Policy developments are made in consultation with affected stakeholders	118	4.5
Our CEC effectively communicates information on policy to stakeholders	119	4
Our committee assesses the impact of revised policies/ guidelines	119	4

It can be seen from table 5.6, that the statement 'Our CEC's current bioethical policies/ guidelines are consistent with our hospital's mission.' had the highest median (Mdn= 6), indicating this statement had the strongest level of agreement for participants regarding Policy and guidelines.

The statements 'Our committee assesses the impact of revised policies/ guidelines' and, 'Our CEC effectively communicates information on policy to stakeholders', were the statements with the weakest level of agreement for participants. For each of these statements the median value was 4. The relevance of this finding will be discussed in the formulation of guidelines for CECs in chapter 8.

In addition to the above analysis, descriptive statistics for the statements in this section are presented below.

a. Our ethics committee adequately deals with revising/ reviewing hospital bioethical policies/ guidelines.

In response to the above statement, 72% of all participants in the study (n=125) agreed that their committee adequately dealt with the revision/ reviewing of such hospital policies/ guidelines. A further 17% of participants stated that they neither agreed nor disagreed with the statement or that the statement was not applicable. Therefore, 11% of the study participants believed that their committee did not

adequately deal with the revision/ reviewing of hospital bioethical policies/ guidelines.

b. Our ethics committee adequately deals with identifying areas where bioethical policies or guidelines are required.

Overall, 71% of respondents (n=125) agreed that their committee adequately dealt with identifying areas where bioethical policies or guidelines were required. In this area, 14% of respondents indicated that they neither agreed nor disagreed with the statement or that the statement was not applicable. This meant that 15% of respondents believed that their committee did not adequately identify areas where bioethical policies or guidelines were required.

c. Current bioethical policies/ guidelines are consistent with our hospital's mission.

Overall, 71% of all study participants (n=126) agreed that current bioethical policies and guidelines were consistent with their hospital's mission. A further 18% of the participants neither agreed nor disagreed with the statement or indicated that it was not applicable to them. This meant that 11% of the participants in the study disagreed that current bioethical policies and guidelines were consistent with their hospital's mission.

d. There is sufficient consultation with affected stakeholder groups when developing bioethical policies or guidelines.

Overall, 47% of the study participants (n=126) agreed that there was sufficient consultation with affected stakeholder groups when developing bioethical policies or guidelines for their hospital. In this area, 25% of participants indicated that they neither agreed nor disagreed with the statement or indicated that the statement was not applicable. Therefore, 28% of the participants did not believe that there was sufficient consultation with affected stakeholder groups when developing bioethical policies or guidelines.

e. Revisions to bioethical policies/ guidelines are made in consultation with affected stakeholder groups.

Overall, 57% of the study participants (n=127) agreed that revisions to bioethical policies and guidelines were made in consultation with affected stakeholder groups. After accounting for the 19% of participants who neither agreed nor disagreed with the statement or indicated that it was not applicable, this resulted in the finding that 24% of participants disagreed with the above statement relating to revision of bioethical policies/ guidelines.

f. Our committee effectively communicates information on bioethical policies and guidelines to members of the hospital community.

Overall, 46% of all study participants (n=127) agreed that their committee effectively communicated information on bioethical policies and guidelines to members of their hospital community. Almost one-quarter (23%) of participants responded that they neither agreed nor disagreed with the statement or that the statement was not applicable to them. This meant that 31% of participants disagreed that there was effective communication of information on bioethical policies/ guidelines to the hospital community.

g. Our committee assesses the impact of revised policies/ guidelines

Overall, 31% of participants (n=127) agreed that their committee assessed the impact of revised policies/ guidelines. For this statement, 22% of participants indicated that they neither agreed nor disagreed with the statement or that the statement was not applicable to them. Therefore, 47% of participants disagreed that their committee assessed the impact of revised policies and guidelines.

2. Committee Membership Status

Table 5.7. Committee Member Viewpoint: Committee Membership Status

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Our CEC adequately deals with policy review	Member	106	5	62.40			
	Chair	19	6	66.37			
	Total	125	5		943.000	.652	.04
Our CEC adequately identifies areas policy required	Member	106	5	62.42			
	Chair	19	5	66.24			.03
	Total	125	5		945.500	.663	
Our CEC's current policy consistent with hospital mission	Member	97	6	58.04			
	Chair	19	6	60.84			
	Total	116	6		877.000	.732	.03
Policy developments are made in consultation with affected stakeholders	Member	99	4	58.87			
	Chair	19	5	62.76			
	Total	118	4.5		878.500	.645	.04
Policy revisions are made in consultation with affected stakeholders	Member	102	5	59.73			
	Chair	17	5	61.62			
	Total	119	5		839.500	.831	.02
Our CEC effectively communicates information on policy to stakeholders	Member	100	4	59.80			
	Chair	19	5	61.08			
	Total	119	4		929.500	.880	.01
Our CEC assesses the impact of revised policy	Member	100	4	60.73			
	Chair	19	3	56.16			
	Total	119	4		877.000	.592	.05

Table 5.7, shows that, in contrast with the results obtained for participants by country of origin, where there was a statistically significant difference for each of the statements on policy/ guidelines, the responses by committee membership status did not show any statistically significant difference for any of the statements.

The study also undertook to investigate whether there was an association between the chairperson's assessment of the time spent on dealing with policy issues and individual member's views that they adequately deal with policy issues.

In order to analyse this type of association, cross tabulations were constructed for, Time spent on review of policies / individual member's views on whether their committee

adequately deals with reviewing policies, and Time spent on policy development / individual member's views on whether their committee adequately identifies areas where policies are required to be developed. The findings for these two areas are presented in tables 5.8 and 5.9.

Table 5.8. Time Spent on Policy Review / Member Viewpoint on Reviewing Policies

	Our ethics committee adequately deals with reviewing hospital bioethical policies				
Time spent on review of policies	Disagree	Neither Agree nor Disagree	Agree	Total	% Agree
Little (n=6)	8	6	15	29	51.7%
Some (n=13)	8	10	55	73	75.3%
Most (n=3)	0	0	19	19	100.0%

Table 5.8, shows that all of the members (19) of the committees which indicated they spent most of their time on reviewing policies agreed that their committee adequately performed this function. This compared with 52% of members of committees which indicated they spent little time on reviewing policies.

Table 5.9. Time Spent on Policy Development / Member Viewpoint on Policy Development

	Our ethics committee adequately deals with identifying areas where bioethical policies are required to be developed				
Time spent on policy development	Disagree	Neither Agree nor Disagree	Agree	Total	% Agree
Little (n=5)	7	2	15	24	62.5%
Some (n=10)	12	5	42	59	71.2%
Most (n=1)	0	1	5	6	83.3%

Table 5.9, shows that 5 of the 6 members (83%) of the committee which indicated that it spent most of its time on developing policies agreed that their committee adequately performed this function. This compared with 62% of members of committees which indicated they spent little time on developing policies.

The findings from tables 5.8 and 5.9 show that the more time that committees spent on aspects relating to policy issues, the greater was the level agreement from individual members that the committee adequately dealt with those issues.

5.3. Education

5.3.1. Introduction

In the 1980's education was seen as being the main function of a clinical ethics committee (CEC). The belief was that members of a CEC, by being knowledgeable about the mechanics of ethical decision-making, would be able to act as bioethics consultants (Harding, 1994). The committee was therefore seen as a mechanism which could convey information from the world of bioethics to healthcare professionals and other stakeholders (Ross, 2000). Further, education was believed to be instrumental in altering practice and this was considered as being vital in the shaping of the culture of an institution (Ross, 2000; Wildes, 1997).

More recently, Slowther et al (2001) considered education as an important means of raising the profile of a CEC within an institution. This could be accomplished by initiatives such as seminars, workshops on specific issues or individual committee members teaching specific groups (Slowther et al., 2001b).

One important criticism which may be leveled at a CEC in regard to education is articulated by Slowther et al (2002, p7) as 'how can CEC members, who may have little or no formal education in ethics, provide credible education for healthcare practitioners within their hospital?' Slowther et al consider that a formal education in ethics is not a necessary condition of wisdom in practical clinical ethics. They maintain that experience also counts –' perhaps it counts for more'(Slowther et al., 2002, p8).

5.3.2. Study Findings

The study was designed to gather information on 1. The recipients of committee educational offerings; 2. The amount of time spent by committees on providing education activities; 3. The viewpoint of individual committee members participating in the study regarding how successful they believed their committees to be in providing education, and; 4. Factors contributing to success of the committee in providing education.

The study findings are given below:

5.3.2.1. Recipients of Educational Offerings

Participating CECs were asked, in survey instrument 2, to indicate who the recipients of committee educational offerings were. The subdivisions made were; a. committee member education; b. hospital staff education and; c. community education.

Questionnaire 2 was completed by the Chairperson (or other nominated individual) of each committee, and, wherever reference is made to views of the Committee this should be understood to refer to the views presented by the Chairperson (or other nominated individual). Due to the small sample size, a two-sided Fisher's Exact Test (FET) test was used for statistical analysis and p value less than .05 was considered statistically significant.

The results regarding the recipients of committee educational offerings are shown below.

a. Education for Committee Members

Table 5.10. Education for Committee Members

			Does your committee provide education for committee members?		Total	p
			yes	no		
Origin	UK	Count	14	2	16	
	AUS	Count	5	1	6	
Total		Count	14	3	22	1.00
		% of Total	86	114	100	

From table 5.10, it can be seen that 86% of participating committees indicated that they provided education for their members. Statistical analysis (two-sided Fisher's exact test, FET) showed there was no statistically significant difference between UK and Australasian committees (p=1.00, FET).

b. Education for Hospital Staff

Table 5.11. Education for Hospital Staff

			Does your committee provide education for hospital staff?		Total	p
			yes	no		
Origin	UK	Count	13	3	16	
	AUS	Count	6	0	6	
Total		Count	19	3	22	0.532
		% of Total	86	14	100	

From table 5.11, it can be seen that 86% of participating committees indicated that they provided education for the hospital staff. There was no statistically significant difference between UK and Australasian committees (p=0.532, FET).

c. Education for the General Community

Table 5.12. Education for the General Community

			Does your committee provide education for the general community?		Total	p
			yes	no		
Origin	UK	Count	4	12	16	
	AUS	Count	1	5	6	
Total		Count	5	17	22	1.00
		% of Total	23	77	100	

From table 5.12, it can be seen that 23% of participating committees indicated that they provided education for the general community. There was no statistically significant difference between UK and Australasian committees (p=1.00, FET).

5.3.2.2. Time spent on Education

In addition to identifying the areas in which participating committees had provided educational activities, the study also sought to provide an estimate of the time each committee had spent on providing such educational activities. The areas investigated in the study were time spent by committees on; a. education for committee members; b. education for the hospital community and: c. education for the general community.

a. Time spent on Education for Committee Members

Table 5.13, shows the amount of time spent by committees in the provision of bioethics education for their committee members.

Table 5.13. Time Spent on Education for Committee Members

			Time spent on education for CEC members				Total
			none	little	some	most	
Origin	UK	Count	1	7	7	2	17
	AUS	Count	0	3	3	0	6
Total		Count	1	10	10	2	23
		% of Total	4	43.5	43.5	9	100

It can be noted that 87% of participating CECs indicated that they spent ‘little’ or ‘some’ time in the provision of education for their members.

b. Time spent on Education for the Hospital Community

Table 5.14, shows the amount of time spent by committees in the provision of bioethics education for their hospital community.

Table 5.14. Time Spent on Education for the Hospital Community

			Time spent on education for the hospital community				Total
			none	little	some	most	
Origin	UK	Count	7	2	6	2	17
	AUS	Count	0	2	3	1	6
Total		Count	7	4	9	3	23
		% of Total	30	17	39	13	100

In this area, 39% of participating CECs indicated they spent ‘some’ time on providing education for their hospital community, while 30% of CECs did not provide any education for their hospital community.

c. Time spent on Education for the General Community

Table 5.15, shows the amount of time spent by committees in the provision of bioethics education for their general community.

Table 5.15. Time spent on Education for the General Community

			Time spent on education for the general community				Total
			none	little	some	most	
Origin	UK	Count	14	2	1	0	17
	AUS	Count	4	2	0	0	6
Total		Count	18	4	1	0	23
		% of Total	78	17	4	0	100

It can be seen, from table 5.15 that 95% of participating CECs indicated they spent little or no time on providing education for their general community.

In order to determine if there was a significant difference between UK and Australasian CECs in regard to time spent on policy/ guidelines issues, non-parametric statistical analysis was undertaken. The results are given in table 5.16, below.

Table 5.16. Analysis for Time Spent on Education

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Time spent on education for committee members	U.K.	17	2.5	207.00			
	Australasia	6	3	69.00			
	Total	23	3		48.00	.818	.05
Time spent on education for hospital community	U.K.	17	3	187.00			
	Australasia	6	2	89.00			
	Total	23	3		34.00	.211	.26
Time spent on education for the general community	U.K.	17	1	197.00			
	Australasia	6	1	79.00			
	Total	23	1		44.00	.495	.14

Table 5.16, shows a Mann-Whitney test indicated no significant difference between Australasian and U.K. committees for the statements; Time spent on education for

committee members; Time spent on education for hospital community; Time spent on education for the general community.

The median values indicate that committees spent the least amount of time on education for the general community (Mdn = 1). This finding indicates that the provision of bioethics education for the general community is not seen to be a role of hospital CECs.

5.3.2.3. Committee Member Viewpoint

Section A of Questionnaire 1, was designed to gather information on individual committee members' perceptions of the success of their committee regarding its activities concerning education. Participants were requested to respond to 7 statements concerning their committee's educational offerings, using a 7-point Likert Scale.

Statistical analysis for this section was undertaken to determine whether there was any statistically significant difference between responses for participants from Australasian and UK CECs. In addition, analysis of responses from CEC chairpersons and committee members was undertaken to investigate any differences between these groups of study participants. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant.

1. Committee Member Viewpoint on Education: Country of Origin

Table 5.17. Committee Member Viewpoint: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Our CEC adequately addresses the bioethical education needs of the hospital community	Australasia	28	5	77.71			
	UK	98	4	59.44			
	Total	126	4.5		974.00	.017	.21
Our CEC adequately addresses the bioethical education needs of its members	Australasia	28	6	76.80			
	UK	99	5	60.38			
	Total	127	5		1027.50	.034	.19
Our CEC adequately addresses the bioethical education needs of the community at large	Australasia	24	3	61.94			
	UK	91	2	56.96			
	Total	115	3		997.50	.506	.06
I feel sufficiently prepared for my role on this committee	Australasia	29	7	87.21			
	UK	100	5	58.56			
	Total	129	5		806.00	.000	.32
Initial training is provided for committee members	Australasia	28	2	52.80			
	UK	100	4	67.78			
	Total	128	4		1072.50	.055	.17
Ongoing training is provided for committee members	Australasia	28	5	66.52			
	UK	99	5	63.29			
	Total	127	4		1315.50	.676	.04
Education offerings are evaluated by participants	Australasia	26	4	53.69			
	UK	90	5	59.89			
	Total	116	5		1045.00	.402	.08

The results shown in table 5.17 are summarised as follows.

a. **Our ethics committee adequately addresses the bioethical education needs of the hospital community.** The hospital community was understood to include healthcare providers, hospital staff, patients, and the families of patients. For this statement, a Mann-Whitney test indicated a significant difference between Australasian (Mdn = 5) and UK respondents (Mdn = 4), U =974.00, p= .017, with Australasian respondents agreeing more strongly with the statement than their UK counterparts.

b. **Our ethics committee adequately addresses the bioethical education needs of its members.** For this statement, a Mann-Whitney test indicated a significant difference between Australasian (Mdn = 6) and UK respondents (Mdn = 5), U =1027.50, p= .034, with Australasian respondents agreeing more strongly with the statement than their UK counterparts.

c. Our ethics committee adequately addresses the bioethical education needs of the community at large. For this statement, a Mann-Whitney test indicated no significant difference between Australasian (Mdn = 3) and UK respondents (Mdn = 2).

d. **I feel sufficiently prepared for my role on this ethics committee.** For this statement, a Mann-Whitney test indicated a significant difference between Australasian (Mdn = 7) and UK respondents (Mdn = 5), U =806.00, p= <.001, with Australasian respondents agreeing more strongly with the statement than their UK counterparts.

e. Initial qualification training is provided for committee members. For this statement, a Mann-Whitney test indicated no significant difference between Australasian (Mdn = 2) and UK respondents (Mdn = 4).

f. **Ongoing training is provided for committee members.** For this statement, a Mann-Whitney test indicated no significant difference between Australasian (Mdn = 5) and UK respondents (Mdn = 5).

g. **Educational offerings are evaluated by participants.** For this statement, a Mann-Whitney test indicated no significant difference between Australasian (Mdn = 4) and UK respondents (Mdn = 5), U =1045.00, p= .402. In this instance, U.K. respondents agreed more strongly with the statement than their Australasian counterparts.

Table 5.18 below, summarises the median values for each of the statements in this section pertaining to education.

Table 5.18. Education Median Values

Statement	N	Median
I feel sufficiently prepared for my role on this ethics committee	129	5
Our ethics committee adequately addresses the bioethical education needs of its members	127	5
Educational offerings are evaluated by participants	116	5
Our ethics committee adequately addresses the bioethical education needs of the hospital community	126	4.5
Ongoing training is provided for committee members	127	4
Initial qualification training is provided for committee members	128	4
Our ethics committee adequately addresses the bioethical education needs of the community at large	115	3

It can be seen from table 5.18, that the statements, I feel sufficiently prepared for my role on this ethics committee'; 'Our ethics committee adequately addresses the bioethical education needs of its members'; and, 'Educational offerings are evaluated by participants', each had a median value of 5.

The statement 'Our ethics committee adequately addresses the bioethical education needs of the community at large' was the statement with that participants least agreed with (Mdn = 3).

In addition to the above findings, a cross tabulation was formulated in order to analyse if there was any relationship between an individual feeling sufficiently prepared for their role on the committee and whether initial training was provided for committee members. The study findings are presented in table 5.19.

Table 5.19. Initial Training / Preparedness for Role on Committee

	Initial training is provided for committee members				
I feel sufficiently prepared for my role on this ethics committee	Disagree	Neither Agree nor Disagree	Agree	Total	% Agree
Agree (n=76)	37	6	33	76	43.4%
Neither agree nor Disagree (n=20)	10	3	7	20	35.0%
Disagree (n=31)	14	3	14	31	45.1%

Table 5.19, shows that 43% of participants (n=76) who felt sufficiently prepared for their role on the committee agreed that initial training was provided. A similar result

was found for those participants who did not feel prepared for their role on the committee (n=31), with 45% of these participants agreeing that initial training was provided. This finding suggests that there is no positive or negative relationship between feeling prepared for their role on the committee and whether initial training is provided.

Descriptive statistics for the statements in this section are presented below.

a. Our ethics committee adequately addresses the bioethical education needs of the hospital community.

In response to the above statement, 50% of all participants in the study (n=129) agreed that their committee adequately addressed the bioethical needs of their hospital community. The hospital community was understood to include healthcare providers, hospital staff, patients, and the families of patients. A further 17% of participants indicated they neither agreed nor disagreed with the statement or that the statement was not applicable to them. This meant that 34% of the study participants did not believe that their committee adequately addressed the bioethical educational needs of their hospital community.

b. Our ethics committee adequately addresses the bioethical education needs of its members

Overall, 59% of respondents (n=129) agreed that their committee adequately addressed the bioethical education needs of its members. In this instance, 13% of respondents indicated that their neither agreed nor disagreed with the statement or that the statement was not applicable to them. Therefore, 28% of respondents did not believe that their committee adequately addressed the bioethical needs of its members.

c. Our ethics committee adequately addresses the bioethical education needs of the community at large.

Overall, 19% of all study participants responding to this statement (n=128) agreed that their committee adequately addressed the bioethical education needs of the community at large. The community at large was understood as the community external to the hospital. In response to this statement, 10% of respondents indicated they neither agreed nor disagreed with the statement and a further 10% of respondents indicated that this statement was not applicable. This meant that 61% of respondents did not believe that their committee adequately addressed the bioethical education needs of the community at large.

d. I feel sufficiently prepared for my role on this ethics committee

Overall, 60% of participants in the study indicated that they felt sufficiently prepared for their role on the committee. A further 15% of respondents stated they neither agreed nor disagreed with the statement. In this instance, no respondents indicated that the statement was not applicable to them. This meant that 25% of respondents did not feel that they were sufficiently prepared for their role on their clinical ethics committee.

e. Initial qualification training is provided for committee members

Overall, 42% of participants (n=129) agreed that initial training is provided for committee members. This initial training was understood to include such things as ethical principles, case consultation techniques, and group communication processes. In this area, 9% of participants indicated that they neither agreed nor disagreed with the statement or that the statement was not applicable. This resulted in 49% of participants indicating that there was no initial qualification training provided for committee members.

f. Ongoing training is provided for committee members

Overall, 59% of study participants agreed that ongoing training is provided for committee members. Ongoing training was understood to include new procedures, current events, and legal updates. A further 7% of participants indicated that they neither agreed nor disagreed with the statement or that the statement was not

applicable to them. Therefore, 34% of the participants in the study disagreed that ongoing training is provided for members of their committee.

g. Educational offerings are evaluated by participants

Overall, 53% of respondents (n=126) agreed with the statement that educational offerings provided by their committee were evaluated by participants. In this instance, 11% of participants indicated that they neither agreed nor disagreed with the statement or that the statement was not applicable. Therefore, 36% of respondents disagreed that educational offerings from their committee were evaluated by participants.

2. Committee Membership Status

Table 5.20. Committee Member Viewpoint: Committee Membership Status

Statement	CEC membership status	N	Median	Mean Rank	Mann-Whitney U	p	r
Our CEC adequately addresses the bioethical education needs of the hospital community	Member	106	4	62.69			
	Chair	20	5	67.80			
	Total	126	4.5		974.000	.558	.05
Our CEC adequately addresses the bioethical education needs of its members	Member	107	5	66.86			
	Chair	20	4	48.73			
	Total	127	5		764.500	.040	.18
Our CEC adequately addresses the bioethical education needs of the community at large	Member	96	3	60.78			
	Chair	19	1	43.97			
	Total	115	3		645.500	.040	.18
I feel sufficiently prepared for my role on this committee	Member	109	5	63.37			
	Chair	20	6	73.90			
	Total	129	5		912.000	.238	.10
Initial training is provided for committee members	Member	108	3.5	63.49			
	Chair	20	4	69.98			
	Total	128	4		970.500	.465	.06
Ongoing training is provided for committee members	Member	107	5	64.99			
	Chair	20	4.5	58.73			
	Total	127	5		964.500	.477	.06
Education offerings are evaluated by participants	Member	97	5	59.44			
	Chair	19	3	53.71			
	Total	116	5		830.500	.492	.06

Table 5.20, shows that there was a statistically significant difference in responses between committee chairpersons and other committee members to the statements, 'Our CEC adequately addresses the bioethical education needs of its members', U = 764.50, p= .040, and 'Our CEC adequately addresses the bioethical education needs of the community at large', U = 645.50, p= .040. In each instance, the median values indicate that committee members agreed more strongly with the statements than committee chairpersons.

5.3.2.4. Education: Success Factors

Participants in the study were asked to assess the importance of a number of factors which might contribute to the success of their committee. The factors relating to education, together with the results of the responses given by participants are given below.

a. Both committee members and other employees can attend ethics education and training.

This factor was listed in Questionnaire 1 (appendix 8), under the section pertaining to administrative support given to the committee.

Overall, 96% of respondents (n=129) believed that committee members and other employees being able to attend ethics education and training events, for example, ethics conferences, was an important factor in relation to the overall success of their ethics committee. The remaining 4% of respondents indicated that they neither agreed nor disagreed with the statement. This meant that none of the respondents in the study indicated that this factor was unimportant in contributing to the overall success of their committee.

b. The committee sponsors workshops, speakers, and other events

This factor was listed in Questionnaire 1, under the section relating to the Structure, Function, and Process of the committee.

Overall, 43% of study participants (n=129) believed that the sponsoring of workshops, speakers, and other events by their committee was an important factor relating to the overall success of their committee. A further 33% of the respondents indicated that they neither agreed nor disagreed that the statement played a role in the overall success of their committee. Therefore, 24% of participants did not believe that the sponsoring of such educational activities by their committee was an important factor in contributing to the overall success of the committee.

The study found that 52% of Australasian participants (n=29) and 40% of U.K. participants (n=100) believed that the sponsoring of the educational events articulated above was an important factor in contributing to the overall success of their committee. After accounting for those respondents who indicated that they neither agreed nor disagreed that the statement contributed to the overall success of their committee, it was found that 26% of U.K. respondents and 17% of Australasian respondents believed that their committee's sponsoring of workshops, speakers, and other events was not an important factor in contributing to the overall success of the committee.

c. Education is provided for members/ new members

This factor was listed in Questionnaire 1, under the section relating to the Structure, Function, and Process of the committee.

Overall, 87% (n=129) of respondents believed that the provision of education for new and existing members of the committee was an important factor in contributing to the overall success of their committee. In this case, 9% of respondents indicated that they neither agreed nor disagreed that such provision of education contributed to the overall success of their committee. This meant that 4% of respondents did not believe that the provision of education for members of their committee was an important factor in contributing to the overall success of their committee.

It was found that 89% of U.K respondents (n=100) and 79% of Australasian respondents (n=29) believed that the provision of education for new and existing committee members was an important factor in the overall success of their

committee. After accounting for respondents who neither agreed nor disagreed that the provision of such education contributed to the overall success of the committee, it was determined that 4% of Australasian respondents and 3% of U.K respondents disagreed that the provision of committee member education was important to the overall success of their committee.

In addition, the study undertook to investigate whether there was an association between the chairperson's assessment of the time spent on dealing with issues relating to education and individual member's views that they adequately deal with education issues.

In order to analyse this type of association, cross tabulations were constructed for, Time spent on committee member education / individual member's views on whether their committee adequately addresses the educational needs of its members; Time spent on hospital community education / individual member's views on whether their committee adequately addresses the education needs of the hospital community; and, Time spent on general community education / individual member's views on whether their committee adequately addresses the education needs of the community at large. The findings for these three areas are presented in tables 5.21, 5.22 and 5.23.

Table 5.21. Time Spent on Member Committee Member Education / Member Viewpoint on Education for Committee Members

	Our ethics committee adequately addresses the bioethical education needs of its members				
Time spent on committee member education	Disagree	Neither Agree nor Disagree	Agree	Total	% Agree
Little (n=10)	15	5	35	55	63.6%
Some (n=10)	13	10	31	54	57.4%
Most (n=2)	4	2	8	14	80.0%

Table 5.21, shows that 80% of members of the committees which indicated they spent most of their time on committee member education agreed that their committee adequately addressed the education needs of its members. This compared with 64% of members of committees which indicated they spent little time on committee member education.

Table 5.22. Time Spent on Hospital Community Education / Member's Views on Education for Hospital Community

	Our ethics committee adequately addresses the bioethical education needs of the hospital community				
Time spent on hospital community education	Disagree	Neither Agree nor Disagree	Agree	Total	% Agree
Little (n=4)	9	4	9	22	40.9%
Some (n=9)	21	7	23	51	45.0%
Most (n=3)	0	3	14	17	82.3%

Table 5.22, shows that 82% of members of the committees which indicated they spent most of their time on hospital community education agreed that their committee adequately addressed the education needs of the hospital community. This compared with 41% of members of committees which indicated they spent little time on hospital community education.

The findings from tables 5.21 and 5.22 show that the more time that committees spent on education of committee members and education for the hospital community, the greater was the level agreement from individual members that the committee adequately dealt with those issues.

Table 5.23. Time Spent on General Community Education / Member's Views on Education for General Community

	Our ethics committee adequately addresses the bioethical education needs of the community at large				
Time spent on general community education	Disagree	Neither Agree nor Disagree	Agree	Total	% Agree
Little (n=4)	12	2	7	21	33.3%
Some (n=1)	2	0	1	3	33.3%

In contrast to the findings presented in tables 5.21 and 5.22, table 5.23, shows that only 33% of members of committees which indicated they spent some or little time on education for the general community agreed that their committee adequately addressed the bioethical education needs of the general community. It can be seen that only 5 of the 23 participating committees indicated they spent any time on education for the general community, and none of these committees indicated they spent most of their time on general community education. This finding supports the conclusion from Section 5.3.2.2, that the provision of bioethics education is not seen to be a role for hospital CECs.

5.4. Case Consultation

5.4.1. Introduction

Clinical ethics consultation has developed for dispute resolution and mediation in clinical settings and is premised on the belief that various healthcare perspectives should be taken into account when making treatment decisions in ethically complex cases (Rorty et al., 2004).

According to Gill et al, clinical consultations are desirable because the traditional 'three wise men approach' i.e. turning to respected colleagues for guidance, is open to criticism on several counts. For example, it does not respect non-clinicians viewpoints. It also assumes that medical expertise confers the capacity to make difficult moral decisions. Further, such informal practices are less acceptable in contemporary society, where professional practices come under ever closer scrutiny (Gill et al., 2004).

However, there are some problems with the process of ethics consultation highlighted in the literature. One of the most often cited problems being that physicians may feel their professional autonomy is threatened and therefore may not utilize the service (Gill et al., 2004; Slowther et al., 2001b; Szeremeta et al., 2001). There are also fears expressed that individual clinicians might abnegate personal responsibility for difficult ethical decisions by becoming overly reliant on CECs (Doyal, 2001; Leavitt, 2000).

Several authors make the point that variability in decisions or failure to reach a consensus does not necessarily render ethics consultation pointless. Benefits of ethics consultation include the clarification and communication of what is and is not considered to be acceptable practice. Highlighting moral differences can be considered as important as their resolution (Kaiser, 2001; Somerville, 2004).

Ethical issues typically involve a conflict of values. Therefore, the process of dealing with these issues usually involves prioritizing values. One of the main features of 'doing ethics' is the justification of any breaches of values that may arise in attempts to resolve issues. An important function of a CEC can be seen as the provision of justification for decisions it may make (Somerville, 2004).

A significant problem highlighted by (Gill et al., 2004) is that there is a lack of formal evaluation of the process of such consultations.

5.4.2. Study Findings

Participating CECs were asked, in Questionnaire 2, to indicate whether they undertook Case Consultation. Questionnaire 2 was completed by the Chairperson (or other nominated individual) of each committee, and, wherever reference is made to views of the Committee this should be understood to refer to the views presented by the Chairperson (or other nominated individual). Due to the small sample size, a two-sided Fisher's Exact Test (FET) test was used for statistical analysis and p value less than .05 was considered statistically significant.

Table 5.24. Committees Undertaking Case Consultation

			Case consultation		Total	p
			yes	no		
Origin	UK	Count	17	0	17	
	AUS	Count	5	1	6	
Total		Count	22	1	23	.261
		% of Total	96	4	100	

Table 5.24, shows that 22 (96%) of the committees participating in the study (n=23) indicated that they undertook case consultation (including retrospective). Statistical analysis (two-sided Fisher's exact test, FET) showed there was no statistically significant difference between UK and Australasian committees (p= .261, FET).

The study was designed to gather information on 1. the methods and volume of case consultation; 2. the amount of time spent by committees undertaking case consultation; 3. issues arising in case consultation undertaken by committees; 4. who can request case consultation by committees; 5. the outcome of case consultation; 6. the viewpoint of individual committee members participating in the study regarding how successful their committees are in providing case consultation, and; 7. factors contributing to the success of committees in providing case consultation.

The study findings are given below:

5.4.2.1. Case Consultation: Methods and Volume

Committees participating in the study were asked to indicate the methods of case consultation in which their committee engaged. In addition, committees were asked to indicate the numbers of acute and retrospective cases that they had dealt with in the preceding twelve months.

1. Methods of Case Consultation

Committees were asked whether they engaged in a. acute case consultation; b. retrospective case consultation; c. a combination of acute and retrospective case consultation; d. no case consultation (either acute or retrospective).

Table 5.25. Methods of Case Consultation

Method of case consultation		UK	AUS	Total	p
Acute	Count	1	2	3	
Retrospective	Count	4	0	4	
Acute and Retrospective	Count	12	3	15	
None	Count	0	1	1	
Total	Count	17	6	23	.062
	% of Total	74	26	100	

a. Acute Case Consultation

Overall, 3 of the participating committees (n=23) indicated that they undertook only acute case consultation. In this category, 1 of the U.K. committees (n=17) and 2 of the Australasian committees (n=6) stated that they only undertook acute case consultation.

b. Retrospective Case Consultation

In this category, while 4 of the U.K. committees (n=17) responded that they dealt only with retrospective cases, none of the Australasian committees (n=6) indicated that this was the case.

c. Acute and Retrospective Case Consultation

Overall, 15 of the participating committees (n=23) indicated that they dealt with a combination of acute and retrospective cases. In this category, 12 of the U.K. committees (n=17) and 3 of the Australasian committees (n=6) stated that they dealt with such a combination of cases.

Statistical analysis showed there was no statistically significant difference between UK and Australasian committees in their methods of case consultation (p= .062, FET).

5.4.2.2. Volume of Case Consultation

Committees were asked to indicate the number of acute and retrospective cases that they had dealt with in the preceding twelve months.

a. Acute Cases

Table 5.26. Acute Case Consultations conducted in the Last 12 Months

			Number of acute consultations in last 12 months					Total
			0	1-3	4-6	7-9	10-12	
origin	UK	Count	4	5	4	1	1	15
	AUS	Count	1	3	1	0	1	6
Total		Count	5	8	5	1	2	21
		% of Total	24	38	24	5	9	100

In order to investigate whether there is a difference between UK and Australasian CECs in regard to the number of acute case consultations conducted, a Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The results are given in table 5.27, below.

Table 5.27. Analysis of the Number of Acute Case Consultations Conducted

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Number of acute consultations in last 12 months	UK	15	2	10.87			
	Australasia	6	2	11.33			
	Total	21	2		43.00	.871	.035

Table 5.27, shows that a Mann-Whitney test indicated no significant difference between Australasian (Mdn = 2) and UK respondents (Mdn = 2), U = 43.00, p= .871, for the number of acute case consultations conducted over the previous 12 months.

b. Retrospective Cases

Table 5.28. Retrospective Case Consultations Conducted in the Last 12 Months

			Number of retrospective consultations in last 12 months					
			0	1-3	4-6	7-9	10-12	Total
origin	UK	Count	2	6	4	2	1	15
	AUS	Count	5	0	0	1	0	6
Total		Count	7	6	4	3	1	21
		% of Total	33	29	19	14	5	100

In order to investigate whether there is a difference between UK and Australasian CECs in regard to the number of retrospective case consultations conducted a Mann-Whitney U test was used for statistical analysis. The results are shown in table 5.29, below.

Table 5.29. Analysis of the Number of Retrospective Case Consultations Conducted

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Number of retrospective consultations in last 12 months	UK	15	2	12.80			
	Australasia	6	1	6.50			
	Total	21	2		18.00	.029	.475

Table 5.29, shows that a Mann-Whitney test indicated that there was a significant difference between Australasian (Mdn = 1) and UK respondents (Mdn = 2), U = 18.00, p= .029, for the number of retrospective case consultations conducted over the previous 12 months, with U.K. committees being more active than Australasian committees in this area.

5.4.2.3. Time Spent on Case Consultation

In addition to identifying the methods of case consultation that the committees participating in the study undertook, responding committees were also asked to estimate the proportion of time that they had spent in dealing with case consultation over the

previous twelve months. In this category, committees were asked to estimate time spent on a. acute case consultation and, b. retrospective case consultation.

a. Acute Case Consultation

Table 5.30. Time Spent on Acute Case Consultation

			Time spent on acute case consultation				Total
			none	little	some	most	
Origin	UK	Count	4	2	5	5	16
	AUS	Count	1	2	2	1	6
Total		Count	5	4	7	6	22
		% of Total	23	18	32	27	100

Table 5.30, shows that, overall, of the committees responding to this question (n=22), 13 indicated that they spent some or most of their time spent on case consultation dealing with acute cases. Table 5.30, also shows that 4 of the 16 (25%) committees from the U.K. compared with 1 of the 6 (17%) Australasian committees indicated that they had not spent any time on acute case consultation in the previous twelve months.

b. Retrospective Case Consultation

Table 5.31. Time Spent on Retrospective Case Consultation

			Time spent on retrospective case consultation				Total
			none	little	some	most	
Origin	UK	Count	1	2	9	4	16
	AUS	Count	4	0	1	0	5
Total		Count	5	2	10	4	21
		% of Total	24	9	48	19	100

Table 5.31, shows that 14 of the participating committees that responded to this question (n=21), indicated that they had spent some or most of the time spent on case consultation in the previous twelve months dealing with retrospective cases, while five committees indicated that they had not spent any time on retrospective case consultation.

In order to investigate whether there is a difference between UK and Australasian CECs in regard to the time spent on case consultation, a Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The results are given in table 5.32, below.

Table 5.32. Analysis of Time Spent on Case Consultation

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Time spent on acute case consultation	UK	16	3	11.84			
	Australasia	6	2.5	10.58			
	Total	22	3		42.50	.674	.089
Time spent on retrospective case consultation	UK	16	3	12.91			
	Australasia	5	1	4.90			
	Total	21	3		9.50	.007	.588

Table 5.32, shows that a Mann-Whitney test indicated that there was a significant difference between Australasian (Mdn = 1) and UK committees (Mdn = 3), U = 9.50, p= .007, for the time spent on retrospective case consultations over the previous 12 months, with U.K. committees being more active than Australasian committees in this area.

From table 5.32, it can be seen that a Mann-Whitney test indicated that there was no significant difference between Australasian (Mdn = 2.5) and UK committees (Mdn = 3), for the time spent on acute case consultation over the previous 12 months.

5.4.2.4. Case Consultation: Issues Arising

Committees participating in the study were requested to indicate the issues which had been raised in case consultation undertaken. These issues, accompanied by the results obtained are shown in table 5.33.

Table 5.33. Case consultation: Issues Arising

Issue	Overall (n=23)	U.K. (n=17)	Australasia (n=6)	% of Total	p
Patient autonomy	21	17	4	91	.059
End of life issues	21	16	5	91	.462
Resource allocation	16	13	3	70	.318
Refusal of intervention	14	12	2	61	.162
Confidentiality	14	12	2	61	.162
Uncertain goal of treatment	12	9	3	52	1.00
Request for futile treatment	10	8	2	43	.660
New technologies	10	6	4	43	.341
Truth telling	8	7	1	35	.369
Conflicts of interest	7	6	1	30	.621
Problematic proxy	6	6	0	26	.144
Other	3	2	1	13	1.00

It can be seen from table 5.33, that overall, 'patient autonomy' and 'end of life issues' were the most commonly raised issues in case consultation, with 21 of all participating committees (n=23) indicating that they had dealt with such issues. All of the U.K. committees (n=17) and 4 of the Australasian committees (n=6) responded that the issue of 'patient autonomy' had been raised in case consultation and, 16 of the U.K. committees and 5 of the Australasian committees indicated that 'end of life issues' had been discussed in case consultation.

Issues arising less frequently, overall, during case consultations included 'problematic proxy' (6/23), 'conflicts of interest' (7/23), and 'truth telling' (8/23). Similarly, these issues arose less frequently in both the committees from the U.K. and in the committees from Australasia.

'Other' issues were reported as arising in case consultations in 3 of all participating committees (n=23), 2 of U.K. committees (n=17), and Australasian committee (n=6). These 'other' issues included 'legal issues', and issues concerned with 'disclosure of information.'

In order to investigate whether there were any differences in the issues arising between Australasian and U.K. committees, a two-sided Fisher's Exact Test (FET) test was used for statistical analysis and p value less than .05 was considered statistically significant. It can be seen from table 5.33, that there were no statistically significant differences between Australasian and U.K. committees for issues arising.

5.4.2.5. Case Consultation: Who Can Request Case Consultation?

Committees participating in the study were requested to indicate all persons who could request case consultation by the committee. The results obtained are shown in table 5.34.

As stated previously, Questionnaire 2 was completed by the Chairperson (or other nominated individual) of each committee, and, wherever reference is made to views of the Committee this should be understood to refer to the views presented by the Chairperson (or other nominated individual).

Table 5.34. Who Can Request Case Consultation.

	Overall (n=23)	U.K. (n=17)	Australasia (n=6)	% of Total	p
Nursing staff	20	16	4	87	0.155
Hospital staff	19	16	3	83	0.040
Any CEC member	19	16	3	83	0.040
Attending physician	19	16	3	82	0.040
Resident physician	18	14	4	78	0.576
Social worker	14	10	4	60	1.00
Family member	9	7	2	39	1.00
Patient/ surrogate	8	6	2	35	1.00
Other	8	6	2	35	0.131
Outside agency	7	6	1	30	0.621

Table 5.34, shows that, overall, 20 (87%) of participating committees (n=23) indicated that nursing staff could request case consultation. Second equal in ranking for those able to request case consultation were the attending physician, any CEC member, and any member of the hospital staff. In each instance, 19 (83%) of all participating committees indicated that case consultation could be requested by those persons.

Patients (or surrogates) and family members of patients were able to request case consultations in a considerably lower number of committees compared with those persons able to request consultations mentioned above. 8 (35%) of all participating committees (n=23) responded that that patients, or their surrogates, could request case consultation, and 9 (39%) of committees indicated that family members of patients could request consultations. Overall, it can be seen that only request for consultations by an 'outside agency' (7 (30%) committees), rated lower than requests by a patient or family of a patient. Responses from 8 (35%) committees overall (n=23) indicated that case consultation could be requested by 'others'. These 'others' included allied healthcare practitioners and nursing administrators.

In order to investigate any differences between Australasian and U.K. committees a two-sided Fisher's Exact Test (FET) test was used for statistical analysis and p value less than .05 was considered statistically significant.

Table 5.34, shows that there were significant differences between Australasian and U.K. committees for hospital staff ($p = .040$, FET), any CEC member ($p = .040$, FET) and attending physician ($p = .040$, FET), when considering who could request case consultation. In each case a greater proportion of U.K. committees indicated this to be the case.

5.4.2.6. Case Consultation: Outcome

Participating committees were requested to indicate the outcomes of case consultation undertaken. These outcomes, along with the results obtained, are shown in table 5.35.

Table 5.35. Case Consultation Outcome

Outcome	Overall (n=23)	U.K. (n=17)	Australasia (n=6)	% of Total	p
Recommendations to physicians and staff	21	16	5	91	0.462
Communication with patient/ family	7	5	2	30	1.000
Publication of case study	5	4	1	22	1.000
Consultation with risk management	5	4	1	22	1.000
Arbitration with third parties	2	1	1	9	0.462
Binding decision	1	1	0	4	1.000

It can be seen from table 5.35, that the most common outcome of case consultation was 'recommendations to physicians and staff', with 21 (91%) of all participating committees (n=23) indicating that this was the case. The second most common outcome of case consultation for participating committees was 'communication with patient/ family,' with 7 (30%) of the committees indicating that this was the case.

Notably, the least common outcome of case consultation was the making of 'binding decisions.' Only 1 committee overall (n=23), from the U.K. (n=17), stated that the making of binding decisions was an outcome of case consultation. None of the 6 Australasian committees indicated this to be the case. This serves to highlight the fact that, in both Australasia and the U.K., clinical ethics committees function in an advisory capacity.

In order to investigate any differences between Australasian and U.K. committees a two-sided Fisher's Exact Test (FET) test was used for statistical analysis and p value less than .05 was considered statistically significant.

Table 5.35, shows that there were no statistically significant differences found between participating committees from Australasia and U.K. for case consultation outcomes.

5.4.2.7. Case Consultation: Committee Member Viewpoint

Section A of Questionnaire 1, was designed to gather information on individual committee members' perceptions and beliefs regarding the success of their committee in its activities concerning case consultation. Participants were requested to respond to 6

statements concerning their committee's case consultation process, using a 7-point Likert Scale.

Statistical analysis for this section was undertaken to determine whether there was any statistically significant difference between responses for participants from Australasian and UK CECs. In addition, analysis of responses from CEC chairpersons and committee members was undertaken to investigate any differences between these groups of study participants. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant.

1. Committee Member Viewpoint on Case Consultation: Country of Origin

Table 5.36. Committee Member Viewpoint on Case Consultation: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Our CEC is successful in its role of conducting acute case consultation	Australasia	25	6	71.64			
	UK	90	5	54.21			
	Total	115	6		784.00	.017	.22
Our CEC is successful in its role of conducting retrospective review of cases	Australasia	25	6	62.46			
	UK	96	6	60.62			
	Total	121	6		1163.50	.808	.02
Our committee has an effective protocol in place to guide case consultation	Australasia	27	6	75.13			
	UK	96	5	58.31			
	Total	123	6		941.50	.027	.20
Case consultation activities are documented	Australasia	26	7	68.17			
	UK	96	6	59.69			
	Total	122	6		1074.50	.246	.10
A retrospective evaluation of the case consultation process is conducted periodically	Australasia	26	5	70.77			
	UK	92	4	56.32			
	Total	118	4		903.00	.054	.18
Case reviews are conducted in accordance with established protocols	Australasia	25	6	66.02			
	UK	93	5	57.75			
	Total	118	5		999.50	.274	.10

The statements, followed by the results obtained from participants are given below:

a. Our committee is successful in its role of conducting acute case consultation

Table 5.36, shows that a Mann-Whitney test indicated there was a significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 5), U = 784.00, p= .017, in the level of agreement with the statement, with Australasian participants showing a greater level of agreement.

b. Our committee is successful in its role of conducting retrospective review of cases

Table 5.36, shows that a Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 6), in the level of agreement with the statement.

c. Our committee has an effective procedure/ protocol in place to guide case review/ consultation

It can be seen from table 5.36, that a Mann-Whitney test indicated there was a significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 5), U = 941.50, p= .027, with Australasian participants showing a greater level of agreement with the statement than the U.K. participants.

d. Case review/ consultation activities are documented

Table 5.36, shows that a Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 6), in the level of agreement with the statement.

e. A retrospective evaluation of the case review/ consultation process is conducted periodically

Table 5.36, shows that a Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 5) and UK participants (Mdn = 4), in the level of agreement with the statement.

f. Case reviews/ consultations are conducted in accordance with established protocols/ procedures

Table 5.36, shows that a Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 5), in the level of agreement with the statement.

Table 5.37 below, summarises the median values for each of the statements in this section pertaining to case consultation.

Table 5.37. Case Consultation Median Values

Statement	N	Median
Case consultation activities are documented	122	6
Our CEC is successful in its role of conducting retrospective review of cases	121	6
Our CEC is successful in its role of conducting acute case consultation	115	6
Our committee has an effective protocol in place to guide case consultation	123	6
Case reviews are conducted in accordance with established protocols	118	5
A retrospective evaluation of the case consultation process is conducted periodically	118	4

It can be seen from table 5.37, that the statements, 'case review/ consultation activities are documented'; 'our CEC is successful in its role of conducting acute case consultation'; 'our committee is successful in its role of conducting retrospective review of cases'; and, 'our committee has an effective protocol in place to guide case consultation', each had a median value of 6.

The statement, 'case reviews are conducted in accordance with established protocols', had a median value of 5, indicating that there was less agreement with this statement compared with the statements mentioned above. The statement which exhibited the lowest level of agreement in this section, with a median value of 4, was 'a retrospective evaluation of the case consultation process is conducted periodically'.

In addition to the above analysis, descriptive statistics for the statements in this section are presented below.

a. Our committee is successful in its role of conducting acute case consultation

Overall, 65% of respondents (n=128) agreed with the statement that their committee is successful in its role of conducting acute case consultation. A further 15% of respondents indicated that they neither agreed nor disagreed with the statement or that the statement was not applicable to them. Therefore, 20% of respondent disagreed that their committee was successful in its role of conducting acute case consultation.

b. Our committee is successful in its role of conducting retrospective review of cases

In response to the above statement, 79% of all study participants (n=128) agreed that their committee was successful in its role of conducting retrospective review of cases. A further 9% of participants indicated that they neither agree nor disagreed with the statement or that the statement was not applicable. This meant that 12% of participants did not believe that their committee was successful in its role of conducting retrospective case consultation.

c. Our committee has an effective procedure/ protocol in place to guide case review/ consultation

Overall, 63% of participants (n=128) responded that they agreed with the above statement regarding their committee having an effective procedure/ protocol in place to guide case review/ consultation. A further 13% of participants indicated that they neither agreed nor disagreed with the statement or that the statement was not applicable. Therefore, 24% of participants responded that they disagreed that their committee had an effective procedure in place to guide case consultation.

d. Case review/ consultation activities are documented

Overall, 80% of all participants responding to this statement (n=127) indicated that they agreed that case consultation/ review activities were documented. A further 8% of participants stated that they neither agreed nor disagreed with the statement or that the statement was not applicable. Thus, 12% of respondents disagreed that case consultation activities were documented.

e. A retrospective evaluation of the case review/ consultation process is conducted periodically

Overall, 43% of participants responding to this statement (n=127) indicated that they agreed that their committee periodically conducted a retrospective evaluation of its case review/ consultation process. A further 22% of respondents indicated that they neither agreed nor disagreed with the statement or that the statement was not applicable. Therefore, 35% of respondents disagreed that a retrospective evaluation of the case review/ consultation process was conducted periodically.

f. Case reviews/ consultations are conducted in accordance with established protocols/ procedures

Overall, 56% of participants (n=126) who responded to this statement agreed that case consultations/ reviews were conducted in accordance with established procedures/ protocols. A further 20% of respondents indicated they neither agreed nor disagreed with the statement or that the statement was not applicable. Therefore, 24% of the study participants disagreed that case reviews/ consultations undertaken by their committee were conducted in accordance with established protocols/ procedures.

2. Committee Membership Status

Table 5.38. Committee Member Viewpoint on Case Consultation: Committee Membership Status

Statement		N	Median	Mean Rank	Mann-Whitney U	p	r
Our CEC is successful in its role of conducting acute case consultation	Member	97	6	58.12			
	Chair	18	5.5	57.36			
	Total	115	6		861.500	.928	.008
Our CEC is successful in its role of conducting retrospective review of cases	Member	103	6	61.18			
	Chair	18	6	59.97			
	Total	121	6		908.500	.889	.012
Our committee has an effective protocol in place to guide case consultation	Member	104	6	60.96			
	Chair	19	6	67.68			
	Total	123	6		880.000	.439	.069
Case consultation activities are documented	Member	103	6	60.28			
	Chair	19	7	68.11			
	Total	122	6		853.000	.344	.086
A retrospective evaluation of the case consultation process is conducted periodically	Member	99	4	61.02			
	Chair	19	4	51.61			
	Total	118	4		790.500	.267	.102
Case reviews are conducted in accordance with established protocols	Member	99	5	59.83			
	Chair	19	5	57.79			
	Total	118	5		908.000	.809	.022

Table 5.38, shows that there were no statistically significant differences between CEC chairpersons and members for any of the 6 statements.

5.4.2.8. Case Consultation: Success Factors

In Section B of Questionnaire 1, participants were asked to assess the importance of a number of factors which might contribute to the success of their committee. The factors relating to case consultation, together with the results of the responses given by participants are given below.

a. Committee handles a high number of cases/ interventions

This factor was listed in Section B, of Questionnaire 1, under the section pertaining to Structure, Function, and Process.

Overall, 34% of study participants (n=126) believed that their committee's handling of a high number of cases was an important contributing factor to the overall success of their committee. A further 49% of participants indicated that they neither agreed nor disagreed with the statement. Therefore, 17% of respondents did not believe that the handling of a high number of cases by their committee was important to the overall success of their committee.

The study findings revealed that 32% of Australasian participants (n=28) and 35% of U.K. participants (n=98) believed that their committee handling a high number of cases was an important factor contributing to the overall success of their committee. It was found that 46% of Australasian participants and 50% of U.K. participants responded that they neither agreed nor disagreed with the statement. Thus, 22% of Australasian participants and 15% of U.K. participants did not believe that their committee's handling of a high number of case consultations was an important factor in contributing to the success of their committee.

b. Options are provided during case consultations

This factor was listed in Section B, of Questionnaire 1, under the section pertaining to Structure, Function, and Process.

Overall, 73% of all respondents (n=123) indicated that they believed options being provided during case consultations was an important factor in contributing to the overall success of their committee. A further 20% of respondents neither agreed nor disagreed with the statement. This meant that only 7% of all respondents did not believe that the provision of options during case consultations was an important factor in contributing to the success of their committee.

In this area, 75% of Australasian participants (n=28) and 73% of U.K. participants (n=95) agreed that the provision of options during case consultations was important

to the success of their committee. A further 14% of Australasian and 22% of U.K. neither agreed nor disagreed with the statement. Therefore, 11% of Australasian participants and 5% of U.K. participants stated that they did not believe the provision of options during case consultations was an important factor in contributing to the success of their committee.

c. The committee, to those seeking consultation, gives a timely response.

This factor was listed in Section B, of Questionnaire 1, in the section pertaining to Structure, Function, and Process.

In response to the above statement concerning their committee giving a timely response to those seeking consultation, 96% of all study respondents (n=129) agreed that this was an important factor contributing to the success of their committee. It was found that 2% of respondents indicated that they neither agreed nor disagreed with the statement, with a further 2% of respondents indicating that they disagreed that a timely response by their committee to those seeking consultation was an important factor in contributing to the overall success of their committee.

In this area, 97% of Australasian participants (n=29) and 96% of U.K. participants (n=100) agreed with the statement. None of the Australasian respondents and 3% of the U.K. respondents neither agreed nor disagreed with the statement. Thus, 3% of Australasian participants and 1% of U.K. participants indicated that they did not believe that the giving of a timely response by their committee to those seeking consultation, was an important factor contributing to the success of the committee.

The study also undertook to investigate whether there was an association between the chairperson's assessment of the time spent on dealing with case consultation and individual member's views that they adequately deal with case consultation.

In order to analyse this type of association, cross tabulations were constructed for, Time spent on acute case consultation / individual member's views on whether their committee is successful in its role of conducting acute case consultation, and Time spent on retrospective case consultation / individual member's views on whether their

committee is successful in its role of conducting retrospective case consultation.. The findings for these two areas are presented in tables 5.39 and 5.40.

Table 5.39. Time Spent on Acute Case Consultation / Member Viewpoint on Acute Case Consultation

	Our committee is successful in its role of conducting acute case consultation				
Time spent on acute case consultation	Disagree	Neither Agree nor Disagree	Agree	Total	% Agree
Little (n=4)	5	1	10	16	62.5%
Some (n=7)	6	1	33	40	82.5%
Most (n=6)	3	1	24	28	85.7%

Table 5.39, shows that 86% of members of the committees which indicated they spent most of their time on hospital community education agreed that their committee was successful in its role of conducting acute case consultation. This compared with 63% of members of committees which indicated they spent little time on acute case consultation.

Table 5.40. Time Spent on Retrospective Case Consultation / Member Viewpoint on Retrospective Case Consultation

	Our committee is successful in its role of conducting retrospective case consultation				
Time spent on retrospective case consultation	Disagree	Neither Agree nor Disagree	Agree	Total	% Agree
Little (n=2)	2	0	7	9	77.7%
Some (n=10)	8	2	47	57	82.4%
Most (n=4)	0	0	12	12	100.0%

Table 5.40, shows that all of the members (12) of the committees which indicated they spent most of their time on retrospective case consultation agreed that their committee adequately performed this function. This compared with 78% of members of committees which indicated they spent little time on reviewing policies.

The findings from tables 5.39 and 5.40 show that the more time that committees spent on acute case consultation and retrospective case consultation, the greater was the level agreement from individual members that the committee adequately dealt with those issues.

5.5. Other Functions.

Overall, 30% of committees in the study (n=23) responded that they undertook activities other than those articulated in the questionnaire. There was no significant difference between Australasian committees (33%) and U.K. committees (29%) in this category.

The 'other' functions undertaken by committees were:

a. Rapid response to clinical ethics issues
b. Distributive justice
c. Round robins with other hospital committees
d. Interaction with undergraduate medical ethics teaching
e. Discussion with clinicians of ethical aspects of new technologies/ procedures prior to (their) introduction.
f. Resource allocation

Of particular interest, with regard to issues that had been raised during case consultation, was that the issue of 'resource allocation' rated highly i.e. 3rd overall and for U.K. committees , and 4th for Australasian committees.

Whether a clinical ethics committee (CEC) should be involved with resource allocation is a contentious issue.

Medical care is a good that should be distributed justly (Emanuel, 2000). According to the National Health and Medical Research Council (NHMRC), (NHMRC, 1993), justice is the primary ethical consideration in the area of healthcare resource allocation. The allocation of scarce resources can be seen as the articulation of an institution's mission since it is concerned with decisions regarding which health services are to be offered or expanded and which ones should be reduced or discontinued (Park-Ridge-Centre, 2003; Wildes, 1997). What criteria should an institution use to ration care? A fair process in distributing goods should be transparent about the grounds for decisions and be able to appeal to rationales other widely accepted has been relevant to meeting health needs fairly (Wildes, 1997).

Several authors have indicated that a CEC is well placed to be involved in the formulation of policies on resource allocation for such things as the organization of fair waiting lists and the prioritization of costly drugs and equipment (Bishop, Cherry, and Darragh, 1999; Doyal, 2001; Flynn, 1991). However, others believe that a CEC is not an appropriate forum for resource allocation decisions since such committees have no responsibility for the healthcare budget. Further, there is the belief that clinical issues around specific patient groups may conflict with decisions about priorities (Slowther and Hope, 2002).

Prior to the analysis of the study findings regarding the evaluative processes of participating CECs, the findings of the study regarding factors individual study participants considered to be most important in contributing to the success of their committee are presented.

5.6. Success Factors

Section B. of Questionnaire 1. was designed to assess the relative importance of a number of factors which might be seen to be contributing to the success of a CEC. As described in Chapter 3 (Method), this section of the study utilised a modified form of the method described in a study by Schick and Guo, which sought to identify factors considered by U.S.A. healthcare ethics committee chairpersons and members to be essential to the success of an ethics committee (Schick, Guo, 2001).

Participants were asked to indicate the degree to which they agreed with statements about factors which contributed to the 'success' of their ethics committee in 4 key areas, 1. Leadership, 2. Participation, Communication, Skills, 3. Administrative Support, 4. Structure, Function and Process. In addition, participants were requested to assess each of these areas in order of importance in contributing to the 'success' of a Clinical Ethics Committee. A 5-point Likert style scale on which 1 corresponded with 'unimportant' and 5 corresponded with 'essential' was used.

Statistical analysis for this section was undertaken to determine whether there was any statistically significant difference between responses for participants from Australasian and UK CECs. In addition, analysis of responses from CEC chairpersons and

committee members was undertaken to investigate any differences between these groups of study participants. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant.

5.6.1. Leadership

Participants were requested to assess four factors associated with leadership in contributing to the success of their committees, Chairperson manages meetings effectively; Chairperson creates a forum that generates results; Chairperson does not encourage hierarchical committee style; Chairperson has formal education in ethics.

1a. Country of Origin

Table 5.41. Leadership: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Chairperson has formal education in ethics	Australasia	29	4.00	57.97			
	UK	100	4.00	67.04			
	Total	129	4.00		1246.00	.226	.11
Chairperson manages meetings effectively	Australasia	29	5.00	66.67			
	UK	100	5.00	64.81			
	Total	129	5.00		1430.50	.858	.02
Chairperson creates a forum that generates results	Australasia	29	5.00	66.05			
	UK	100	5.00	64.70			
	Total	129	5.00		1419.50	.828	.02
Chairperson does not encourage hierarchical committee style	Australasia	28	5.00	61.96			
	UK	100	5.00	65.21			
	Total	128	5.00		1329.00	.638	.04

From table 5.41, it can be seen that there was no statistically significant difference between Australasian and UK respondents for any of the statements included in this section. The table further shows that the statement pertaining to the chairperson having a formal education in ethics had the lowest median value (4.00), indicating it was considered to be the least important factor in this section.

1b. Committee Membership Status

Table 5.42. Leadership: Committee Membership Status

Statement	Membership status	N	Median	Mean Rank	Mann-Whitney U	p	r
Chairperson has formal education in ethics	member	109	4.00	67.96			
	chair	20	4.00	48.88			
	Total	129	4.00		767.50	.027	.19
Chairperson manages meetings effectively	member	109	5.00	67.37			
	chair	20	5.00	52.10			
	Total	129	5.00		832.00	.006	.24
Chairperson creates a forum that generates results	member	109	5.00	66.41			
	chair	20	5.00	57.30			
	Total	129	5.00		936.00	.205	.11
Chairperson does not encourage hierarchical committee style	member	109	5.00	66.21			
	chair	19	4.00	54.71			
	Total	128	5.00		849.50	.151	.13

Table 5.42, shows that a Mann-Whitney test indicated a significant difference between Chairpersons (Mdn = 4) and Members (Mdn = 4), U = 767.50, p= .027, for the statement regarding the chairperson having a formal education in ethics. Similarly, there was a significant difference for the statement concerning the chairperson managing meetings effectively, U =832.00, p= .006. Although, in each case the medians were the same for chairpersons (Mdn = 4) and committee members (Mdn = 4), the mean ranks (MR) which were calculated, indicated that CEC members considered these issues to be more important than did CEC chairpersons. For the statement regarding the chairperson having a formal education in ethics, the MR for members was 67.96 compared with a MR of 48.88 for committee chairpersons. Regarding the chairperson effectively managing meetings, the MR for members was 67.37 compared with a MR of 52.10 for chairpersons.

5.6.2. Participation, Communication, Skills

Participants were requested to assess eight factors associated with participation, communication, and skills, as to their relative importance in contributing to the success of their committee, Committee has multidisciplinary composition; Members respect the point of view of others; Members possess good communication and listening skills; Members actively participate in discussions; Members regularly attend meetings; There

is an ethicist on the committee; Members come to meetings well prepared; Members willing to work on a related task force.

2a. Country of Origin

Table 5.43. Participation, Communication, Skills: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Members come to meetings well prepared	Australasia	29	4.00	77.79			
	UK	100	4.00	61.29			
	Total	129	4.00		1079.00	.021	.20
Members regularly attend meetings	Australasia	29	4.00	63.69			
	UK	100	4.00	65.38			
	Total	129	4.00		1412.00	.808	.02
Members actively participate in discussions	Australasia	29	5.00	67.34			
	UK	100	5.00	64.32			
	Total	129	5.00		1382.00	.633	.04
Committee has multidisciplinary composition	Australasia	29	5.00	66.17			
	UK	100	5.00	64.66			
	Total	129	5.00		1416.00	.760	.02
There is an ethicist on the committee	Australasia	29	5.00	75.09			
	UK	99	5.00	61.40			
	Total	128	5.00		1128.50	.054	.17
Members respect the point of view of others	Australasia	29	5.00	64.76			
	UK	100	5.00	65.07			
	Total	129	5.00		1443.00	.955	.01
Members possess good communication and listening skills	Australasia	29	5.00	68.02			
	UK	100	5.00	64.13			
	Total	129	5.00		1362.50	.533	.05
Members willing to work on a related task force	Australasia	29	5.00	73.59			
	UK	97	4.00	60.48			
	Total	126	4.00		1114.00	.070	.16

Table 5.43, shows that Mann-Whitney testing indicated a significant difference between Australasian and UK respondents for the statement regarding members coming to meetings well prepared, U = 1079.00, p = .021. From table 5.35 it can be seen, that the mean rank indicated that Australasian respondents considered the statement to be more important than did their UK counterparts. It can also be seen from the median values presented in table 5.43, that, the statements regarding members attending meetings regularly; Members come to meetings well prepared, and, Members willing to work on a related task force, were considered to be the least important success factors in this section.

2b. Committee Membership Status

Table 5.44. Participation, Communication, Skills: Committee Membership Status

Statement	Membership Status	N	Median	Mean Rank	Mann-Whitney U	p	r
Members come to meetings well prepared	member	109	4.00	66.86			
	chair	20	4.00	54.88			
	Total	129	4.00		887.50	.147	.12
Members regularly attend meetings	member	109	4.00	64.29			
	chair	20	5.00	68.88			
	Total	129	4.00		1012.50	.569	.05
Members actively participate in discussions	member	109	5.00	62.50			
	chair	20	5.00	78.60			
	Total	129	5.00		818.00	.027	.19
Committee has multidisciplinary composition	member	109	5.00	65.51			
	chair	20	5.00	62.20			
	Total	129	5.00		1034.00	.561	.05
There is an ethicist on the committee	member	108	5.00	65.58			
	chair	20	4.50	58.65			
	Total	128	5.00		963.00	.397	.07
Members respect the point of view of others	member	109	5.00	65.55			
	chair	20	5.00	62.00			
	Total	129	5.00		1030.00	.575	.05
Members possess good communication and listening skills	member	109	5.00	65.18			
	chair	20	5.00	64.00			
	Total	129	5.00		1070.00	.869	.01
Members willing to work on a related task force	member	106	4.00	64.75			
	chair	20	4.00	56.88			
	Total	126	4.00		927.50	.345	.08

Table 5.44, shows that the only statement in this section where a Mann-Whitney Test showed there was a statistically significant difference between Chairpersons and Members responses, was for the statement pertaining to members actively participating in discussions, U = 818.00, p = .027. In this instance, the mean ranks showed that chairpersons (MR = 78.60) considered such participation in committee discussions to be a more important factor than did other committee members.

5.6.3. Administrative Support

Participants were asked to assess the relative importance of seven factors relating to administrative support for their committee in contributing to the success of the committee. The statements in this section were, Members who are employed by the organisation are permitted to leave their jobs to attend committee meetings and

activities; There is open communication between the committee and medical staff; Committee work is valued and respected by the organisation; Both committee members and other employees can attend ethics education and training e.g. conferences; There is open communication between the committee and administration; Committee works autonomously; The administration subsidises printed material and other such as brochures that describe the role and function of the committee.

3a. Country of Origin

Table 5.45. Administrative Support: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Committee works autonomously	Australasia	29	5.00	74.72			
	UK	99	4.00	61.51			
	Total	128	4.00		1139.00	.070	.16
There is open communication between the committee and administration	Australasia	29	5.00	68.38			
	UK	98	4.00	62.70			
	Total	127	4.00		1294.00	.419	.07
Committee work is valued and respected by the organisation	Australasia	29	5.00	64.05			
	UK	100	5.00	65.28			
	Total	129	5.00		1422.50	.855	.02
The administration subsidises printed material and other such as brochures that describe the role and function of the committee	Australasia	29	4.00	68.10			
	UK	100	4.00	64.10			
	Total	129	4.00		1360.00	.586	.05
There is open communication between the committee and medical staff	Australasia	29	5.00	64.60			
	UK	100	5.00	65.12			
	Total	129	5.00		1438.50	.937	.01
Members who are employed by the organisation are permitted to leave their jobs to attend committee meetings and activities	Australasia	29	5.00	58.95			
	UK	99	5.00	66.13			
	Total	128	5.00		1274.50	.243	.10
Both committee members and other employees can attend ethics education and training e.g. conferences	Australasia	29	5.00	61.88			
	UK	100	5.00	65.91			
	Total	129	5.00		1359.50	.554	.05

In this section, Mann-Whitney testing revealed that there was no statistically significant difference between the responses from Australasian and UK participants.

The administration subsidising printed material and other such as brochures that describe the role and function of the committee, was considered to be the least important factor in this section, in contributing to the success of a CEC by both Australasian (Mdn= 4.00) and UK (Mdn= 4.00) participants.

3b. Committee Membership Status

Table 5.46. Administrative Support: Committee Membership Status

Statement	Membership Status	N	Median	Mean Rank	Mann-Whitney U	p	r
Committee works autonomously	member	108	4.00	66.41			
	chair	20	4.00	54.20			
	Total	128	4.00		874.00	.147	.13
There is open communication between the committee and administration	member	107	5.00	66.19			
	chair	20	4.00	52.30			
	Total	127	4.00		836.00	.086	.15
Committee work is valued and respected by the organisation	member	109	5.00	67.72			
	chair	20	4.00	50.15			
	Total	129	5.00		793.00	.023	.20
The administration subsidises printed material and other such as brochures that describe the role and function of the committee	member	109	4.00	67.38			
	chair	20	4.00	52.03			
	Total	129	4.00		830.50	.070	.16
There is open communication between the committee and medical staff	member	109	5.00	67.66			
	chair	20	4.00	50.50			
	Total	129	5.00		800.00	.021	.20
Members who are employed by the organisation are permitted to leave their jobs to attend committee meetings and activities	member	108	5.00	67.29			
	chair	20	4.50	49.45			
	Total	128	5.00		779.00	.012	.22
Both committee members and other employees can attend ethics education and training e.g. conferences	member	109	5.00	67.12			
	chair	20	4.00	53.43			
	Total	129	5.00		858.50	.081	.15

In contrast to the results for these factors presented in the previous section, comparing responses from Australasian and UK participants, Mann-Whitney testing showed there was a statistically significant difference in responses between CEC chairpersons and other CEC members for three of the statements i.e. Committee work is valued and

respected by the organisation, U= 793.00, p = .023; there is open communication between the committee and medical staff, U = 800.00, p = .021; and, members who are employed by the organisation are permitted to leave their jobs to attend committee meetings and activities, U = 779.00, p = .012. For each of these statements, the median values shown in table 5.37, indicates that members considered them to be more important factors than did chairpersons.

5.6.4. Structure, Function, Process

Participants were requested to assess twelve factors pertaining to the structure, function, and process of their committee for their contribution to the success of the committee, Confidentiality exists in all aspects of committee functioning; Committee works with real cases and real issues; The committee, to those seeking consultation, gives a timely response; The medical staff supports the committee; Members have equal power and influence in committee decision-making process; Education is provided for committee members/ new members; Committee has regularly scheduled events; Options are provided during consultations; Committee is accessible to patients, families and staff; Organisational satisfaction with the committee's activities is evaluated periodically; Committee handles a high number of cases/ interventions; Committee sponsors workshops, speakers and other events.

4a. Country of Origin

Table 5.47. Structure, Function, Process: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Committee has regularly scheduled events	Australasia	29	5.00	80.69			
	UK	100	4.00	60.45			
	Total	129	4.00		995.00	.006	.24
The medical staff supports the committee	Australasia	29	5.00	67.74			
	UK	100	5.00	64.21			
	Total	129	5.00		1370.50	.610	.04
Committee works with real cases and real issues	Australasia	29	5.00	60.90			
	UK	100	5.00	66.19			
	Total	129	5.00		1331.00	.371	.08
Confidentiality exists in all aspects of committee functioning	Australasia	29	5.00	61.17			
	UK	100	5.00	66.11			
	Total	129	5.00		1339.00	.362	.08
Committee is accessible to patients, families and staff	Australasia	29	4.00	72.17			
	UK	100	4.00	62.92			
	Total	129	4.00		1242.00	.218	.11
Committee handles a high number of cases/ interventions	Australasia	28	3.00	61.84			
	UK	98	3.00	63.97			
	Total	126	3.00		1325.50	.769	.26
Options are provided during consultations	Australasia	28	4.00	61.36			
	UK	95	4.00	62.19			
	Total	123	4.00		1312.00	.908	.01
Committee sponsors workshops, speakers and other events	Australasia	29	4.00	71.57			
	UK	100	3.00	63.10			
	Total	129	3.00		1259.50	.264	.10
Members have equal power and influence in committee decision-making process	Australasia	29	4.00	58.26			
	UK	100	5.00	66.96			
	Total	129	5.00		1254.50	.217	.11
Organisational satisfaction with the committee's activities is evaluated periodically	Australasia	29	4.00	60.69			
	UK	100	4.00	66.25			
	Total	129	4.00		1325.00	.449	.07
Education is provided for committee members/ new members	Australasia	29	4.00	59.28			
	UK	100	4.00	66.66			
	Total	129	4.00		1284.00	.306	.09
The committee, to those seeking consultation, gives a timely response	Australasia	29	5.00	64.33			
	UK	100	5.00	65.20			
	Total	129	5.00		1430.50	.894	.01

From table 5.47, it can be seen that the only statement where a Mann-Whitney test showed a statistically significant difference between Australasian and UK respondents, was the statement pertaining to the committee having scheduled regularly scheduled events, U = 995.00, p = .06. Table 5.47, shows that Australian respondents (Mdn= 5.00) considered this factor to be more important than did UK respondents (Mdn= 4.00). In addition, table 5.47, shows that the committee handling a high number of cases (Mdn= 3.00), and the Committee sponsoring workshops, speakers and other events (Mdn = 3.00), were considered to be the least important factors in this section.

4b. Committee Membership Status

Table 5.48. Structure, Function, Process. : Committee Membership Status

Statement	Membership Status	N	Mean Rank	Median	Mann-Whitney U	p	r
Committee has regularly scheduled events	member	109	64.70	4.00			
	chair	20	66.65	4.00			
	Total	129		4.00	1057.00	.817	.02
The medical staff supports the committee	member	109	66.90	5.00			
	chair	20	54.65	4.00			
	Total	129		5.00	883.00	.126	.13
Committee works with real cases and real issues	member	109	65.25	5.00			
	chair	20	63.65	5.00			
	Total	129		5.00	1063.00	.815	.02
Confidentiality exists in all aspects of committee functioning	member	109	66.83	5.00			
	chair	20	55.03	5.00			
	Total	129		5.00	890.50	.059	.17
Committee is accessible to patients, families and staff	member	109	66.69	4.00			
	chair	20	55.80	4.00			
	Total	129		4.00	906.00	.209	.11
Committee handles a high number of cases/ interventions	member	106	64.92	3.00			
	chair	20	56.00	3.00			
	Total	126		3.00	910.00	.281	.10
Options are provided during consultations	member	104	62.06	4.00			
	chair	19	61.68	4.00			
	Total	123		4.00	982.00	.964	.04
Committee sponsors workshops, speakers and other events	member	109	65.50	3.00			
	chair	20	62.30	3.00			
	Total	129		3.00	1036.00	.715	.03
Members have equal power and influence in committee decision-making process	member	109	66.39	5.00			
	chair	20	57.43	4.00			
	Total	129		5.00	938.50	.270	.10
Organisational satisfaction with the committee's activities is evaluated periodically	member	109	67.02	4.00			
	chair	20	54.00	4.00			
	Total	129		4.00	870.00	.125	.12
Education is provided for committee members/ new members	member	109	65.38	4.00			
	chair	20	62.95	4.00			
	Total	129		4.00	1049.00	.770	.03
The committee, to those seeking consultation, gives a timely response	member	109	67.92	5.00			
	chair	20	49.08	4.00			
	Total	129		5.00	771.50	.012	.22

Table 5.48, shows that the statement regarding the committee giving a timely response to those seeking consultation, was the only statement to show a statistically significant difference between committee chairpersons and other committee members, U = 771.50, p = .012. In this instance, committee members (Mdn= 5.0) regarded this factor to be more important than did committee chairpersons (Mdn= 4.0).

As was the case with the analysis of these factors by the country of origin of respondents (table 5.47), table 5.48, shows that the statements concerning the committee handling a high number of cases (Mdn = 3), and the committee sponsoring workshops, speakers and other events (Mdn = 3) were considered to be the least important factors in this section.

5.6.5. Relative Importance

This section of the study concluded with a request for participants to assess the relative importance of each of the above four areas in their overall importance to the success of their committee 1.Leadership, 2.Participation, communication, skills, 3.Administrative support, 4.Structure, function, process.

5a. Country of Origin

Table 5.49. Relative Importance: Country of Origin

Statement	Country of Origin	N	Mean Rank	Median	Mann-Whitney U	p	r
Leadership	Australasia	29	68.16	5.00			
	UK	100	64.09	5.00			
	Total	129		5.00	1358.50	.556	.05
Participation, Communication, Skills	Australasia	29	65.83	5.00			
	UK	100	64.76	5.00			
	Total	129		5.00	1426.00	.864	.01
Administrative Support	Australasia	29	84.81	5.00			
	UK	100	59.26	4.00			
	Total	129		4.00	875.50	.001	.30
Structure, Function, Process	Australasia	29	77.22	4.00			
	UK	100	61.46	4.00			
	Total	129		4.00	1095.50	.029	.19

Table 5.49**,** shows that a Mann-Whitney test indicated there was a statistically significant difference between responses from Australasian and UK participants regarding the relative importance of Administrative Support, U = 875.50, p = .01, and

Structure, Function, Process, U = 1095.50, p = .029, as factors contributing to the success of their CEC. In each of these instances, the mean ranks shown in table 49, indicate that Australasian participants considered them to be more important factors than did UK participants.

5b. Committee Membership Status

Table 5.50. Relative Importance: Committee Membership Status

Statement	Membership Status	N	Mean Rank	Median	Mann-Whitney U	p	r
Leadership	member	109	66.58	4.00			
	chair	20	56.40	4.00			
	Total	129		4.00	918.00	.202	.11
Participation, Communication, Skills	member	109	64.61	5.00			
	chair	20	67.10	5.00			
	Total	129		5.00	1048.00	.729	.03
Administrative Support	member	109	65.78	5.00			
	chair	20	60.73	5.00			
	Total	129		5.00	1004.50	.563	.05
Structure, Function, Process	member	109	66.77	5.00			
	chair	20	55.38	4.00			
	Total	129		5.00	897.50	.172	.12

Table 5.50, shows that there was no statistically significant difference for these factors between chairpersons and other committee members. It can be seen from table 5.50, that leadership was considered to be the least important factor, with a median value of 4.00.

5.7. Chapter Summary

From an extensive search of the literature concerning clinical ethics committees (CECs), the rationale behind CECs was established. In addition, the main functions of CECs were identified as being policy and guideline development/ review; education; and case consultation. This introduction was followed by the presentation of the findings of the study. These findings aimed to identify and describe the activities of participating committees, with particular reference to the main functions articulated above.

A summary of the main study findings for each of these areas is presented below.

Policy and Guidelines

It was found that only one of the committees (n=22) indicated it did not undertake Policy and Guidelines development/ review. It was determined there was no statistically significant difference between Australasian and U.K. committees for participation in undertaking Policy and Guidelines development/ review.

From the study results, it was found that the policy/ guideline issues most discussed by committees participating in the study were Consent (74%), DNR orders (65%) and Advance directives (56%). In each of these cases there was no significant difference between UK and Australasian committees.

Regarding time spent by CECs dealing with policy issues, this was divided into a. time spent dealing with policy review or revision and, time spent dealing with policy development. There was no significant difference found between Australasian and U.K. committees for either of these areas.

The study investigated individual committee members' perceptions and beliefs regarding the success of their committee regarding its activities concerning policies and guidelines. Seven statements were included in this section: Our CEC adequately deals with policy review; Our CEC adequately identifies areas policy required; Our CEC's current policy consistent with hospital mission; Policy developments are made in consultation with affected stakeholders; Policy revisions are made in consultation with affected stakeholders; Our CEC effectively communicates information on policy to stakeholders; Our CEC assesses the impact of revised policy.

The results showed a significant difference between Australasian and U.K. participants for each of these statements. For each statement, Australasian respondents showed greater agreement than their U.K. counterparts. In contrast with the results obtained for participants by country of origin, the responses by committee membership status did not show a statistically significant difference for any of the statements.

Education

It was found that 86% of CECs provided education for committee members and for hospital staff. 23% of CECs provided education for the general community. No statistically significant difference was found between Australasian and U.K. committees in this area. Similarly, analysis of time spent on education revealed no statistically significant difference between Australasian and U.K. committees.

The study investigated individual committee members' perceptions and beliefs regarding the success of their committee regarding its activities concerning education. Seven statements were included in this section. A significant difference between Australasian and U.K. participants was found for 3 of these statements, namely; Our ethics committee adequately addresses the bioethical education needs of the hospital community; Our ethics committee adequately addresses the bioethical education needs of its members; and, I feel sufficiently prepared for my role on this ethics committee. In each case, the median values indicated greater agreement by Australasian participants. There was a statistically significant difference found in responses between committee chairpersons and other committee members to the statements, Our CEC adequately addresses the bioethical education needs of its members, and, Our CEC adequately addresses the bioethical education needs of the community at large. In each instance, the median values indicated that committee members agreed more strongly with the statements than committee chairpersons.

Case Consultation

22 of the committees participating in the study indicated that they undertook case consultation (including retrospective). Statistical analysis revealed no statistically significant difference between UK and Australasian committees.

The study results showed no statistically significant difference between U.K. and Australasian committees in their methods of case consultation.

In terms of volume, committees were asked to indicate the number of acute and retrospective cases that they had dealt with in the preceding twelve months. While no significant difference was found between Australasian and U.K. CECs for acute case

consultations, a significant difference was found for retrospective cases. U.K. committees were shown as being more active than Australasian committees in this area.

Consideration of issues arising during case consultation, 'patient autonomy' and 'end of life issues' were the most commonly raised issues. There were no statistically significant differences found between Australasian and U.K. committees for issues arising.

Committees participating in the study were requested to indicate all persons who could request case consultation by the committee. In this area, significant differences were found between Australasian and U.K. committees for hospital staff, any CEC member and attending physician. In each of these instances, a greater proportion of U.K. committees indicated that these groups could request case consultation.

Participating committees were requested to indicate the outcomes of case consultation undertaken. The most common outcome of case consultation was 'recommendations to physicians and staff', with 21 (91%) of all participating committees (n=23) indicating this was an outcome. The least common outcome of case consultation was the making of 'binding decisions.' There were no statistically significant differences found between participating committees from Australasia and U.K. for case consultation outcomes.

The study investigated individual committee members' perceptions and beliefs regarding the success of their committee regarding its activities concerning case consultation. Six statements were included in this section. A significant difference between Australasian and U.K. participants was found for 2 of these statements, namely; Our committee is successful in its role of conducting acute case consultation; and, Our committee has an effective procedure/ protocol in place to guide case review/ consultation. In each case, Australasian participants showed a greater level of agreement with the statement than the U.K. participants. The study found no statistically significant differences between CEC chairpersons and members for any of the 6 statements.

Other Functions.

Overall, 30% of committees in the study (n=23) responded that they undertook activities other than those articulated in the questionnaire. There was no significant difference

found between Australasian committees (33%) and U.K. committees (29%) in this category. The 'other' functions undertaken by committees were: Rapid response to clinical ethics issues; Distributive justice; Round robins with other hospital committees; Interaction with undergraduate medical ethics teaching; Discussion with clinicians of ethical aspects of new technologies/ procedures prior to (their) introduction; and, Resource allocation.

Success Factors

Section B. of Questionnaire 1, was designed to assess the relative importance of a number of factors which might be seen to be contributing to the success of a CEC. Participants were asked to indicate the degree to which they agreed with statements about factors which might contribute to the 'success' of their ethics committee in 4 key areas, Leadership, Participation, Communication, Skills, Administrative Support, Structure, Function and Process.

Leadership

Participants were requested to assess four factors associated with leadership in contributing to the success of their committees, Chairperson manages meetings effectively; Chairperson creates a forum that generates results; Chairperson does not encourage hierarchical committee style; Chairperson has formal education in ethics.

No statistically significant difference was found between Australasian and UK respondents for any of the statements included in this section. Median values revealed the statement pertaining to the chairperson having a formal education in ethics was considered to be the least important factor in this section. In contrast, a significant difference between Chairpersons and Members was found for the statement regarding the chairperson having a formal education in ethics and the statement concerning the chairperson managing meetings effectively. In each instance, committee members showed a greater level agreement.

Participation, Communication, Skills

Participants were requested to assess eight factors associated with participation, communication, and skills, as to their relative importance in contributing to the success of their committee: Committee has multidisciplinary composition; Members respect the

point of view of others; Members possess good communication and listening skills; Members actively participate in discussions; Members regularly attend meetings; There is an ethicist on the committee; Members come to meetings well prepared; Members willing to work on a related task force.

A significant difference between Australasian and UK respondents was found for the statement regarding members coming to meetings well prepared, with Australasian respondents considering the statement to be more important than their UK counterparts. A statistically significant difference between Chairpersons and Members responses was found for the statement pertaining to members actively participating in discussions, with chairpersons considering such participation in committee discussions to be a more important factor than did other committee members.

Administrative Support

Participants were asked to assess the relative importance of seven factors relating to administrative support for their committee in contributing to the success of the committee. The statements in this section were, Members who are employed by the organisation are permitted to leave their jobs to attend committee meetings and activities; There is open communication between the committee and medical staff; Committee work is valued and respected by the organisation; Both committee members and other employees can attend ethics education and training; There is open communication between the committee and administration; Committee works autonomously; The administration subsidises printed material and other such as brochures that describe the role and function of the committee.

Statistical analysis revealed no significant difference between the responses from Australasian and UK participants in this section. In contrast, the study results showed there was a statistically significant difference in responses between CEC chairpersons and other CEC members for three of the statements i.e. Committee work is valued and respected by the organisation; there is open communication between the committee and medical staff; and, members who are employed by the organisation are permitted to leave their jobs to attend committee meetings and activities. For each of these statements, the median values indicated that members considered them to be more important factors than did chairpersons.

Structure, Function, Process

Participants were requested to assess twelve factors pertaining to the structure, function, and process of their committee for their contribution to the success of the committee, Confidentiality exists in all aspects of committee functioning; Committee works with real cases and real issues; The committee, to those seeking consultation, gives a timely response; The medical staff supports the committee; Members have equal power and influence in committee decision-making process; Education is provided for committee members/ new members; Committee has regularly scheduled events; Options are provided during consultations; Committee is accessible to patients, families and staff; Organisational satisfaction with the committee's activities is evaluated periodically; Committee handles a high number of cases/ interventions; Committee sponsors workshops, speakers and other events.

A statistically significant difference between Australasian and UK respondents was found for the statement pertaining to the committee having scheduled regularly scheduled events, Australian respondents considered this factor to be more important than did UK respondents. The statement regarding the committee giving a timely response to those seeking consultation, was the only statement to show a statistically significant difference between committee chairpersons and other committee members, with committee members regarding this factor to be more important than committee chairpersons.

Relative Importance

This section of the study concluded with a request for participants to assess the relative importance of each of the above four areas in their overall importance to the success of their committee Leadership; Participation, Communication, Skills; Administrative Support; Structure, Function, Process.

Analysis revealed a statistically significant difference between responses from Australasian and UK participants regarding the relative importance of Administrative Support, and Structure, Function, Process. In each of instance, Australasian participants considered them to be more important factors than did UK participants. No statistically significant difference was found for these factors between chairpersons and other

committee members. Calculation of median values showed that leadership was considered to be the least important factor.

In conjunction with results obtained from the study regarding the structure, deliberative processes, and evaluation of CECs, the results obtained from this section, regarding committee functions, may enhance our understanding of the processes by which CECs arrive at their outcomes. These findings will be discussed in detail in Chapters 6 and 7.

Chapter 6

Clinical Ethics Committee Evaluation

6.1. Introduction

In this chapter, the study findings regarding the evaluation processes of participating committees are presented and discussed.

The study undertook to identify those participating committees which have a formal evaluation process in place. Where this was found to be the case, a number of key areas concerning the nature of this evaluative process were investigated in order to provide some insight on the effectiveness of such processes. Section 2.4, Pluralism in Bioethics, from chapter 2 (Methodology in Bioethics) provides some theoretical background to the importance of CECs having a formal evaluation process in place.

For the purposes of the study, sections regarding committee evaluation were included in both questionnaires 1 and 2. Questionnaire 1 was completed by individual study participants and solicited the views of individual participants on a number of areas concerning committee evaluation. Questionnaire 2 was completed by the Chairperson (or other nominated individual) of each committee, and wherever reference is made to the views of the committee this should be understood to refer to the views presented by the chairperson (or other nominated individual). The responses to questionnaire 2 were taken to represent what actually obtains for participating committees.

It is believed that by drawing comparisons between responses obtained from questionnaires 1 and 2 that it will be possible to gather information regarding what committees are currently doing and what individual committee members believe their committees should be doing in key areas regarding committee evaluation. This information may prove useful in guiding the future development of CEC evaluation processes. For example, in the area of how information is gathered to evaluate the committees, questionnaire 2 asks how participating committees currently gather information, while questionnaire 1 asks individual participants to give their views on how effective they believe these means of gathering information to be.

Prior to enunciating the areas of committee evaluation investigated in the study, a background to the broad area of evaluation together with a more specific background to the evaluation of ethics committees is presented.

6.2. Evaluation

Although the term 'Evaluation' has been in common usage for centuries, it is only since the latter part of the twentieth century, that the term has taken on a more precise definition. According to Stufflebeam and Shinkfield (2007, p3), this definition is taken to include 'specificity to basic concepts and more explicit explanations about its aims as a functioning entity'.

Regarding the importance of Evaluation, Stufflebeam and Shinkfield (2007) assert that Evaluation is one of society's most fundamental disciplines, since it is a process which is able to provide evidence concerning matters, such as the reliability, effectiveness, and efficiency of objects of interest. Further, Stufflebeam and Shinkfield (2007, pp4-5), maintain that Evaluation serves society by providing affirmations on such things as the worth and value of entities being scrutinised. In addition, Evaluation can make a statement on how these entities might be improved (including how and when this should happen), and how they may be held accountable.

However, Stufflebeam and Shinkfield also warn that sound evaluation in itself is not sufficient to provide any guarantee of high quality or guide improvement in services. Nor can it guarantee that those in authority will pay attention to the lessons of evaluation and take appropriate corrective actions. Stufflebeam and Shinkfield (2007, pp5-6), state that evaluation provides only one ingredient required for quality assurance and improvement, and further, that for 'evaluations to make a positive difference, policymakers, regulatory bodies, service providers, and others must obtain and act responsibly on evaluation findings'.

Historically, there have been many different definitions of Evaluation. According to Stufflebeam and Shinkfield (2007), one of the earliest and still most prominent definitions, defines Evaluation in terms of determining whether objectives have been achieved. However, Stufflebeam and Shinkfield reject this definition, arguing that

following it can cause evaluations to fail, since some objectives may be deemed unworthy of achievement. They further argue that an entity should not be judged to be successful solely because it has achieved its own objectives, since these objectives could be corrupt, dysfunctional, unimportant, or not oriented to the needs of the intended beneficiaries.

An important problem with defining Evaluation in terms of whether objectives have been achieved lies in the fact that this definition guides evaluations in the direction of looking only at outcomes. For Stufflebeam and Shinkfield (2007, p7), 'Evaluations should also examine an entity's goals, structure, and process'. They state that this is particularly the case in instances where an evaluation is designed to contribute to program improvement. In addition, Stufflebeam and Shinkfield (2007,p7) assert that 'a focus on objectives might cause evaluators not to search for important side effects, which can be critically important in determining whether an entity is safe.' One further limitation of evaluations which employ an objectives-based definition, for Stufflebeam and Shinkfield, is that they only provide feedback at the end of a program, thereby missing their important role in aiding the planning and guidance of programs toward successful outcomes.

According to Stufflebeam and Shinkfield (2007, p3), the Joint Committee on Standards for Educational Evaluation (1994) defined evaluation as 'the systematic assessment of the worth or merit of an object'. Advantages of this definition are seen by Stufflebeam and Shinkfield to be that it is concise and consistent with common dictionary meanings of Evaluation. Further, they state that this is the definition to use when discussing evaluation at a general level.

However, Stufflebeam and Shinkfield (2007, p9), point out that Evaluation's root term, value, denotes that evaluations essentially involve making value judgments. Accordingly, evaluations are not value free. They need to be grounded in some defensible set of guiding principles or ideals and should determine the evaluand's standing against these values. For Stufflebeam and Shinkfield, this truism presents evaluators with the need to choose the appropriate values for judging an evaluand. In view of this, Stufflebeam and Shinkfield (2007, p13), extended the general definition to

highlight what they considered to be a range of important, generic criteria for consideration when assessing programs.

Stufflebeam and Shinkfield (2007, p13) provided what they termed an ‘operational definition of evaluation’. According to this definition, evaluation is the systematic process of delineating, obtaining, reporting, and applying descriptive and judgmental information about some object’s merit, worth, probity, feasibility, safety, significance, and/or equity. Adopting this definition of evaluation requires the evaluator to collect and report both descriptive and judgmental information.

In terms of descriptive information, according to Stufflebeam and Shinkfield (2007, p18), a final evaluation report should describe the program's goals, plans, operations, and outcomes objectively. As much as possible, the descriptive information should be kept separate from judgments of the program. The evaluator also has a vested interest in getting a clear view of the program apart from how observers judged it. This is especially important when interpreting a program's outcomes and judging its success.

Stufflebeam and Shinkfield (2007, p18), state in regard to judgemental information, that beyond the collection of descriptive information, it is equally important to gather, assess, and summarize judgments of the program. Since evaluations inevitably involve valuing, that is, judgment, judgment-oriented feedback can be a vital, positive force when it is integral to development, directed to identifying strengths as well as weaknesses, and focused on improving the evaluand. Appropriate sources of judgments include program beneficiaries, program staff pertinent experts, and, of course, the evaluator, among others.

Stufflebeam and Shinkfield (2007, p22), consider there to be four main uses of evaluations: improvement, accountability, dissemination, and enlightenment. Based on this, they make a distinction between what they term ‘formative’ and ‘summative’ evaluations. These distinctions are discussed below.

Evaluations may be used to provide information for developing a service, ensuring its quality, or improving it. Evaluations to serve this use typically are labelled formative evaluations. Basically, they provide feedback for improvement. They are prospective

and proactive. They are conducted during development of a program or its ongoing operation. Formative evaluations offer guidance to those who are responsible for ensuring and improving the program's quality and, in doing so, should pay close attention to the nature and needs of the consumers. Formative evaluations assess and assist with the formulation of goals and priorities and guide program management by assessing implementation of plans and interim results. Information from all such formative evaluations is directed to improving operations. In the main, formative evaluations serve quality assurance purposes Stufflebeam and Shinkfield (2007, p23)

For Stufflebeam and Shinkfield (2007, p23), the second main use of evaluation is to produce accountability or summative reports. These are retrospective assessments of entities such as established programs. Summative evaluations typically occur at the end of a service cycle. They draw together and supplement previously collected information and provide an overall judgment of the evaluand's value. Summative evaluations are useful in determining accountability for successes and failures, informing consumers about the quality and safety of products and services, and helping interested parties increase their understanding of the assessed phenomena.

According to Stufflebeam and Shinkfield (2007, p24), the relative emphasis of formative and summative evaluations will change according to the nature and circumstances of the evaluand. In general formative evaluation will be dominant in the early stages of a program and less so as the program matures. Summative evaluation will take over as the program matures.

A further point of interest concerning formative and summative evaluation, highlighted by Stufflebeam and Shinkfield (2007, p26), is that formative evaluations often form the basis for summative evaluations. If this is to occur, Stufflebeam and Shinkfield assert that those who commission the studies and the evaluators must make it clear to all involved that this will occur. They also point out that it should be recognised that on occasions, the merit or worth of a formative evaluation may be strengthened by the intervention of summative evaluations (usually carried out by external personnel) at critical points of a program's development.

A central theoretical component in the consideration of evaluation is the consideration of 'informal' and 'formal' evaluation. This aspect of evaluation for the current study is investigated in detail later in this chapter.

Stufflebeam and Shinkfield (2007, p27), believe it is important to distinguish formal evaluation from informal evaluation. In fact, they believe the distinction to be at the root of the need for and emergence of the evaluation profession. Aspects of a. informal evaluations and b. formal evaluations are discussed below.

a. Informal Evaluations

According to Stufflebeam and Shinkfield (2007, p28)**,** the conduct of informal evaluations is prone to haphazard data collection and other forms of misinformation, errors of judgment, acting on old preferences or prejudices, relying on out-of-date information, or making expedient choices. In many cases, the steps in an informal evaluation are unsystematic, lacking in rigor, and based on biased perspectives. Thus, informal evaluations typically offer a weak basis for convincing decision makers and others of the validity of evaluation findings and appropriateness of ensuing conclusions and recommendations. More formal evaluations are called for when there is a need to inform critically important decisions, especially ones that will affect many people, require substantial expenditures, or pose substantial risk.

b. Formal Evaluations

In accordance with the definition of evaluation given earlier, formal evaluations should be systematic and rigorous. By systematic, Stufflebeam and Shinkfield refer to evaluations that are relevant, designed and executed to control bias, kept consistent with appropriate professional standards, and otherwise made useful and defensible. In particular, Stufflebeam and Shinkfield (2007, p28), define formal evaluations as ones that are held up to scrutiny against appropriate standards of the evaluation profession.

For Stufflebeam and Shinkfield (2007, p29) in order to meet accountability requirements, each profession, public service area, and society should regularly subject services to formal evaluations. Some of the evaluation work is appropriately directed at

regulation and protection of the public interest. It should be conducted by independent bodies, including government agencies, accrediting boards, and external evaluators. Equally important are the formative and summative evaluations of services that professionals and other service providers and their organizations themselves conduct or commission. These internal or self-evaluations are an important aid to continually scrutinizing and improving services and also supplying data needed by the independent or external evaluators.

Stufflebeam and Shinkfield (2007, pp29-30) assert that, in order to keep their services up to date and ensure that they are effectively and safely meeting their stakeholders' needs, service institutions should continually obtain pertinent evaluative feedback. Stufflebeam and Shinkfield see conducting such internal evaluations as being a challenging task. They maintain that the credibility of internal evaluation is enhanced when it is subjected periodically to metaevaluation, in which an independent evaluator evaluates and reports publicly on the quality of internal evaluation work. Such independent metaevaluation also provides direction for strengthening the internal evaluation services.

6.2.1. Evaluation of Ethics Committees

Looking more specifically at evaluation in a clinical ethics setting, Hoffman (1993) was one of the first researchers to postulate a systematic framework for evaluating ethics committees. She accomplished this by providing a conceptual framework for the evaluation of committees from a public policy or societal perspective.

Hoffmann noted the need for a systematic framework for evaluating ethics committees since, at that time, few studies had attempted the development of such a comprehensive evaluation framework or had considered the perspective from which ethics committees should be evaluated.

Hoffman's model for evaluating ethics committees involved the criteria of access, quality and cost effectiveness. She believed that these criteria should be applied in assessing the major functions performed by such committees. In the current study,

these major functions have been identified as education, policy development, and case consultation.

In terms of Access, Hoffmann was interested in determining whether an ethics committee was reaching the appropriate target population. In the current study, this would mean for the committee function pertaining to education, for example, the target population might include committee members, hospital staff, and the general public.

For case consultation, Hoffman pointed out that access is important, since without it potential users would not utilise the committee. There is therefore a requirement to determine whether there are any obstacles to using the committee. Obstacles to committee use, according to Hoffmann, would include factors such as whether potential users knew about the committee's existence and whether the procedures for using the committee were uncomplicated. In addition, the evaluation process should include questions regarding whether potential users understand exactly what the committee does and whether or not they would use the committee.

In terms of policy development and education, Hoffmann postulated that it should be ensured that all relevant stakeholders be included. For example, if the goal of the committee is to educate hospital staff or the wider community, there should be measures in place to ensure these groups have access to committee educational offerings.

Hoffmann asserts that the quality of an ethics committee is the most important evaluative criterion. However, in Hoffmann's opinion, the assessment of a committee's quality is the most difficult to define and apply.

In the consideration of how to evaluate a committee's quality, Hoffmann adopted the framework proposed by Donabedein (1980), citing structure, process and outcome as being the accepted components with which to begin the evaluation of a committee. In terms of structure, the main concern, according to Hoffmann, would be regarding the individuals serving on the committee, including their qualifications and expertise. Aspects of the structure of committees involved in the current study were considered at length in chapter 4 (Structure).

In the following section, the evaluation components relating to 1. Descriptive Quantitative Evaluation 2. Process Evaluation and 3. Outcome Evaluation are discussed in more detail.

1. Descriptive Quantitative Evaluation

In a paper entitled the 'Evaluation of Clinical Ethics Support Services (CESS) and its Normativity', Schildmann, Molewijk, Benaroyo et al et al (2013), define the evaluation of CESS as 'the systematic gathering of data with empirical research methods for the purpose of acquiring knowledge about the structure, functioning, quality and results of CESS' (Schildmann et al, 2013, p681). One of the approaches that Schildmann et al describe is descriptive evaluation.

According to Schildmann et al (2013, p682), descriptive evaluation provides numeric data on access, activities and structural features of CESS. Example of descriptive quantitative analysis, according to Schildmann et al, could include cross-sectional studies which provide information on the professional background of members of an ethics committee. Other topics which might be investigated in a descriptive quantitative analysis could, for example in case consultation, include the topics of case consultation or the number of case consultations undertaken by the committee within a given time frame. One particular value of this type of evaluation, according to Schildmann et al, is that it can stimulate further development of the ethics committee. In addition, this type of evaluation can provide results that can be used to substantiate judgements concerning the functioning of an ethics committee (Schildmann et al, 2013, p682).

However, Schieldmann et al (2013, p682), warn that a drawback of this type of evaluative process is that it only gathers data which fit into predefined categories and this may lead to relevant, but unanticipated information being overlooked. In order to help circumvent this problem, Schildmann et al (2013), suggest that deliberation on potential evaluative criteria with all stakeholders concerned with an ethics committee would provide researchers with information regarding priorities of evaluative criteria from the perspective of different stakeholders.

The current study utilises features of this type of descriptive quantitative evaluation, with the structure and functions of participating committees being examined in depth in chapters 4 (Structure) and 5 (Function). Since the study is primarily exploratory, one of the central aims of the study is to determine if committees have an evaluation process in place, and if so, to provide information on the nature of the process.

2. Process Evaluation

For Hoffmann, process should be evaluated in terms of due process issues and the exchanges between committee members at committee meetings. According to Hoffmann, there is little consensus as to what constitutes deliberative, internal procedures. Questions posed by Hoffmann regarding this deliberative process included the necessity for discussing formal ethical concepts, and, whether a committee used a process of consensus or majority vote to reach a recommendation.

Whilst acknowledging the difficulty of determining objective criteria for evaluating the internal processes of an ethics committee, Hoffmann believed that the following specific measures should be considered.

a. Did all relevant stakeholders have an opportunity to speak?
b. Were all committee members able to participate freely in committee deliberations, rather than the discussion being dominated by a few individuals?
c. For case consultations, did anyone gather facts about the patient's wishes?
d. In instances where there was insufficient information available about the patient's preferences, how were the best interests of the patient determined?
e. Was the relevant medical, legal, and ethical information to hand? Also, in this regard, Hoffman asked the important question of who decides what is relevant.
f. Did the committee use a process designed to reach a consensus and vote on the outcome?

Many of these questions, posed by Hoffmann regarding process evaluation, are discussed in depth in Chapter 7(Deliberative Process)

3. Outcome Evaluation

Schildmann et al (2013, p682), describe an approach to committee evaluation utilising outcomes. They believe that the key element in this type of evaluation is that it focuses on 'outcomes in the sense of parameters for the quality of the CESS'. In order to accomplish this, Schildmann et al describe two categories used in outcome evaluation. In the first instance, the categories in outcome evaluation are predetermined in terms of what data are gathered. This is similar to the process used in descriptive evaluation mentioned previously. The second category highlights that the evaluation categories are predefined in terms of what comprises good or bad outcomes.

According to Hoffmann (1993, p694) and Schildmann et al (2013, p682), evaluation of outcomes may be divided into research which uses subjective or objective criteria.

In terms of subjective research, Hoffmann and Schildmann et al acknowledge that a commonly used criterion is the perception of satisfaction of committee outcomes by those persons or groups using the committee's services. In this instance, the guiding question is 'are stakeholders who are involved in CESS satisfied with the processes and outcomes of the services delivered?' (Schildmann et al, 2013, p682). The relevant stakeholders would include those who requested the service, the hospital administration, the health professionals or members of the ethics committees themselves. However, for Hoffmann, although important, it is not sufficient to rely solely on subjective measures. In similar fashion, Schildmann et al, point out that a problem with using 'satisfaction' as a criterion in the evaluation of outcomes, lies in questions regarding whom should be asked as part of an evaluation of ethics committees and how satisfaction is relevant for a judgement on the quality of a CEC. In the current study, outcome measures investigated in terms of user satisfaction include whether committees solicit feedback from individuals or groups who use the committees' services.

Regarding objective criteria, Hoffmann asserts that there is difficulty in determining what these criteria should be. In terms of case consultation if there is no evidence of the patient's wishes then deciding on the appropriate criteria is controversial. For example, in end of life cases, questions may arise whether continuing or terminating life support is ethically appropriate. In such cases, Hoffmann states that, rather than a committee

being expected to come up with a 'best answer', it should be expected to arrive at a recommendation that is ethically and socially acceptable. This in itself may be problematic in as much as it would somehow have to be determined who might be the appropriate arbiters of what is 'socially appropriate'. Schildmann et al (2013, p682), suggest that objective outcome parameters used to demonstrate the effectiveness of a committee, might include sources of information such as treatment documentation, hospital bills, and questionnaires to relevant stakeholders.

According to Schildmann et al, 2013, p682, 'evaluation of outcomes has been widely advocated as a tool for the quality assurance of CESS'. They see one of the benefits of this type of evaluation being that it 'may foster trust and confidence among patients, families and members of the healthcare team as a necessary prerequisite for the successful and sustained implementation of these services' (Schildmann et al, 2013, p682). In addition, the evaluation of outcomes may be able to inform the members of an ethics committee about the perceived quality of their work (Schildmann et al, 2013, p682).

The stakeholders consulted regarding the criteria for evaluation and their priorities in the current study were members of the participating committees. Whilst acknowledging the relevance of consulting other stakeholders, for example, patients and hospital staff, it was not within the scope of this study to include such groups. This may be a fruitful avenue to pursue in developing the results of this study further.

As we have seen in the above introduction, a key question in the evaluation of clinical ethics committees (CECs) is 'How effective are CECs in providing ethics support?' Slowther et al (2002) found little evidence of CEC effectiveness in the U.K. They concluded that this could have been due, in part, to confusion about what the committee objectives might be. Several authors found that another reason for this apparent lack of effectiveness was that many CECs were 'invisible' to practitioners (Flynn, 1991). For example, Bell found that 88 (91%) of respondents to a survey were unaware of the existence of a CEC at their institution (Bell, 2003). Therefore, the need to raise awareness of a CEC within an institution was deemed to be of fundamental importance (Harding, 1994; Rudd, 2002; Slowther et al., 2001b).

The Royal College of Physicians (RCP) Working Party Report (2005) suggested that CECs should undergo regular and methodologically sound evaluation of their work. In addition to keeping accurate records of the committee's deliberations they should be able to provide evidence of what the report considers to be the central measures of the success of a CEC.

These measures were considered to be

1. A measure of satisfaction of those who use the services of the committee e.g. those who bring issues for discussion, those who are recipients of the committee's policy work, and those who attend education events.

2. A measure of the CEC's success in facilitating development of ethical practice within the institution (RCP, 2005).

A further important question to be answered, according to Campbell (2001), is 'what measures do committees take to remedy deficiencies in their own procedures?' (Campbell, 2001, p156).

One method of assessing a CEC's purpose, composition and activities, proposed by Hofmann, is that of a 'Committee Audit'. This entails the self assessment of a CEC by its members with regard to:

1. Vision, Values, and scope of services.

2. Structure, authority, location within institution.

3. Process for evaluating its accomplishments, strengths and weaknesses, effectiveness of its policies and guidelines, communication within and outside the organization.

4. Success in defining and addressing its educational needs and those of the hospital community.

5. Development, revision and impact of ethical policies and guidelines.

6. Case consultation process.
(Hofmann, 2001, p59)

A number of studies have identified the need for this type of evaluation of CECs (Slowther and Hope, 2000; Szeremeta et al., 2001; Wenger et al., 2002). However, the general findings of these studies indicate that few CECs actually implement this type of assessment and that there is no consensus as to how this should be carried out.

A study, by Dobbs (2000), developed a self assessment model to measure performance of nine CECs in New Mexico. Dobbs concluded that using a recognized performance measurement system enhances a CEC's ability to assess its services and improve its performance. Further, performance assessment is strengthened by quantitative measurement. The study did not reveal statistically significant changes in CEC member perception of committee performance based on the comprehensive CEC self assessment (Dobbs, 2000).

The purpose of an audit should be to provide a CEC with opportunities to investigate the quality of its work and, where needed, to improve the function of the committee.

Other studies have suggested that an independent audit of a committee and its deliberations by external review could prove to be the most effective form of accountability for a CEC. For Emanuel, some external measures of outcomes for a CEC might include confidential surveys of stakeholders or more tangible outcomes such as 'the proportion of avoidable adverse outcomes e.g. lawsuits regarding disputes'(Emanuel, 2000, p163). This would provide relevant information to all stakeholders having a legitimate interest in the proper function of a CEC (Crawley, 2002; Wenger, 2000). However, according to Wenger, legal issues and problems with confidentiality might present significant difficulties for such an approach (Wenger, 2000).

A number of studies have asserted that, in evaluating a CEC, there is a need to consider precisely how outcomes are reached (Kaiser, 2001; RCP, 2005). According to Kaiser the majority of CECs have no clear philosophy which provides guidelines for their operations (Kaiser, 2001). This is in contrast to Research Ethics Committees in

Australia for example, where there are rigid protocols set by the National Health and Medical Research Council (NHMRC) for such committees. As mentioned earlier, in the discussion on CEC structure, this raises the question of whether there could or should be a set of national guidelines for CECs. The basic problem is that there is no apparent consensus on the method required for a CEC to competently deal with an ethical issue (Kaiser, 2001). Kaiser makes the relevant point that while it is not possible to develop a decision-making algorithm which could solve all our practical ethical problems, there is a requirement for quality assurance that the moral reasoning of CECs lies within the values of the pluralist society and meets a high standard of argumentation. As things stand, from the perspective of many stakeholders, CEC recommendations might be seen as coming out of a ‘ black box’ (Kaiser, 2001). However, in attempting to accomplish this quality assurance, we need to be mindful that ethical issues, by their very nature, and not solved merely by applying strict logic or appealing to impersonal procedures. The process is often more important than the outcome (Kaiser, 2001).

This study undertook to identify participating committees which had a formal evaluation process in place. Where this was found to be the case, a number of key areas concerning the nature of such an evaluative process were investigated in order to provide some insight on the effectiveness of such processes.

The questions addressed in this section of the study derive from the overall study aims and questions of the study, as stated in chapter 1. Specifically, the areas investigated with respect to CEC evaluation are stated below.

1. Who evaluates committees?
   Questions for this area were developed from the literature, with particular reference to Moore (2005); Slowther and Hope (2000); Szeremeta et al (2001); Wenger et al (2002); Dobbs (2000).

2. Effective means of gathering information for evaluating of committees.
   Questions for this area were developed from Moore (2005).

3. Effective indicators of committee success.
   Questions for this area were developed from Moore (2005).

4. Obstacles to successful committee development.
   Questions for this area were developed from Slowther et al (2001b).

5. Committee members' viewpoints of committee success
   Questions for this area were developed from Moore (2005), Dobbs (2000), Slowther et al (2001b).

The areas considered and questions posed in this section were developed in order to provide a nuanced overview of the evaluation processes of participating CECs, and assist in achieving the overall aims of the study as stated in chapter 1.

6.3. Study Findings

In Section C of questionnaire 2, participating committees were asked to indicate if they had a formal evaluation process in routine use.

Questionnaire 2 was completed by the Chairperson (or other nominated individual) of each committee, and, wherever reference is made to views of the Committee this should be understood to refer to the views presented by the Chairperson (or other nominated individual).

The study results are presented in table 6.1.

Table 6.1. Formal Evaluation Process

			Does your committee have a formal evaluation process?		Total
			yes	no	
Origin	UK	Count	6	11	17
	AUS	Count	5	1	6
Total		Count	11	12	23
		% of Total	48	52	100

Table 6.1, shows that 11 of the 23 committees participating in the study confirmed that they had a formal evaluation process in place. 5 of the 6 Australasian committees compared with 6 of the 17 U.K. committees indicated that they had such a process in

routine use. In the case of U.K. committees, this finding is somewhat surprising, particularly in light of the Royal College of Physicians (RCP) Working Party Report (2005), which recommended that CECs should undergo regular and methodologically sound evaluation of their work. Specifically, a measure of satisfaction of those who use the services of the committee and a measure of the CEC's success in facilitating development of ethical practice within the institution, should be undertaken (RCP, 2005).

From the discussion presented earlier in this chapter, it can be seen that it should considered to be imperative that an evaluative process is required in order to be able to provide a CEC with opportunities to investigate the quality of its work and, where needed, to improve the function of the committee. Given the study findings on the comparatively low number of CECs which actually have an evaluative process in place, the first recommendation of the study in this area is that CECs should ensure that they have a formal evaluation process in place.

6.3.1. Who Evaluates Committees?

A key question posed in study instrument questionnaire 2 was set to determine who is responsible for evaluating committees.

From the literature, the three main sources of committee evaluation were identified as being; the committee self-assesses; the Hospital Board assesses the committee; the Hospital Chief Executive Officer (CEO) assesses the committee (Slowther and Hope, 2000; Szeremeta et al., 2001; Wenger et al., 2002; Dobbs, 2000). In addition to the above three alternatives, respondents were offered the opportunity to elaborate on any other sources of evaluation of their committee.

Table 6.2. Who Assesses the Committee?

Method of assessment	Australasia	UK	Count	%of Total
Committee self-assesses	4	3	7	64
Hospital board	0	2	2	18
Committee assessed by means other than listed above	1	1	2	18
Total	5	6	11	100

Table 6.2, shows that of the 11 committees that indicated that they had a formal evaluation process in place, 7 indicated that their committee self-assessed. 4 of the 5 Australasian committees in the study which had a formal evaluation process stated that they self-assessed, compared with 3 of the 6 U.K. committees. 2 committees indicated that the Hospital Board was responsible for evaluating their committee. Both of the committees in this category were based in the U.K. 1 committee from the U.K. responded that evaluation of the committee was undertaken by the committee itself in conjunction with the hospital's clinical governance committee. One Australasian committee stated that evaluation of the committee was achieved by regular reporting to the hospital's Quality and Safety committee. From the above results it can be noted that self-assessment is, by a considerable margin, the most common form of committee evaluation. However, in the overall analysis of committee evaluation, this methodology is only utilised by just under one third of participating committees (7 out of 23). The findings of the study support Kaiser's (2001) assertion that there is no apparent consensus on the method required for a CEC to competently deal with ethical issues.

As discussed earlier, approaches to committee evaluation basically divide into two categories, self-assessment and independent audit. Both approaches would appear to have merit. Self-assessment allows a committee to reflect on its performance of the activities it undertakes and provide it with an opportunity to take measures to, as Campbell (2001) suggests, remedy deficiencies in their own procedures. Independent audit has the advantage of being a more objective measure of a committee's performance, and, in addition to providing a committee with formal organisational assessment of its performance, could, as stated by Emmanuel (200), be the most effective form of accountability for a CEC. Given the study findings showing the low number of committees having a formal evaluation process in place and the variety of evaluation processes of those committees having such a process in place, the

recommendation of the study is that in addition to ensuring that CECs have a formal evaluation process in place, that such a formal evaluation process should include mechanisms which permit both external and self-assessment.

It is apparent from the discussion on the methodology for evaluating CECs, presented above, that there is no consensus on the optimal means of carrying out such evaluation. In view of this lack of consensus, the study undertook to more fully investigate methodology for evaluating CECs, and provide some recommendations on how such a process might be optimised. A key element of the study was to examine how participating CECs were currently undertaking evaluation of their activities, and also elicit the viewpoints of individual study participants on what they believed to be the most effective mechanisms in contributing to a methodology to best evaluate their committees' activities. It was believed that by drawing some comparisons between what is actually the case for participating committees and CECs' members' beliefs on what would constitute an effective evaluative process would provide valuable insight for the study to make some recommendations regarding the methodology for evaluating CECs.

The two main areas the study undertook to draw comparisons between what actually was the case for participating committees and CECs' members' beliefs on what would constitute an effective evaluative process were, 1. Effective means of gathering information for evaluating of committees, and, 2. Effective indicators of committee success. There follows a discussion of the study results for each of these two areas.

6.3.2. Means of Gathering Information

In this section of the study, the means by which participating committees which indicated they had an evaluation process gather information for use in such a process was investigated. In addition, all study participants were asked provide their views on what they considered to be effective means of gathering information in order to evaluate their committee. The results for a. Committees and b. Individual Participants are presented below.

a. Committees

In Section C.2 of study instrument questionnaire 2, committees indicating that they had an evaluation process in routine use were asked to provide information on how information is gathered to allow analysis for evaluation. As stated previously, Questionnaire 2 was completed by the Chairperson (or other nominated individual) of each committee, and, wherever reference is made to views of the Committee this should be understood to refer to the views presented by the Chairperson (or other nominated individual). For the purposes of the study, this information is taken to represent what actually obtains for committees.

The options given in this section were; solicited feedback from individuals; unsolicited feedback from individuals; solicited feedback from other organisational bodies; unsolicited feedback from other organisational bodies; follow up of case consultation to see whether advice given has been acted upon. The results are shown in table 6.3.

Table 6.3. Means of Gathering Information for Evaluation

Statement	CEC Country	Yes	No	Total
Solicited feedback from individuals	Australasia	5	0	5
	UK	5	1	6
	Total	10	1	11
	% of Total	91	9	100
Unsolicited feedback from individuals	Australasia	4	1	5
	UK	3	3	6
	Total	7	4	11
	% of Total	64	36	100
Solicited feedback from other organisational bodies	Australasia	3	2	5
	UK	3	3	6
	Total	6	5	11
	% of Total	55	45	100
Unsolicited feedback from other organisational bodies	Australasia	1	4	5
	UK	2	4	6
	Total	3	8	11
	% of Total	27	73	100
Follow-up of case consultation to see whether advice given has been acted upon	Australasia	1	4	5
	UK	4	2	6
	Total	5	6	11
	% of Total	45	55	100

The overall responses to this question, for the 11 committees indicating they had a formal evaluation process in use, may be summarised as follows,

10 (91%) of the committees indicated that information for committee evaluation was obtained from solicited feedback from individuals e.g. questionnaires, personal contact. 7 (64%) of committees stated that information gathered was from unsolicited feedback from individuals. 6 (55%) committees used solicited feedback from other organisational bodies e.g. the hospital board, committees or groups which had sought advice from the committee. 5 (45%) of committees used follow-up of case consultation to see whether advice given had been acted upon. 3 (27%) of committees took into account unsolicited feedback from other organisational bodies in their evaluative process.

Two committees indicated that they utilised methods other than those stated above to gather information for their evaluation process. These methods included; attendance at educational events and; annual review of ethics committee register.

Comparing study findings between Australasian and U.K. committees on how information for their evaluation process is gathered revealed, that in both the Australasian and the U.K committees, solicited feedback from individuals was the most commonly used source of information, with all 5 of the Australasian committees and 5 of the 6 U.K. committees using this source for gathering information. The most notable difference between U.K. and Australasian committees being that 4 of the 6 U.K. committees utilised 'follow-up of case consultation to see whether advice given has been acted upon', compared with 1 of the 5 Australasian committees, employed this method to gather information for their evaluation process. From the results presented in Chapter 4, it was determined that, overall, 22 of the 23 participating committees indicated that they undertook case consultation (including retrospective). All 17 of the committees from the U.K. and 5 of the 6 Australasian committees stated that case consultation was undertaken. Despite the difference in numbers of participating committees from Australasia and the U.K., this finding regarding the difference in use of 'follow-up of case consultation to see whether advice given has been acted upon', highlights a difference in evaluation methodology between Australasian and U.K. committees.

The other difference of note between Australasian and U.K. committees in methods used to gather information to evaluate their committees was that Australasian committees placed more emphasis on 'Unsolicited feedback from individuals', than

their U.K. counterparts. However, this difference was less than the difference found between the committees regarding 'follow-up of case consultation'. In this instance 4 out of 5 Australasian committees compared with 3 out of 6 U.K. committees, indicated they utilised 'Unsolicited feedback from individuals' as part of their evaluative process.

The findings of the study showed that, of the eleven participating committees (6 from the U.K. and 5 from Australasia) that indicated they had a formal evaluation process in routine use, there was little uniformity overall among the committees in the methods of information gathering to allow analysis for evaluation. Table 6.4, shows the combinations of methods of information gathering for each of the eleven committees.

Table 6.4. Information Gathering

	Country of origin	Solicited feedback - individuals	Unsolicited feedback - individuals	Solicited feedback - organisation	Unsolicited feedback - organisation	Follow-up of advice given
1	UK	X		X		X
2	UK	X				
3	UK	X	X	X	X	X
4	UK	X	X	X		X
5	Aus	X	X	X	X	
6	Aus	X		X		
7	Aus	X	X	X		X
8	Aus	X	X			
9	Aus	X	X			
10	UK	X				X
11	UK		X		X	

It can be seen from table 6.4, that there were only two instances where two committees used exactly the same combination of sources of information for evaluation. These were:

a. Two committees (8 and 9) from Australasia used solicited and unsolicited feedback from individuals.
b. Two committees (4 and 7), one committee each from Australasia and the U.K. used a combination of solicited and unsolicited feedback from individuals, solicited feedback from other organisational bodies, and, follow-up of case consultation to see whether advice given had been acted upon, as sources of information for evaluation of their committee.

It may also be noted that four committees (1,3,4, and 7), three from the U.K. and one from Australasia included solicited feedback from individuals, solicited feedback from

organisational bodies, and, follow-up of case consultation in their information gathering process. Similarly, four committees (3, 4, 5, and 7), two each from the U.K. and Australasia, included solicited and unsolicited feedback from other organisational bodies in their information gathering process.

The most common sources of information for evaluating committees were solicited and unsolicited feedback from individuals, which occurred in six the committees' responses (2 from the U.K. and 4 from Australasia), and solicited feedback from other organisational bodies, which also coincided in six committees' responses.

In terms of the number of sources each committee utilises in gathering information there is a considerable variation e.g. one committee uses only a single source of information, while another committee utilises six sources of information, a further two committees use three sources, and three committees use four sources.

The above results highlight that there is little uniformity among the committees in the methods of information gathering to allow analysis for evaluation. The development of a more structured approach to the means by which information is gathered in order to evaluate a CEC is articulated in the 'Guidelines for Clinical Ethics Committees (CEC)' section of chapter 8.

b. Individual Participants

In addition to establishing how participating committees gather information for use in their evaluative process, individual study participants were asked, in Section A.6 of study instrument questionnaire 1, to indicate their view on statements they would consider being effective means of gathering information to be used to evaluate their committee. The study investigated responses to these statements from participants by, 1. Country of Origin and 2. Committee Membership Status. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant.

The results are shown in tables 6.5. and 6.6.

1. Country of Origin

Table 6.5. Effective Means of Gathering Information: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Solicited feedback from individuals	Australasia	28	6	62.63			
	UK	99	6	64.39			
	Total	127	6		1347.00	.817	.020
Unsolicited feedback from individuals	Australasia	27	6	64.02			
	UK	100	6	64.00			
	Total	127	6		1349.50	.998	.0002
Solicited feedback from other organisational bodies	Australasia	28	6	62.55			
	UK	98	6	63.77			
	Total	126	6		1345.50	.869	.015
Unsolicited feedback from other organisational bodies	Australasia	28	5	59.71			
	UK	97	6	63.95			
	Total	125	6		1266.00	.576	.050
Follow-up of case consultation to see whether advice given has been acted upon	Australasia	26	6.5	70.65			
	UK	99	6	60.99			
	Total	125	6		1088.00	.196	.115

Table 6.5, shows that there were no significant differences between participants from Australasia and the U.K. for what were considered to be effective means of gathering information to evaluate CECs. Further, table 6.5, shows, that each of the five measures put forward as being effective means of gathering information to evaluate the success of a clinical ethics committee had, overall, a median value of 6, thereby indicating that participants agreed that these measures are effective indicators of gathering information for committee evaluation.

2. Committee Membership Status

Table 6.6. Effective Means of Gathering Information: Committee Membership Status

Statement	CEC membership status	N	Median	Mean Rank	Mann-Whitney U	p	r
Solicited feedback from individuals	Member	107	6	63.11			
	Chair	20	6	68.78			
	Total	127	6		974.50	.513	.058
Unsolicited feedback from individuals	Member	107	6	63.63			
	Chair	20	5.5	65.98			
	Total	127	6		1030.50	.788	.024
Solicited feedback from other organisational bodies	Member	106	6	64.79			
	Chair	20	5.5	56.68			
	Total	126	6		923.50	.335	.086
Unsolicited feedback from other organisational bodies	Member	106	6	64.52			
	Chair	19	5	54.53			
	Total	125	6		846.00	.255	.102
Follow-up of case consultation to see whether advice given has been acted upon	Member	105	6	63.23			
	Chair	20	6	61.80			
	Total	125	6		1026.00	.863	.015

Table 6.6, shows that there were no significant differences between Chairpersons and Members for what were considered to be effective means of gathering information to evaluate CECs. Further, table 6.6, shows, that each of the five measures put forward as being effective means of gathering information to evaluate the success of a clinical ethics committee had, overall, a median value of 6, thereby indicating that participants agreed that these measures are effective indicators of gathering information for committee evaluation.

Discussion of Study Results: Means of Gathering Information

In comparing the findings between the methods used by CECs to gather information for their evaluation process and the methods believed by individual participants to be most effective for gathering such information, shown in tables 6.4, 6.5 and 6.6, the most notable difference is for ‘follow-up of case consultation to see whether advice given has been acted upon’. As noted previously, the main reason for the difference is the finding

that fewer Australasian CECs currently utilise this form of gathering information compared to their U.K. counterparts. It was also noted that individual Australasian participants, along with U.K. CECs and individual participants, consider this type of measure as being an important method of gathering information for committee evaluation. Clearly, the reason for this being that the degree to which advice given by a CEC is acted on would be seen to give an unambiguous measure of the success of the CEC in this area. For this reason, the recommendation of the study is that CECs, and in particular, Australasian CECs, should ensure that 'follow-up of case consultation to see whether advice given has been acted upon' is included and given a position of considerable weight in any formal evaluation process of their committee.

As mentioned previously, the study results revealed that little uniformity among the committees in the methods they are currently using to of information gathering to allow analysis for evaluation. However, in contrast, the study results for individual participants show agreement that each of the five measures postulated would be effective means of gathering information to evaluate the success of a clinical ethics committee. There was no statistically significant difference between Australasian and U.K. participants, or between Chairpersons and Committee members. These results indicate that the development of a more structured approach to the means by which information is gathered in order to evaluate a CEC, may be beneficial. To this end, the following recommendations, in addition to the recommendation concerned with follow-up of case consultation given above, regarding the means by which CECs gather information to be used in their evaluation process are offered.

1. Feedback from prominent individuals within the organisation, for example the CEO or chairperson of the hospital board, should be solicited and utilised in the gathering of information to be used in the formal committee evaluation process.

2. The formal evaluation process of a CEC should have in place mechanisms which allow unsolicited feedback from individuals to be taken into consideration in evaluating the committee. This allows the possibility of richer, more comprehensive sources of feedback from all stakeholders.

3. CECs should actively solicit feedback from other organizational bodies with which it has dealings. The importance of this kind of feedback derives from the fact that it provides the opportunity for a CEC to obtain formal comment and opinion on its performance from other bodies within the organisation with which it has dealings e.g. the hospital board, or, committees or groups who have sought advice from the committee. As was the case with 'follow-up of case consultation to see whether advice given has been acted upon', this type of feedback would be seen to give a clear measure of the success of the CEC. In addition, this type of contact with other bodies within the organisation could help to raise the profile of the committee. This is important since, as discussed in chapter 5, many CECs are 'invisible' within their hospital community, and therefore, the need to raise awareness of a CEC within an institution is deemed to be of fundamental importance (Harding, 1994; Rudd, 2002; Slowther et al., 2001).

4. The formal evaluation process of a CEC should have in place mechanisms which allow unsolicited feedback from other organisational bodies to be taken into consideration in evaluating the committee. It is recognised that the potentially sporadic nature of obtaining this kind of feedback means that it may not provide a sufficiently regular flow of feedback required by an effective methodology for gathering information. However, it should not be discounted since this type of feedback increases the opportunity for a committee to gather feedback from all stakeholders.

6.3.3. Measures Utilised to Indicate Committee Success

In this section, measures used by participating committees to indicate the success of the committee were investigated. In addition, all study participants were asked to provide their views on a number of statements pertaining to measures that they believed might indicate the success of their committee. The results for a. Committees and b. Individual Participants are presented below.

a. Committees

In Section C.3 of study instrument questionnaire 2, committees indicating that they had an evaluation process in routine use were asked to provide information on measures they used to indicate the success of their committee. Once again it should be

emphasised that Questionnaire 2 was completed by the Chairperson (or other nominated individual) of each committee, and, wherever reference is made to views of the Committee this should be understood to refer to the views presented by the Chairperson (or other nominated individual). For the purposes of the study, this information is taken to represent what actually obtains for committees.

The options given in this section were for case consultation, continuing or increasing referrals over time; input into policy/ guideline making formally acknowledged; documentation of ethical changes to policy/ guidelines that have been applied to practice; annual (or regular) report to organisation; documentation of ethics training programs initiated by the committee, and; ongoing institutional support for the committee.

The responses to this question, for the 11 committees indicating they had a formal evaluation process in use are shown in table 6.7.

Table 6.7. Measures of Success: Committee

Statement	CEC Country of Origin	Yes	No	Total
Continuing or increasing referrals to committee over time	Australasia	3	2	5
	UK	3	3	6
	Total	6	5	11
	% of Total	55	45	100
Input into policy making formally acknowledged	Australasia	3	2	5
	UK	2	4	6
	Total	5	6	11
	% of Total	45	55	100
Documentation of ethical changes to policy that have been applied to practice	Australasia	3	2	5
	UK	2	4	6
	Total	5	6	11
	% of Total	45	55	100
Ongoing institutional support for the committee	Australasia	4	1	5
	UK	4	2	6
	Total	8	3	11
	% of Total	73	27	100
Annual (or regular) report to the organisation	Australasia	5	0	5
	UK	6	0	6
	Total	11	0	11
	% of Total	100	0	100
Documentation of ethics training programs initiated by the committee	Australasia	1	4	5
	UK	2	4	6
	Total	3	8	11
	% of Total	27	73	100

Table 6.7 shows, that all 11 participating committees indicated that annual (or regular) report to their organisation was employed as a measure to indicate the success of their committee. 8 (73%) committees stated that ongoing institutional support for the committee was taken as an outcome measure to indicate the success of the committee. For 6 (55%) of the committees, continuing or increasing referrals over time, particularly for case consultation, was an outcome measure used to indicate committee success. Two outcome measures taken to be an indication of the success of their committees for 5 (45%) of the participating committees were the documentation of ethical changes to policy/ guidelines that have been applied to practice, and, input into policy/ guideline

being formally acknowledged. In this category, the outcome measure least taken to be a measure of committee success was the documentation of ethics training programs initiated by the committee. In this instance, 3 of the 11 committees (27%) indicated this to be the case. Table 6.7, also shows general agreement between Australasian and U.K. committees in measures used by participating committees to indicate the success of the committee.

b. Individual Participants

As was the case with the gathering of information for use in the evaluative process, in addition to establishing measures are used by participating committees to indicate the success of their committee, individual respondents were asked to indicate their view on each statements relating to measures which they would consider to be effective indicators of the success of their committee. The study investigated responses to these statements, presented in Section A.7 of study instrument questionnaire 1, from participants by, 1. Country of Origin and 2. Committee Membership Status. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The results are shown below.

1. Country of Origin

Table 6.8. Effective Measures of Success: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Continuing or increasing referrals to committee over time	Australasia	27	6	70.50			
	UK	100	6	62.25			
	Total	127	6		1174.50	.270	.098
Input into policy making formally acknowledged	Australasia	29	6	63.78			
	UK	99	6	64.71			
	Total	128	6		1414.50	.899	.011
Documentation of ethical changes to policy that have been applied to practice	Australasia	29	6	66.57			
	UK	100	6	64.55			
	Total	129	6		1404.50	.784	.024
Ongoing institutional support for the committee	Australasia	29	6	70.59			
	UK	100	6	63.38			
	Total	129	6		1288.00	.328	.086
Annual (or regular) report to the organisation	Australasia	29	6	69.90			
	UK	100	6	63.58			
	Total	129	6		1308.00	.402	.074
Documentation of ethics training programs initiated by the committee	Australasia	27	6	69.96			
	UK	100	6	62.39			
	Total	127	6		1189.00	.322	.088

Table 6.8, shows that there were no significant differences between participants from Australasia and the U.K. for measures they considered might be effective indicators of the success of their committees. Further, table 6.8 shows, that each of these six measures had, overall, a median value of 6, thereby indicating that participants agreed that these measures are effective indicators in the measurement of the success of their committee.

2. Committee Membership Status

Table 6.9. Effective Measures of Success: Committee Membership Status

Statement	CEC membership status	N	Median	Mean Rank	Mann-Whitney U	p	r
Continuing or increasing referrals to committee over time	Member	107	6	63.19			
	Chair	20	6	68.33			
	Total	127	6		983.50	.541	.054
Input into policy making formally acknowledged	Member	108	6	65.07			
	Chair	20	6	61.40			
	Total	128	6		1018.00	.666	.039
Documentation of ethical changes to policy that have been applied to practice	Member	109	6	65.39			
	Chair	20	6	62.90			
	Total	129	6		1048.00	.771	.026
Ongoing institutional support for the committee	Member	109	6	65.08			
	Chair	20	6	64.55			
	Total	129	6		1081.00	.950	.006
Annual (or regular) report to the organisation	Member	109	6	66.95			
	Chair	20	5.5	54.38			
	Total	129	6		877.50	.148	.127
Documentation of ethics training programs initiated by the committee	Member	107	6	64.56			
	Chair	20	6	61.00			
	Total	127	6		1010.00	.678	.037

Table 6.9, shows that there were no significant differences between Chairpersons and Members for measures considered to be effective indicators of the success of their committees. In addition, table 6.9, shows that each of these six measures had, overall, a median value of 6, thereby indicating that participants agreed that these outcome measures are effective indicators in the measurement of the success of their committee.

Discussion of Study Results: Measure of Committee Success

The study results showed there little uniformity in the measures were taken to be an indication of success by committees. For example, all 11 participating committees, which have a formal evaluation process in place, indicated that annual (or regular) report to their organisation was employed as a measure to indicate the success of their committee. On the other hand, only 3 committees (2/6 U.K. and 1/5 Australasia)

indicated that documentation of ethics training programs initiated by the committee was used in the process of evaluating the success of their committee.

However, in contrast, the study results for individual participants show agreement that each of the six measures postulated would be effective measures to evaluate the success of a clinical ethics committee. There was no statistically significant difference between Australasian and U.K. participants, or between Chairpersons and Committee members. These results indicate that, as was the case with the means by which information is gathered in order to evaluate a CEC, the development of a more structured approach to establishing measures to gauge the success of a committee may be beneficial. To this end, the following recommendations are offered.

1. Annual (or regular) report to the organisation, should be considered an important measure of a CEC's success, and as such, the recommendation of the study is that CECs should ensure that such reporting to the organisation is incorporated into the formal evaluative process for their committee.

2. CECs should be aware that that ongoing institutional support for the committee is an important factor, and as such, consideration of such ongoing support should be a factor incorporated into the formal evaluative process for their committee.

3. A measure of referrals to the committee over time should be recognised as a key component of the formal evaluation process. This kind of measure can be made quite readily at predetermined intervals, for example annually, and would serve as an excellent measure of indicating the success of a committee, since it affords the committee an opportunity to collect tangible evidence regarding its performance in this area.

4. Documentation of ethics training programs initiated by the committee should be included in the formal evaluative process of CECs. The rationale for this being along similar lines to the measure concerning referrals to the committee since,once again, this can be seen as a tangible measure of committee success.

5. 'Input into policy/ guideline making formally acknowledged' and 'documentation of ethical changes to policy/ guidelines that have been applied to practice', are measures which should be included by CECs in their formal evaluation process. Once again these measures are capable of delivering tangible evidence regarding a committee's performance.

It is worth highlighting the study finding that, comparatively few committees use the measures, described in recommendation 5, is to some extent unexpected, since as mentioned previously, the Royal College of Physicians (RCP) Working Party Report (2005), recommended that CECs should undergo regular and methodologically sound evaluation of their work and should be able to provide evidence of the central measures of the success of a CEC. These measures included, a measure of satisfaction of those who use the services of the committee including those who are recipients of the committee's policy work, and, a measure of the CEC's success in facilitating development of ethical practice within the institution (RCP, 2005). Further, in the self - assessment by 'Committee Audit' method of assessing CEC's activities, proposed by a number of studies, for example Slowther and Hope, 2000; Szeremeta et al., 2001; Wenger et al., 2002; and, Hofmann, 2001, the self assessment of a CEC by its members with regard to a number of key areas, should include a process for evaluating effectiveness of its policies and guidelines and the development, revision and impact of ethical policies and guidelines for the organisation.

6.3.4. Obstacles to Successful Committee Development

In Section A.5 of study instrument questionnaire 1, individual respondents were asked to indicate their view on each of five statements which might be perceived as obstacles to the successful development and effectiveness of their committee. The study investigated responses to these statements from participants by, 1. Country of origin and 2. Committee membership status. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The results are shown in tables 6.10. and 6.11.

1. Country of Origin

Table 6.10. Perceived Obstacles to Committee Development: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Lack of resources (financial and human)	Australasia	26	3.5	44.83			
	UK	98	6	67.19			
	Total	124	6		814.50	.004	.260
Lack of training available for committee members	Australasia	27	5	50.11			
	UK	97	6	65.95			
	Total	124	5		975.00	.039	.186
Lack of appropriate expertise on the committee	Australasia	27	2	45.69			
	UK	97	4	67.18			
	Total	124	3		855.50	.005	.250
Reluctance of clinicians to recognise and use the committee	Australasia	26	4	49.81			
	UK	97	5	65.27			
	Total	123	5		944.00	.046	.178
Difficulties in raising the profile of the committee within the hospital	Australasia	25	4	38.42			
	UK	96	6	66.88			
	Total	121	6		635.50	.000	.336

From table 6.10**,** it can be seen that there was a significant difference between Australasian and U.K. respondents for all of the statements. In each case the median values indicate stronger agreement with the statement by U.K. respondents.

2. Committee Membership Status

Table 6.11. Perceived Obstacles to Committee Development: Committee Membership Status

Statement	CEC membership status	N	Median	Mean Rank	Mann-Whitney U	p	r
Lack of resources (financial and human)	Member	105	6	60.90			
	Chair	19	6	71.32			
	Total	124	6		830.00	.233	.105
Lack of training available for committee members	Member	105	5	61.23			
	Chair	19	6	69.50			
	Total	124	5		864.50	.346	.084
lack of appropriate expertise on the committee	Member	105	3	61.82			
	Chair	19	5	66.24			
	Total	124	3		926.50	.617	.045
Reluctance of clinicians to recognise and use the committee	Member	104	5	62.73			
	Chair	19	4	58.00			
	Total	123	5		912.00	.590	.049
Difficulties in raising the profile of the committee within the hospital	Member	102	5.5	60.13			
	Chair	19	6	65.68			
	Total	121	6		880.00	.516	.059

In contrast to the study results for study participants by country of origin, table 6.11, shows that there were no significant differences between Chairpersons and Members for any of the statements concerning obstacles to the successful development and effectiveness of their committees.

In order to gain insight into which of the obstacles to the successful development and effectiveness of their committees were considered the most important, the median values for responses to the statements from Australasian and U.K. participants were compared. Table 6.12, shows the median values score for each statement regarding obstacles to the successful development and effectiveness of respondents' committees.

Table 6.12. Obstacles to Successful Committee Development: Medians

Obstacle	Median		
	Overall	Australasia	U.K.
Lack of resources (financial and human)	6	3.5	6
Difficulties in raising the profile of the committee Within the hospital community	6	4	6
Lack of training available for committee members	5	5	6
Reluctance of clinicians (particularly doctors) to recognise and use the committee	5	4	5
Lack of appropriate expertise on the committee	3	2	4

It can be seen from table 6.12 that, overall lack of resources (financial and human) (Mdn = 6) and difficulties in raising the profile of the committee within the hospital community (Mn = 6), were considered to be the main obstacles to the successful development and effectiveness of committees**.** Lack of appropriate expertise on the committee (Mdn = 3) was regarded as being the least important obstacle investigated in this category.

As highlighted in the results presented in table 6.10 above**,** there were significant differences in the responses given by Australasian and U.K. participants in this category. For Australasian participants, lack of training available for committee members (Mdn = 5), was seen as being the main obstacles to the successful development and effectiveness of committees, with lack of appropriate expertise on the committee (Mdn = 2) being regarded as the least important obstacle investigated in this category. For U.K. participants, lack of training available for committee members (Mdn = 6), along with lack of resources (financial and human) (Mdn = 6), and, difficulties in raising the profile of the committee within the hospital community (Mn = 6), were all seen as being the main obstacles to the successful development and effectiveness of committees. In similar fashion to Australasian participants, lack of appropriate expertise on the committee (Mdn = 4) being regarded as the least important obstacle.

6.2.5. Committee Member Viewpoint on the Overall Success of their Committee

Section A.4 of study instrument questionnaire 1, was designed to gather information regarding individual committee members' views on the overall success of their committee. Participants were asked to respond to a six statements concerning the overall success of their committee; a. Overall, I believe our ethics committee is successful in its activities; b. I am satisfied with the combination of educational, policy/ guideline involvement, and the case consultation/ review activities pursued by our committee; c. Our committee periodically evaluates its overall performance; d. Our committee's performance is measured against established criteria/ standards; e. Our committee receives adequate feedback on whether advice given has been taken or ignored; f. Our committee has credibility within the hospital community.

The study investigated responses to these statements from participants by, 1. Country of Origin and 2. Committee Membership Status. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The results are shown in tables 6.13. and 6.14.

1. Country of Origin

Table 6.13. Committee Member Viewpoint : Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Overall, I believe our CEC is successful in its activities	Australasia	29	6	80.84			
	UK	99	5	59.71			
	Total	128	6		961.50	.005	.247
I am satisfied with the combination of educational, policy/ guideline involvement, and the case consultation activities pursued by our CEC	Australasia	28	5.5	75.89			
	UK	99	5	60.64			
	Total	127	5		1053.00	.047	.176
Our committee periodically evaluates its overall performance	Australasia	28	5	71.71			
	UK	97	5	60.48			
	Total	125	5		1114.00	.142	.131
Our CEC's performance is measured against established standards/ criteria	Australasia	25	4	69.26			
	UK	94	3	57.54			
	Total	119	3		943.50	.126	.140
Our CEC receives adequate feedback on whether advice has been taken or ignored	Australasia	28	5	80.27			
	UK	97	3	58.02			
	Total	125	4		874.50	.004	.260
Our CEC has credibility within the organisation	Australasia	29	6	78.03			
	UK	93	5	56.34			
	Total	122	6		869.00	.003	.266

Table 6.13, shows there was a significant difference between Australasian and U.K. respondents for the following statements.

a. Overall, I believe our ethics committee is successful in its activities.

For this statement, a Mann-Whitney test indicated a significant difference between Australasian (Mdn = 6) and UK respondents (Mdn = 5), U = 961.50, p= .005, with Australasian respondents agreeing more strongly with the statement than their U.K. counterparts.

b. I am satisfied with the combination of educational, policy/ guideline involvement, and the case consultation/ review activities pursued by our committee.

For this statement, a Mann-Whitney test indicated a significant difference between Australasian (Mdn = 5.5) and UK respondents (Mdn = 5), U = 1053.00, p= .047, with U.K. respondents agreeing more strongly with the statement than their Australasian counterparts.

c. Our committee receives adequate feedback on whether advice given has been taken or ignored

For this statement, a Mann-Whitney test indicated a significant difference between Australasian (Mdn = 5) and UK respondents (Mdn = 3), U = 874.50, p= .004, with Australasian respondents agreeing more strongly with the statement than their U.K. counterparts.

d. Our committee has credibility within the hospital community

For this statement, a Mann-Whitney test indicated a significant difference between Australasian (Mdn = 6) and UK respondents (Mdn = 5), U = 869.00, p= .003, with Australasian respondents agreeing more strongly with the statement than their U.K. counterparts.

2. Committee Membership Status

Table 6.14. Committee Member Viewpoint : Committee Membership Status

Statement	CEC membership status	N	Median	Mean Rank	Mann-Whitney U	p	r
Overall, I believe our CEC is successful in its activities	Member	108	6	65.19			
	Chair	20	5	60.78			
	Total	128	6		1005.50	.612	.045
I am satisfied with the combination of educational, policy/ guideline involvement, and the case consultation activities pursued by our CEC	Member	107	5	63.86			
	Chair	20	5	64.75			
	Total	127	5		1055.00	.919	.009
Our committee periodically evaluates its overall performance	Member	105	5	60.40			
	Chair	20	5.5	76.65			
	Total	125	5		777.00	.062	.167
Our CEC's performance is measured against established standards/ criteria	Member	99	3	58.82			
	Chair	20	3	65.85			
	Total	119	3		873.00	.399	.077
Our CEC receives adequate feedback on whether advice has been taken or ignored	Member	105	4	63.61			
	Chair	20	3.5	59.80			
	Total	125	4		986.00	.662	.034
Our CEC has credibility within the organisation	Member	102	6	60.51			
	Chair	20	6	66.53			
	Total	122	6		919.50	.478	.064

Table 6.14, shows that there were no significant differences between Chairpersons and Members for any of the statements concerning the overall success of their committee.

In order to gain insight into which statements regarding individual committee members' views on the overall success of their committee were considered the most important, the median values for responses to the statements from Australasian and U.K. participants were compared. Table 6.14, shows the median values score for each statement.

Table 6.15. Evaluation of Committee Activities: Medians

Statement	Median		
	Overall	Australasia	U.K.
Overall, I believe our ethics committee is successful in its activities	6	6	5
'Our committee has credibility within the hospital community	6	5	6
I am satisfied with the combination of educational, policy/ guideline involvement, and case review/ consultation activities pursued by our committee	5	5.5	5
Our committee periodically evaluates its overall performance	5	5	5
Our committee receives adequate feedback on whether advice given is taken or ignored	4	5	3
Our committee's performance is measured against established standards/ criteria	3	4	4

It can be seen from table 6.15 that, overall, the statements, 'Overall, I believe our ethics committee is successful in its activities' (Mdn = 6) and 'Our committee has credibility within the hospital community' (Mn = 6), were the statements participants most strongly agreed with in this section, while 'Our committee's performance is measured against established standards/ criteria (Mdn = 3), was the statement which had the lowest level of agreement. Therefore, while participants believe their committees to be successful in their activities, this success is not measured against established criteria or standards.

For Australasian participants, 'Overall, I believe our ethics committee is successful in its activities' (Mdn = 6), was the statement with the strongest level of agreement, with 'Our committee's performance is measured against established standards/ criteria (Mdn = 3), being the statement having the lowest level of agreement. For U.K. participants, 'Our committee has credibility within the hospital community' (Mdn = 6), was the statement with the strongest agreement, with 'Our committee receives adequate feedback on whether advice given is taken or ignored' (Mdn = 3), having the lowest level of agreement.

6.3. Chapter Summary

The findings of the study regarding Committee Evaluation aimed to provide a description of evaluative processes being employed by participating committees, and where appropriate, highlight significant differences between Australasian and U.K. committees. In particular, questions concerning who evaluates committees; effective means of gathering information for evaluating committees; effective indicators of committee success; obstacles to the successful development and effectiveness of committees; and, the viewpoints of individual committee members participating in the study, on evaluative processes employed by their committees, were addressed.

It was found that 11 of the 23 CECs participating in the study had a formal evaluation in place. Following the discussion presented in this chapter regarding the value of having such a process, the recommendation was made that CECs should ensure they have a formal evaluation process in place.

The findings of the study showed that, of the eleven participating committees (6 from the U.K. and 5 from Australasia) that indicated they had a formal evaluation process in routine use, there was little uniformity overall among the committees in the methods of information gathering to allow analysis for evaluation. This finding suggested that recommendations on the methods considered most useful in the gathering information for evaluation may be helpful for CECs. The study results revealed no significant difference between individual participants from Australasia and the U.K., or between CEC chairpersons and other CEC members on what these individuals believed would be effective means of gathering information to evaluate their CECs. Based on these results, a number of recommendations were put forward regarding mechanisms which might be utilised by CECs for gathering information to evaluate their committee.

1. Follow-up of case consultation to see whether advice given has been acted upon.
2. Feedback from prominent individuals within the organisation, for example the CEO or chairperson of the hospital board, should be solicited and utilised.
3. The formal evaluation process of a CEC should have in place mechanisms which allow unsolicited feedback from individuals to be taken into consideration in evaluating the committee.

4. CECs should actively solicit feedback from other organizational bodies with which it has dealings.
5. The formal evaluation process of a CEC should have in place mechanisms which allow unsolicited feedback from other organisational bodies to be taken into consideration in evaluating the committee.

Measures employed by participating committees to indicate the success of the committee were investigated. In addition, individual participants were asked to provide their views on a number of statements pertaining to measures that they believed might indicate the success of their committee. In terms of methods currently employed by CECs, there was general agreement between Australasian and U.K. committees in measures used to indicate the success of the committee, with 'annual (or regular) report to organisation', being universally utilised by participating CECs. The study results revealed no significant difference between individual participants from Australasia and the U.K., or between CEC chairpersons and other CEC members on what these individuals believed would be measures that they believed might indicate the success of their committee. Based on these results, a number of recommendations were put forward regarding measures which could be used to indicate the success of a CEC.

1. Annual (or regular) report to the organisation.
2. CECs should be aware that that ongoing institutional support for the committee is an important factor, and as such, consideration of such ongoing support should be a factor incorporated into the formal evaluative process for their committee.
3. A measure of referrals to the committee over time should be recognised as a key component of the formal evaluation process.
4. Documentation of ethics training programs initiated by the committee should be included in the formal evaluative process of CECs.
5. 'Input into policy/ guideline making formally acknowledged' and 'documentation of ethical changes to policy/ guidelines that have been applied to practice', are measures which should be included by CECs in their formal evaluation process.

Individual study participants were asked to indicate their view on each of five statements which might be perceived as obstacles to the successful development and effectiveness of their committee. The study results showed there was a significant

difference between Australasian and U.K. respondents for all of the statements. In each case the median values indicate stronger agreement with the statement by U.K. respondents. In contrast to the study results for study participants by country of origin, there were no significant differences between Chairpersons and Members for any of the statements concerning obstacles to the successful development and effectiveness of their committees.

The study sought to gather information regarding individual committee members' views on the overall success of their committee. It was determined that there was a significant difference between Australasian and U.K. respondents for the 4 of the 6 statements presented in this section. In contrast, there were no significant differences found between Chairpersons and Members for any of the statements concerning the overall success of their committee. For the all study participants, it was found that 'Overall, I believe our ethics committee is successful in its activities' and 'Our committee has credibility within the hospital community', were the statements participants most strongly agreed with in this section. For Australasian participants, 'Overall, I believe our ethics committee is successful in its activities', was the statement with the strongest level of agreement, while for U.K. participants, 'Our committee has credibility within the hospital community', was the statement with the strongest agreement.

By considering such questions regarding committee evaluation, it may be possible to gain valuable insight into the nature of processes used by committees to evaluate their performance, and where improvements to such processes might be made. In conjunction with findings obtained from the study regarding the structure, function, and deliberative processes of CECs, the results obtained from this section, regarding committee evaluation, may enhance our understanding of the processes by which CECs arrive at their outcomes.

Chapter 7

The Deliberative Processes of Clinical Ethics Committees

> *Ethics is a deliberative process best practised in groups with reasons presented to others. There are no right answers oftentimes, especially when there is significant scientific uncertainty. Therefore, having collaborative partners with whom to search for and deliberate ethically acceptable options helps to achieve the goal of coming to a well reasoned, publicly justified decision* (Melnick, Kaplowitz, Lopez, Murphy, and Bernheim, 2005, p.102).

7.1. Introduction

What we seek is *practical wisdom* in the controversial issues that arise in bioethics. For K.M. Boyd, practical wisdom is 'the art of inventing the best course of action in the circumstances, all things considered' (Boyd, 2005, p.483). According to Boyd, 'all things' encompasses a wide range of things from 'the smallest scientific detail to our deepest intuitions about human nature and destiny' (Boyd, 2005, p.483). Since no scientific or ethical perspective is able to accomplish this in isolation, relevant solutions to perplexing bioethical issues can only be reached through 'sustained public conversation between many diverse perspectives' (Boyd, 2005, p.483). This assumes that each of the parties involved in such a conversation is prepared to learn from the others and approaches the issue in question with a commitment to 'seeking a common mind' (Boyd, 2005, p.483).

The purpose of this chapter is the analysis of the findings of the study concerning the deliberative process of participating clinical ethics committees (CECs). As described in Chapter 3, Section C. of Questionnaire 1, was designed to investigate participants' views and beliefs concerning the deliberative process of their committees. Participants were requested to assess twenty-nine statements pertaining to the deliberative process of their committee. For the purposes of analysis the statements were divided into 3 broad areas,

1. The Clinical Ethics Committee meeting as a forum for discussing bioethical issues.

2. Procedural characteristics of the deliberative process.

3. Committee deliberation outcome

Sections 7.2, 7.3 and 7.4 provide detailed analysis of the study findings for each of the above areas. The theoretical underpinnings for much of this chapter are derived from chapter 2, Methodology in Bioethics.

7.2. Area 1. The Clinical Ethics Committee (CEC) Meeting as a Forum for Discussing Bioethical Issues

In this area of the study, participants were asked to respond to a number of statements concerning whether they believed their committee meetings provided a useful forum for discussing bioethical issues. In order to facilitate analysis of the results obtained by the study, area 1 was subdivided into 3 sections,

1. Committee member representation from the professional disciplines. This section, in addition to seeking respondents' views on the statement 'our committee has sufficient member representation from the professional disciplines,' also includes analysis of the composition of CECs participating in the study.

2. Committee membership represents diverse bioethical perspectives. In this section, participants were requested to provide their view on the statement 'Our committee membership represents diverse bioethical perspectives.' In order to draw some conclusions about the diversity of bioethical perspectives among study respondents, one potential indicator of such diversity was analysed – religious beliefs.

3. Committee meetings as a useful forum for discussing bioethical issues. In this section, participants' views were sought regarding the statement 'Our committee meetings provide a useful forum for discussing bioethical issues.' Following

this, the section examined factors which might impede a committee's usefulness as a forum for discussing bioethical issues. These factors included; how members of a committee are selected, and; problems associated with 'groupthink', including measures taken by participating committees to avoid such problems.

There follows a presentation and discussion of the findings for each of the above sections.

7.2.1. Committee Member Representation from the Professional Disciplines

For Jonathan Moreno, 'diversity of representation is normally thought to be an essential feature of ethics committees in a diverse, liberal, democratic society' (Moreno, 1995, p.66). This derives its importance from the fact that, according to Benjamin (1995, p.255), consensus among members of a clinical ethics committee would have greater normative significance if the committee is broadly constituted, thus enabling it to represent the diverse views that participate in society's overlapping consensus. An example which highlights the importance of such diversity of representation in CECs, is that all participants in a 1998 study by Schick and Moore, which presented four key success factors for 15 healthcare ethics committees from the perspective of members and leaders of such committees in the USA, identified multidisciplinary and diverse membership as one of four key ingredients for the success of a committee (Schick & Moore, 1998).

In recent years, there have been important publications in Australia and the U.K. which have specifically acknowledged the need for such a multidisciplinary and diverse membership of a CEC. In the section regarding membership of a CEC, the policy directive entitled 'Clinical Ethics Processes in NSW Health', which provides guidance to Public Health Organisations (PHOs) in New South Wales that have chosen to establish clinical ethics committees, states that, in constituting a CEC regard has to be given to 'the benefits of appropriate multidisciplinary and community input where the committee undertakes education and policy development roles', and, 'membership should reflect the local context and the likely issues that will be referred to the committee for deliberation' (NSW Health, 2006). Similarly, a Working Party Report for

the Royal College of Physicians (RCP) in the U.K. (RCP, 2005), suggested that CEC membership be such that it is able to provide a 'multidisciplinary and informed forum for the discussion of ethical issues likely to arise in the healthcare setting it serves' (RCP, 2005,p38). The report emphasises the need for input from a wide range of stakeholders involved in the provision of healthcare by the institution. For example, in addition to health professionals, a CEC should involve hospital management, lay persons, ethical and legal expertise, and, where appropriate, spiritual input. The beliefs, practices and language of the population being served by a healthcare institution are also important, and ethics support will need to be sensitive to them (RCP, 2005).

However, despite wide acknowledgement regarding the importance of the diversity of representation of members serving on a CEC, as we have seen previously, in Chapter 3, Committee Structure, there is currently no agreed set of guidelines on the composition of a clinical ethics committee (CEC) in Australia/U.K./North America (Hollerman, 1991; Peirce, 2004; RCP, 2005).

In one attempt by Hollerman (1991) to set broad guidelines for CEC composition, it was suggested that the optimum membership for a CEC would be one third physicians, one third nurses and one third 'others'. 'Others' would include members from groups such as social workers, clergy, lawyers, ethicists, administrators, patient representative organizations and lay members. In Australia, during 2006, the New South Wales Government Department of Health initiated 'The New South Wales Ethics Advisory Panel' (NSW CEAP). The structure of this panel might be seen as a model for CECs. The current membership of the CEAP is

Committee chairperson
Two members with expertise in law
Three members with knowledge and experience in research/ clinical ethics
Two members with experience in philosophy or religion
One member with experience in clinical medical practice
One member with experience in nursing or allied health practice
One member with understanding of consumer health issues
One lay woman with understanding of community issues
One lay man with understanding of community issues
(NSW Health, 2006).

There have been a number of studies which have looked at the composition of CECs and found that physicians and nurses provide the majority of membership. For example, a study of North American CEC characteristics in 2000 revealed that physicians (41%) and nurses (21%) dominated the composition of CECs (Guo and Schick, 2003). Similarly, McNeill (2001), in a study of Australian CECs found the membership to include 33% medical graduates and 16% nurses. In a study which looked at the composition of a number of hospital CECs in the U.K., Szeremeta et al. (2001), found that all the committees it investigated were multidisciplinary and included 'non-medical' members. To recap, in the current study, the percentages of physicians and nurses serving on CECs was similar to that found by McNeill, with physicians providing, on average, 32% of the membership of the participating committees (n=23). In committees from the U.K. (n=17), the average percentage of physicians was 34%, while in Australasian committees (n=6) this percentage was lower at 27%. Nurses provided 19% of the membership of all committees participating in the study (n=23). In committees from the U.K. (n=17) and Australasia (n=6) the average percentage of nurses was 21% and 15% respectively.

It may be unsurprising, due to the nature of issues brought before a CEC, that physicians and nurses provide around half of the membership of CECs. However, this dominance of CEC membership by physicians and nurses makes it of paramount importance that the committee should provide a multidisciplinary and diverse membership in addition to physicians and nursing members.

In the current study, the membership of participating committees was analysed in Chapter 4 (Structure). A measure of the diversity of membership may be extrapolated from the results by analysing the membership of committees other than physicians and nurses. A summary of the results obtained, showing the percentages of committees having members from professions / disciplines outside medicine and nursing, is given below, in table 7.1.

Table 7.1. Committee Membership Other than Physicians and Nurses

Profession/ discipline	Overall (n=23)	U.K. (n=17)	Australasia (n=6)
Law	19	13	6
Ethics	19	13	6
Non-medical administrator	14	12	2
Lay/ community representative	22	16	6
Social services	5	1	4
Clergy/ pastoral care	19	15	4
Board member	12	11	1
Allied health	9	7	2

In broad terms, it can be seen from table 7.1, that the committees involved in the study include members from the professions/ disciplines other than physicians and nurses in accordance with recommendations made by NSW Health and the RCP mentioned above. However, from table 7.1 it can also be seen that there is a notable difference between UK and Australasian committees for the number of committees having non-medical administrators and board members as committee members. While 12 of the 17 UK committees indicated they had non-medical administrators serving on their committee, only 2 of the 6 Australasian committees indicated this was the case. Similarly, 11 UK committees (n=17) had a board member serving on their committee compared with only 1 Australasian committees (n=6). This is of particular significance since, as McNeill maintains, committees need a degree of autonomy from management, since this allows basic questions to be posed concerning the institution and greater freedom in evaluating whether the institution is conducting itself ethically (Mc Neill, 2001).

Another difference between the membership of participating CECs from the UK and Australasia was that while 4 of the Australasian committees indicated they had representatives from social services serving on their committee, this was the case for only 1 of the UK committees.

As Benjamin points out, while it may be desirable to advocate that clinical ethics committees include a membership which has access to all relevant aspects of biomedical, social scientific, cultural/ religious, legal, and bioethical expertise in addition to a knowledge of all reasonable ethical positions on matters that might come before it, it would be extremely difficult to form such a committee while retaining workable size. At the same time, however, in order to ensure that any consensus

reached by the committee is accepted by the society in which it operates, 'we must pay careful attention to the breadth of its membership' (Benjamin, 1995, p.256).

In order to determine the views of members of CECs involved in the study, regarding diversity of membership, participants were asked whether they agreed with the statement that 'our committee has sufficient member representation from the professional disciplines.' Overall, 84% of all study participants (n=129) agreed with the statement that their committee had sufficient member representation from the professional disciplines. 6% of participants neither agreed nor disagreed with the statement. Therefore, 10% of all participants did not believe that their committee had sufficient representation from the professional disciplines. Analysis of the responses from participants by country of committee origin revealed that 93% of Australasian respondents (n=29) and 81% of U.K. respondents (n=100) indicated they agreed with the statement. After accounting for respondents who neither agreed nor disagreed with the statement it was found that while none of the Australasian respondents believed that their committee did not have sufficient representation from the professional disciplines, 13% of respondents from U.K. committees disagreed that their committee had sufficient membership from the professional disciplines. In order to compare the responses of participants from Australasia and the UK, A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The Mann-Whitney test indicated there was a statistically significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 6), $U = 1093.50$, $p = .034$, $r = .187$, in the level of agreement with the statement. The median values indicate that participants believe their committees' membership has sufficient representation from the professional disciplines. Calculation of the Mean Rank confirmed that Australasian participants (MR= 77.29) had a greater level of agreement with the statement than UK participants (MR= 61.44).

Of particular note from the above results is the finding that 10% of all respondents disagreed that their committee had sufficient representation from the professional disciplines. This finding might suggest, at least to some extent, a degree of homogeneity among respondents.

To aid in the interpretation of these results, the results from respondents in terms of profession/ discipline was analysed. Table 7.2, below, shows the responses from participants from the various professions/ disciplines to the statement 'our committee has sufficient member representation from the professional disciplines.'

Table 7.2. Committee has Sufficient Membership from Professional Disciplines

Profession/ Discipline	Committee has sufficient membership representation from professional disciplines				
	Disagree	Neither Agree nor Disagree	Agree	Total	% Agree
Provider/ Medical Staff	6	4	44	54	81.5%
Nursing	4	1	20	25	80.0%
Lay/ Community	1	0	9	10	90.0%
Allied Health	0	0	9	9	100.0%
Non-Medical Administrator	1	0	7	8	87.5%
Clergy/ Pastoral	0	1	7	8	87.5%
Ethicist	0	2	4	6	66.7%
Social Services	0	0	2	2	100.0%
Board Member	0	0	3	3	100.0%
Other	1	0	2	3	66.7%
Lawyer	0	0	1	1	100.0%

As previously stated, 84% of study respondents (n=129) agreed their committee has sufficient membership from the professional disciplines while 10% of respondents disagreed that this was the case.

It can be seen from table 7.2, that 6 (11%) of the 54 respondents who were providers/ medical staff disagreed that their committee has sufficient representation from the professional disciplines. In the case of respondents from the nursing profession, 4 (16%) of 25 respondents indicated they disagreed with the statement. These two groups provided 79 (61%) of the total study respondents.

Respondents from professions/ disciplines other than providers/ medical staff and nursing provided 50 (39%) of the total number of study participants. From these groups, table 7.2. shows that 3 (6%) of respondents disagreed that that their committee has sufficient representation from the professional disciplines.

These results indicate that, for study participants, the nursing profession showed a greater level of respondents disagreeing that their committee has sufficient

representation from the professional disciplines than respondents from the provider/medical staff or other categories.

7.2.2. Committee Membership Represents Diverse Bioethical Perspectives

The analysis of complex and often controversial issues in bioethics by a clinical ethics committee necessitates the drawing out of values that may not be equally apparent from all perspectives, which is exactly why a diversity of perspectives is considered to be beneficial. The theoretical importance for this area derives from the discussion in chapter 2.4, regarding Pluralism in Bioethics.

According to Moreno, it is difficult to enunciate precisely why individuals together are able to arrive at innovations that they could not have accomplished individually. The deliberation of individual committee members is directed in dissimilar ways because of differences in disciplinary training, cultural background, age, sex, or other factors. The positive making use of these differences through cooperative inquiry is the practice of what Moreno terms 'social intelligence' (Moreno, 1995, pp.115-116). Moreno asserts 'part of the answer is the economy of group activity, but another part is surely the richness and attendant complexity, that various participants can bring to the table' (Moreno, 1995, p.116). Further, according to Gutman and Thompson, 'deliberative forums should expand to include the voices of as many as possible of those now excluded. Such inclusion risks intensifying moral conflict. But the benefit of taking this risk is that inclusive deliberation brings into the open legitimate moral dissatisfactions that are suppressed by power-oriented methods of dealing with disagreement' (Gutman and Thompson, 1997, p39).

In order to assess the views of members of the CECs involved in the study regarding the diversity of bioethical perspectives on their committees, participants were requested to indicate whether they agreed or disagreed with the statement that their committee membership represented diverse bioethical perspectives. Overall, 80% of respondents (n=126) indicated that they agreed with the statement. 12% of respondents neither agreed nor disagreed with the statement or indicated that it was not applicable. Therefore, 8% of respondents disagreed that their committee membership represented diverse bioethical perspectives. Analysis of the responses from participants by country

of committee origin revealed similar results for agreement with the statement, with 81% of U.K. respondents (n=97) and 79% of Australasian respondents (n=29) believing that their committee membership represented diverse bioethical perspectives. After accounting for respondents who neither agreed nor disagreed with the statement, it was determined that while 10% of the U.K. respondents disagreed with the statement none of the Australasian respondents believed that their committee did not represent diverse bioethical perspectives. In order to compare the responses of participants from Australasia and the UK, A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 6), U = 1400.50, p= .902, r = .110, in the level of agreement with the statement. The median values indicate that participants believe their committees' membership represents diverse bioethical perspectives.

One explanation for the relatively low level of disagreement with the statement 'our committee's membership represents diverse bioethical perspectives' among study participants, might lie in the possibility of homogeneity within the group. The importance of this lies in the fact that if the group is itself homogenous, it may be prevented from being aware that it isn't aware of everything.

In order to investigate the issue of homogeneity amongst respondents, one potential indicator of diversity of bioethical perspectives was considered – religious beliefs. To this end, analysis of the responses from participants by religious beliefs, to the statement 'our committee's membership represents diverse bioethical perspectives', was undertaken. The results are presented in table 7.3.

Table 7.3. Committee Represents Diverse Bioethical Perspectives

	The committee represents diverse bioethical perspectives				
Religion	Disagree	Neither Agree nor Disagree	Agree	Total	% Agree
Protestant	2	3	43	48	89.6%
Roman Catholic	2	6	15	23	65.2%
Atheist	2	2	14	18	77.8%
Agnostic	2	2	12	16	75.0%
None	1	1	4	6	66.6%
Anglican	0	0	5	5	100.0%
Hindu	0	0	2	2	100.0%
Jewish	1	0	1	2	50.0%
Other	0	0	2	2	100.0%
Other Christian	0	0	2	2	100.0%
Sikh	0	0	1	1	100.0%
Muslim	0	1	0	1	0.0%

As stated previously, 80% of study respondents (n=126) who responded to this question agreed their committee represents diverse bioethical perspectives, while 8% of respondents disagreed that this was the case.

It can be seen from table 7.3 that, of the 10 (8%) study participants who disagreed that their committee represents diverse bioethical perspectives, 5 were from respondents who indicated they were Atheist, Agnostic or had no religious beliefs (n=40), 4 were from Christian denominations (n=78), and 1 respondent was from the Jewish faith (n=2).

It should be noted that, as shown in table 7.3, 78 (62%) of respondents (n=126) were from Christian denominations, 40 respondents (32%) indicated they were either Atheist, Agnostic or had no religious beliefs, and, 8 (6%) respondents belonged to other religious faiths.

Table 7.3, shows that 5% of respondents with Christian religious beliefs (n=78), 12.5% of respondents from religions other than Christianity (n=8) and 12.5% of respondents who indicated they were either atheist, agnostic or had no religious beliefs (n=40) disagreed that their committee membership represents divers bioethical perspectives.

Study participants were requested to indicate their religious beliefs in Section D (Participant Characteristics) of study instrument Questionnaire 1. The results obtained are shown in table 6.3.

Table 7.4. Religious Beliefs of Participants (%)

Religion	Overall (n=129)	U.K. (n=100)	Australasia (n=29)
Protestant	38	41	25
Roman Catholic	18	15	28
Anglican	4	5	0
Other Christian	2	1	4
Jewish	2	1	4
Muslim	<1	1	0
Hindu	2	2	0
Sikh	<1	1	0
Agnostic	13	15	7
Atheist	14	11	28
Other (not specified)	1	2	0
None	5	5	4

It can be seen from table 7.4, that overall (n=129), Christian religious beliefs had the largest representation with 60% of respondents indicating they belonged in this category. It should be noted that within this broad group of Christian beliefs, there may be significantly different perspectives on specific bioethical issues, for example, on the issue of abortion. The second largest group comprised Atheist, Agnostic, and, those indicating they had no particular religious beliefs. This group accounted for 33% of all respondents. The remaining 7% of respondents indicated that belonged to the Jewish (2%), Muslim (1%), Hindu (2%), Sikh (1%) faiths, or that they had other (unspecified) religious beliefs (1%). Analysis of the results from respondents from the UK (n=100) and Australasia (n=29) showed similarities in as much as the Christian category had the largest representation, with 62% of UK respondents and 57% of Australasian respondents indicating they belonged to the Christian faith. Similarly, results for the group comprising Atheism, Agnosticism, and, no particular religious belief, showed that 31% of UK respondents and 39% of Australasian respondents indicated that they belonged to this category. Therefore, 93% of UK respondents and 96% of Australasian respondents belonged to one or other of the aforementioned groups. Of the remainder of respondents, while the results from the UK showed a fairly even distribution among the Jewish (1%), Muslim (1%), Hindu (2%), Sikh (1%) faiths, and, other (unspecified) religious beliefs (2%), the results from Australasian participants indicated that, while 4% of respondents belonged to the Jewish faith, there was no representation from the

Muslim, Hindu, Sikh faiths, and, other unspecified religious beliefs. It is important to note that this is not to suggest that religious belief be a criterion for selection of committee members.

While it is recognised that there was a significantly larger number of respondents from the UK (n=100) than from Australasia (n=29) which may account for this difference, nonetheless, there was a greater diversity of religious beliefs represented by participants from UK committees.

The importance for having a diverse membership for a CEC is emphasised by a discussion on group decision making by Surowiecki in 'The Wisdom of Crowds'. For Surowiecki, 'wise' groups have four elements which help to create good decisions. These are diversity of opinion, independence, decentralization, aggregation of private judgments into group decisions (Surowiecki, 2004). A CEC, therefore, should consider the importance of each committee member in adding diversity of thought, independence, decentralization, and aggregation to the decision making process. Aggregation of information into decisions helps ensure that all relevant information is considered. Therefore, according to Peirce, CECs should be formed from not only diverse professional groups but also by individuals with diverse opinions (Peirce, 2004).

7.2.3. Committee Meetings as a Useful Forum for Discussing Bioethical Issues

The issues concerning diversity of representation and bioethical perspectives have been addressed above. One further area investigated in this section, closely related to the issues of diversity of representation and bioethical perspectives, concerned the question of how useful CEC meetings are in providing a constructive means of discussing bioethical issues. The theoretical importance for this area derives from the discussion in chapter 2.4, regarding Pluralism in Bioethics. In order to examine the views of members of the CECs involved in the study regarding this issue, study participants were requested to indicate whether they agreed or disagreed with the statement, 'Our committee meetings provide a useful forum for discussing bioethical issues.' A majority of all participants (n=129) agreed with the statement, with 91% of respondents indicating that this was the case. 7% of respondents neither agreed nor disagreed with the statement, and, 2% of all respondents disagreed that their committee meetings

provided a useful forum for discussing bioethical issues. Analysis of the responses from participants by country of committee origin revealed almost identical results for agreement with the statement, with 92% of U.K. respondents (n=100) and 90% of Australasian respondents (n=29) believing that their committee meetings provided a useful forum for discussing diverse bioethical issues.

In order to compare the responses of participants from Australasia and the UK, A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The Mann-Whitney test indicated there was no statistically significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 6), U = 1213.00, p= .143, r = .129, for the statement 'our committee meetings provide a useful forum for discussing bioethical issues'. The median values indicate that study participants agreed with the statement.

Of particular note from the above results, regarding committee meetings providing a useful forum for discussing bioethical issues was the similarity of responses between participants from UK and Australasian committees, with a large majority of respondents agreeing with the statement. There was little disagreement with the statement. One interpretation of the fact that there is little disagreement with the statement might be the homogenous nature of the committees involved in the study.

In considering the views of participants regarding the sufficient representation from the professions, the diversity of bioethical perspectives, and how successful CEC meetings are in providing a useful forum for discussing bioethical issues, a key criticism of committee deliberations, as stated by Jonathan Moreno, is that it can be too easily 'infected by social pathologies, leading to a distorted 'groupthink' (Moreno, 1995, p.131) needs to be addressed. 'Groupthink' is defined by Irving Janis as 'a mode of thinking that people engage in when they are deeply involved in a cohesive in-group, when the members' strivings for unanimity override their motivation to realistically appraise alternative courses of action (Janis, 1972, p.9).' A critical factor to be considered when assessing whether a CEC has been 'infected' by groupthink is the question of how CECs are formed, and, more specifically, how members of CECs are selected. In order to examine these issues relating to groupthink, the process of

selecting members of participating CECs, along with some measures to avoiding groupthink were analysed.

Selection of Committee Members

Self and Skeel, in a 1998 study of clinical ethics committees (CECs), noted that while there appeared to be a variety of ways in which CEC members were selected, most appointments involved a degree of self-selection, or at least a willingness to accept the appointment and function in that capacity. The study considered whether the potential self-selection bias meant that CEC members were different in their moral reasoning skills from their colleagues who did not serve on such committees. The conclusion of the study was that there were significant differences among members and non-members of CECs. It was noted that whether due to the self-selection bias of CEC members, or some other factor, the composition of CECs seems to have a profound effect pulling toward homogeneity of the membership. Self and Skeel state that this may not be a bad thing if it leads to the best ethical thinking in the institution – but given the contemporary emphasis on cultural diversity in society, they ask if this homogeneity within CECs is appropriate (Self and Skeel, 1998).

The question of how the members of the CECs involved in the study were selected has been discussed in Chapter 4. To recap, it was found that overall, in 9 of 23 the participating committees, members of the committee were selected by the committee chairperson. There was a marked difference between Australasian and U.K committees in this respect. While 9 committees from the U.K. (n=17) indicated that the committee chairperson selected committee members, this was not the case in any of the committees from Australasia (n=6). Ten of the committees indicated that members were selected by person(s) other than those listed in the questionnaire. Of this sub-group, 6 committees responded that individual committee members were selected by the committee as a whole. One other committee indicated that professional groups nominated medical, nursing, and allied health representatives, with the committee as a whole inviting lay and specialist members (such as ethicists, lawyers, and pastoral care representatives). One committee responded that the chairperson was selected by the hospital's Chief Medical Officer (CMO), and the other committee members by the committee as a whole. Further responses included one committee indicating that the hospital's Chief

Executive Officer (CEO) selected committee members on the recommendation of the committee, one committee indicating that members were selected by a sub-group of the committee, and one committee responding that committee members were selected jointly by the chairperson and the hospital CEO.

The 6 committees from the U.K. that indicated members were chosen by 'other' than the possibilities articulated in the questionnaire all stated that the committee as a whole selected the members. In Australasia, the 4 committees that responded that members were chosen by 'other' than articulated in the questionnaire indicated that members were chosen jointly by the CEO and the committee chairperson (1 committee); by a sub-group of the committee (1 committee); by the hospital CEO on the recommendation of the committee (1 committee) and; one committee indicated that the committee chairperson was chosen by the hospital CEO and the other members by the committee as a whole.

In sum, the results of the study revealed that for 6 of the 23 committees involved in the study, committee members were selected by the committee as a whole. A further 4 committees indicated that the committee members were at least in part involved in the selection of other committee members, meaning that in 10 of the 23 committees involved, the selection of committee members was undertaken to a greater or lesser degree by existing committee members. This method of committee member selection could lead toward homogeneity of the membership. In addition, in a further 9 committees, members were selected by the chairperson. This also has the potential to lead to homogeneity of committee membership since the committee chairperson may, consciously or sub-consciously, show bias in selecting 'like-minded individuals' to themselves. A further benefit of broadening the decision-making base is that by making it more decentralized, it is less likely that a powerful chairman might unduly influence the results (Peirce, 2004).

It should also be noted, however, that some degree of homogeneity is unavoidable since moral reasoning can only justifiably take place against a background of particular cultural practices and traditions. However, such moral reasoning can be aware of and, where appropriate, take account of particular cultural practices and traditions.

Measures to Help Avoid Groupthink

Benjamin (1995, p.257), states that by recognising symptoms of groupthink, an ethics committee can take courses of action to avoid them. These measures may include

> *First, committees can guard against premature agreement. The chairperson may explicitly ask that doubts and objections be expressed or may appoint members to make a case against the majority. Second, committees can scrutinise any second-hand information they receive…….Third, the committee can look for innovative ways to settle disputes* (Lo, 1987, p.48, cited in Benjamin, 1995, p.257).

In order to determine whether the CECs involved in the study implemented any of these measures to help them avoid sources of error in their deliberative process, which may be indicators of the potential dangers of groupthink, participants were presented with two statements pertaining to the courses of action described above.

It should be noted that the items included in this section of the study were not intended to be an assessment of groupthink in participating committees, but rather were included in order to determine if participating committees were utilising either of the two measures identified as means to help avoid some of the sources of error which may be associated with groupthink.

Statistical analysis was undertaken to determine whether there was any significant difference between responses for participants from Australasian and UK CECs. In addition, analysis of responses from CEC chairpersons and committee members was undertaken to investigate any differences between these groups of study participants. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant.

In the first instance, study participants were requested to indicate whether they agreed or disagreed with the statement, ‘the chairperson appoints member(s) to make the case against the majority’. The results are presented in tables 7.5 and 7.6, below.

Table 7.5. Measures to Avoid Groupthink: Country of Origin

Statement	Country of Origin	N	Median	Mann-Whitney U	p	r
The chairperson appoints member(s) to make the case against the majority.	Australasia	27	1			
	UK	82	2			
	Total	109	2	1033.00	.575	.054
Committee members have sufficient opportunity to scrutinise any second-hand information they receive on issues to be discussed at meetings.	Australasia	27	6			
	UK	88	6			
	Total	115	6	911.5	.060	.175

a. The chairperson appoints member(s) to make the case against the majority.

Overall, 7% of study participants (n=109) indicated that they agreed with the statement. 4% of participants indicated that they neither agreed nor disagreed with the statement. Therefore, 89% of participants (n=109) who responded to this statement, indicated that they disagreed that 'the chairperson appoints member(s) to make the case against the majority'. Table 7.5 shows, that a Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 1) and UK participants (Mdn = 2), U = 1033.00, p= .575, in the level of agreement with the statement. The median values shown in table 7.5, indicate that participants disagreed that the committee chairperson appoints member(s) to make the case against the majority at CEC meetings.

b. Committee members have sufficient opportunity to scrutinise any second-hand information they receive on issues to be discussed at meetings.

69% of all study respondents (n=115) indicated that they agreed with the statement. 16% of respondents indicated that they neither agreed nor disagreed with the statement, meaning that 15% of participants who responded to this statement, disagreed that 'committee members have sufficient opportunity to scrutinise any second-hand information they receive on issues to be discussed at meetings'. Table 7.5 shows, that a Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 6), U = 911.50, p = .060, in the level of agreement with the statement.

Table 7.6. Measures to Avoid Groupthink: Committee Membership Status

Statement	CEC membership status	N	Median	Mann-Whitney U	p	r
The chairperson appoints member(s) to make the case against the majority.	Member	91	1			
	Chair	18	2			
	Total	109	2	640.00	.115	.151
Committee members have sufficient opportunity to scrutinise any second-hand information they receive on issues to be discussed at meetings.	Member	97	6			
	Chair	18	5.5			
	Total	115	6	826.50	.712	.034

a. The chairperson appoints member(s) to make the case against the majority.

Table 7.6 shows, that a Mann-Whitney test indicated there was no significant difference between Members (Mdn = 1) and Chairpersons (Mdn = 2), U = 640.00, p= .115, in the level of agreement with the statement.

b. Committee members have sufficient opportunity to scrutinise any second-hand information they receive on issues to be discussed at meetings.

Table 7.6 shows, that a Mann-Whitney test indicated there was no significant difference between Members (Mdn = 6) and Chairpersons (Mdn = 5.5), U = 826.50, p= .712, in the level of agreement with the statement. In this instance the median values indicate that members had a greater level of agreement with the statement.

It is clear from the results of the study that few respondents agreed that the strategy of the chairperson appointing member(s) to make the case against the majority is one which is currently being widely employed. The recommendation of the study is that this could be a strategy which CECs might consider to help guard against one of the potential sources of error in their deliberative process which may be regarded as a symptom of groupthink. The chairperson could either appoint members on a case-by-case basis to make a case against the majority, or make it a particular role for a committee member(s).

On the other hand, there is a high level of consensus (median 6) between Australasian and UK participants for the other measure considered in this section that committee

members have sufficient opportunity to scrutinise any second-hand information they receive on issues to be discussed at meetings.

In addition to being a course of action to aid in avoiding a potential source of error in their deliberative process, as advocated by Benjamin, a further benefit of ensuring that committee members have sufficient opportunity to scrutinise any second-hand information they receive on issues to be discussed at meetings is, quite simply, according to Gutmann and Thompson (1997, p.40), that there are occasions where conflicts arise that do not involve deep disagreement. In such cases, some of these may turn out to be more easily resolved than they first appeared to be as they have arisen as the result of lack of information.

In addition to concerns about groupthink, there have been other issues raised regarding CEC composition. For example, Hollerman found that the members of a CEC would normally be appointed by the person to whom the committee reports (Hollerman, 1991). This could, however, lead to a legitimate concern, expressed by Leavitt, that committee members could be selected to serve the interests of the hospital management. He cites as an example the pursuit of liberal Do Not Resuscitate (DNR) policies to save resources (Leavitt, 2000). The results obtained in the current study did not entirely support this concern by Hollerman, with only 1 of the CECs involved in the study (n=23) indicating that the committee members were chosen by the CEO in conjunction with the committee chairperson. However, as previously noted, in 9 of the 17 UK committees, members were selected by the chairperson (compared with none of Australasian committees). Once again, this might mean that a committee chairperson inclined to serve the interests of the hospital management could show bias in selecting 'like-minded individuals' to themselves.

7.2.4. Area 1. Summary

In Area 1, participants were asked to respond to a number of statements concerning whether they believed their committee meetings provided a useful forum for discussing bioethical issues. In order to facilitate analysis of the results obtained, area 1 was sub-divided into 3 sections; 1. Committee member representation from the professional

disciplines; 2. Committee membership represents diverse bioethical perspectives; 3. Committee meetings usefulness as a forum for discussing bioethical issues.

The key finding of the study was that there was a high level of consensus across the items in each section of this area (median of 6).

However, although there was a high level of consensus (median=6), a statistically significant difference was found between Australasian and UK participants in the level of agreement with the statement that membership of committees has sufficient representation from the professional disciplines. Calculation of the Mean Rank for this item showed that Australasian participants (MR= 77.29) had a greater level of agreement with the statement than UK participants (MR= 61.44).

In light of the study findings, the conclusion from this area of the study is that committee meetings of participating committees provide a useful forum for discussing bioethical issues.

7.3. Area 2. Procedural Characteristics of a Deliberative Process

> *Practical reasoning is deliberative. But deliberation is a very difficult task. It requires many conditions; lack of external constraints, good will, capacity to give reasons, respect for others when they disagree, an ability to listen, disposition to influence and be influenced by arguments, a desire to be understood, cooperate and collaborate. This is the framework of a true deliberation process. Deliberation rests not on 'decision' but on 'commitment.' Within this framework, almost all existing bioethical methods can be useful to some extent. Outside it, not only will they be superfluous but also sometimes dangerous* (Gracia, 2001, p.223).

In this area of the study the views of participants concerning a number of aspects of their committee's deliberative process were examined. To facilitate analysis of the results obtained from the study, the area was sub-divided into 3 sections.

1. Section 1, was designed to investigate whether moral principles and value conflicts are explicitly articulated during committee deliberation on an issue.

2. Section 2, examined respondents' beliefs concerning a number of procedural characteristics of a committee's deliberative process pertaining to a Perspectives approach to deliberation.

3. Section 3,. sought to determine the beliefs of study participants regarding aspects of their participation in committee deliberations.

The theoretical background for this area largely derives from the discussion in chapter 2, Methodology in Bioethics.

The study findings, along with a discussion of these findings, are presented below.

7.3.1. Moral Principles and Value Conflicts

In Section 1, which was designed to investigate whether moral principles and value conflicts are explicitly articulated during committee deliberation on an issue, study participants were asked to indicate their views on two statements; i. Moral principles in the topic of discussion are identified, and, ii. A summary description of the value conflicts or other problems leading to the discussion is presented. Statistical analysis was undertaken to determine whether there was any significant difference between responses for participants from Australasian and UK CECs. In addition, analysis of responses from CEC chairpersons and committee members was undertaken to investigate any differences between these groups of study participants. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant.

The theoretical background to 'principlist' theory in bioethics is presented in chapter 2 (3.4). This provides, at least in part, the theoretical basis for the inclusion of the statements in this section.

The study findings for the two statements included in section 1 are given below. Statistical analysis was undertaken to determine whether there was any significant difference between responses for participants from Australasian and UK CECs. In addition, analysis of responses from CEC chairpersons and committee members was

undertaken to investigate any differences between these groups of study participants. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant..

i. Moral principles in the topic of discussion are identified.

The principal reason for the inclusion of this statement in the study was to determine whether moral principles were explicitly identified during discussions, and therefore, obtain some indication of the influence that a principlist type approach might have on committee discussions.

Table 7.7. Moral Principles in the Topic of Discussion are Identified : Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Moral principles in the topic of discussion are identified	Australasia	27	6	73.07			
	UK	98	6	60.22			
	Total	125	6		1051.00	.088	.153

Study participants were requested to indicate whether they agreed or disagreed with the statement that, during their committee's deliberations on an issue, 'moral principles in the topic of discussion are identified'. Overall, 87% of all study participants (n=125) indicated that they agreed with the statement. 8% of respondents indicated that they neither agreed nor disagreed with the statement. Thus, 5% of study participants who responded to this statement indicated that they disagreed that moral principles in the topic of discussion are identified.

Table 7.7. shows, that a Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 6) and U.K. participants (Mdn = 6), in the level of agreement with the statement.

Table 7.8. Moral Principles in the Topic of Discussion are Identified: Committee Membership Status

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Moral principles in the topic of discussion are identified	Member	105	6	65.18			
	Chair	20	6	51.58			
	Total	125	6		821.50	.107	.144

Table 7.8 shows, that a Mann-Whitney test indicated there was no significant difference between Members (Mdn = 6) and Chairpersons (Mdn = 6), in the level of agreement with the statement.

Of note from the above results is that the majority of respondents (87%) agreed (Mdn = 6) that during their committee's deliberations on an issue, moral principles in the topic of discussion are identified Therefore, at meetings of CECs involved in the study, the identification of moral principles involved in the topic of discussion would appear to be an integral component of committee deliberations.

ii. A summary description of the value conflicts or other problems leading to the discussion is presented.

Since, according to Gracia (2003, p.230), deliberation endeavours to explore all the intricacies of moral problems, which entails consideration of all the values and principles associated with the issue, and also the circumstances and likely consequences, a summary description of the value conflicts or other problems leading to the discussion might be desirable. The theoretical importance for this area derives from the discussion in chapter 2, methodology in Bioethics.

A practical example of this type of deliberative process is given in 'Ethical case deliberation on the ward. A comparison of four methods', in which Steinkamp and Gordijn (2003, p.235) set out to analyse and compare four methods of ethical case deliberation. They conclude that there is not one ideal method of deliberation and that a method can be chosen depending on the type of moral problem to be deliberated upon e.g., a reasonable methodological plurality. One of the methods analysed by Steinkamp

and Gordijn was the 'Nijmegen' method of ethical case deliberation. The aim of this method is to structure multidisciplinary committee deliberations in what are mainly situations of prospective decision making. The central position in the Nijmegen method is to pose a clear cut moral question at the beginning of deliberation. Steinkamp and Gordijn (2003, p.239) assert this derives importance since 'it has emerged in both ethical case deliberation and in the work of ethics committees that deliberating without a distinct question may unnecessarily complicate matters.' For Steinkamp and Gordijn, the Nijmegen method more clearly emphasises the difference between facts and values than other methods of deliberation. 'Facts' in the Nijmegen method are defined as being both the facts themselves and their interpretation during deliberations. The main reason why the difference between facts and values is stressed in such a way, according to Steinkamp and Gordijn (2003, p.240), 'is to guarantee a thorough analysis and understanding of all the relevant details of a case before proceeding to the value judgement.'

In order to investigate this aspect of committee deliberation in CECs involved in the study, participants were requested to indicate whether they agreed or disagreed with the statement that a summary description of the value conflicts or other problems leading to the discussion is presented.

Table 7.9. A summary Description of the Value Conflicts is Presented: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
A summary description of the value conflicts or other problems leading to the discussion is presented	Australasia	29	6	70.02			
	UK	99	6	62.88			
	Total	128	6		1275.50	.347	.083

Overall, 71% of all participants (n=128) indicated that they agreed with the statement. 15% of respondents answered that they neither agreed nor disagreed with the statement or indicated that it was not applicable. Therefore, 14% of the study participants disagreed that a summary description of the value conflicts or other problems leading to the discussion is presented.

Table 7.9 shows, that a Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 6) and U.K. participants (Mdn = 6), in the level of agreement with the statement. The median values indicate agreement with the statement,

Table 7.10. A Summary Description of the Value Conflicts is Presented: Committee Membership Status

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
A summary description of the value conflicts or other problems leading to the discussion is presented	Member	108	6	63.64			
	Chair	20	6	69.13			
	Total	128	6		987.50	.531	.055

Table 7.10 shows, that a Mann-Whitney test indicated there was no significant difference between Members (Mdn = 6) and Chairpersons (Mdn = 6), in the level of agreement with the statement. The median values indicate agreement with the statement,

Since a summary description of value conflicts, in addition to the identification of moral principles in the topic of discussion would be an aid for a CEC in determining all, or at least most, of the possible courses of action possible, the recommendation arising from the study findings in this area is that CECs should add this to the guidelines or protocols for their deliberative process.

7.3.2 Procedural Characteristics of a Perspectives Approach to Deliberation

As noted in chapter 2 (Methodology in Bioethics)**,** the contemporary methodological dominance of principlism in bioethics has increasingly been challenged in recent years. As a result of this dissatisfaction with principlism, a number of alternative methodologies have gained prominence in the literature concerning contemporary bioethics. Several notable examples of these methodologies embrace Diego Gracia's conception of deliberation in which he asserts 'deliberation is the cornerstone of any adequate methodology.' Gracia believes this to be the case because moral decisions are required to take into account emotions, values, and beliefs, in addition to principles and

ideas (Gracia, 2003, p.227). Gutman and Thompson (1997, p.40), elaborate on the nature of this process by contending that 'the number or diversity of voices heard and arguments made is not the only or even most important factor in making deliberations work: the character and will of the deliberators themselves are critical. They must be willing to try and broaden their own perspective in light of what they hear in the deliberative process. They must come to the forum open to changing their own minds as well as to changing the minds of their opponents.' Approaches based on this type of methodology have been termed 'perspectives' approaches by K.M. Boyd (2005). Whilst proponents of a perspectives-based approach do not dispute the relevance that approaches based on principles have when undertaking deliberation on bioethical issues, they contend that these approaches only partially account for the ethical story (Boyd, 2005, p.483).

The aim for Section 7.3.2, was to explore some of the features of a deliberative process based on a perspectives approach, and to investigate the extent to which they obtain for the CECs involved in the study. The theoretical background for examples of such perspectives approaches was presented in chapter 2 (Methodology in Bioethics). In particular, the sections on Clinical Pragmatism, Hermeneutics and the Ethics of Care provide, at least in part, the theoretical basis for the inclusion of the statements in Section 7.3.2.

Study Findings

In Section 2, several of features central to a deliberative process suggested by the clinical pragmatism and hermeneutics approaches, outlined in chapter 2 were considered. Study participants were asked for their views on a number of statements; i. The chairperson encourages members to identify several options and the consequences of each option; ii. Discussions are presented in a manner that encourages all members to express their views; iii. During committee deliberations, the position of each committee member is elicited; iv. The reasons or basis for each member's position are elicited; v. Discussions are marked by a tone of mutuality and respect.

Statistical analysis was undertaken to determine whether there was any significant difference between responses for participants from Australasian and UK CECs. In

addition, analysis of responses from CEC chairpersons and committee members was undertaken to investigate any differences between these groups of study participants. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The Study findings for each of these 5 statements for a. Country of Origin and b. Committee Membership Status, are given below.

a. Country of Origin

Table 7.11. Procedural Characteristics of a Perspectives Approaches to Deliberation: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
The chairperson encourages members to identify several options and the consequences of each option.	Australasia	29	6	69.71			
	UK	99	6	62.97			
	Total	128	6		1284.50	.377	.078
Discussions are presented in a manner that encourages all members to express their views.	Australasia	29	7	78.97			
	UK	100	6	60.95			
	Total	129	6		1045.00	.012	.222
The position of each committee member is elicited	Australasia	29	5	65.90			
	UK	99	5	64.09			
	Total	128	5		1395.00	.814	.021
The reasons or basis for each member's position are elicited.	Australasia	28	5	71.84			
	UK	99	5	61.78			
	Total	127	5		1166.50	.194	.115
Discussions are marked by a tone of mutuality and respect.	Australasia	29	7	77.79			
	UK	100	6	61.29			
	Total	129	6		1079.00	.020	.204

i. The chairperson encourages members to identify several options and the consequences of each option

The United Nations Educational, Scientific and Cultural Organization Division of Ethics of Science and Technology guide 'Establishing Bioethics Committees', states 'the chairperson should encourage the members to raise questions and express doubts that may not be well articulated in bioethical reading materials and case records alone. Thus each Healthcare Ethics Committee (HEC) should seek to cultivate cordial

deliberation – bioethics as conversation.' This statement affirms elements of the clinical pragmatism and hermeneutic methodologies described above.

Participants in the study were asked to indicate whether they agreed or disagreed with the statement that, during committee deliberations on an issue, the chairperson encourages members to identify several options and the consequences of each option. 70% of all study respondents (n=128) indicated that they agreed with the statement. 10% of respondents indicated that they neither agreed nor disagreed with the statement, meaning that a total of 20% of participants disagreed that their committee chairperson encourages members to identify several options and the consequences of each option. Table 7.11 shows, that a Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 6), in the level of agreement with the statement

Given the level of agreement with the statement (Mdn = 6), the recommendation of the study is that CECs include in guidelines or protocols for meetings that the committee chairperson encourages members to identify options and the consequences of each option, in order to facilitate the notion of 'bioethics as conversation'.

ii. Committee members encouraged to express views

Study participants were asked to indicate whether they agreed or disagreed with the statement that 'committee discussions were presented in a manner that encourages all members to express their views'. The majority of all participants (n=129) agreed with the statement, with 95% of respondents agreeing that this was the case. 3% of respondents indicated that they neither agreed nor disagreed with the statement, meaning that 2% of all participants responded that they disagreed that committee discussions were presented in a manner that encourages all members to express their views. Table 7.11 shows, that a Mann-Whitney test indicated there was a significant difference between Australasian (Mdn = 7) and UK participants (Mdn = 6), U = 1045.00, p= .012, in the level of agreement with the statement, with Australasian participants agreeing more strongly than their U.K. counterparts.

The above results highlighted that very few respondents disagreed with the statement, with 2% of respondents indicating that this was the case. It may be concluded, for participants of CECs involved in the study, that committee discussions were considered, to be presented in a manner that encourages all members to express their views.

iii. The position of each committee member is elicited

One purpose of deliberation, according to Gutman and Thompson (1997, pp.40-41), is to help correct the mistakes that professionals and administrators inevitably make when they take collective decisions. This is in response to a source of disagreement, namely, that incomplete understanding characterises almost all moral disagreements. For Gutman and Thompson, 'a well-constituted bioethics forum provides an opportunity for advancing both individual and collective understanding. Through the give-and-take of argument, participants can learn from each other, come to recognize their individual and collective misapprehensions, and develop new views and policies that can more successfully withstand critical scrutiny.' When members of a CEC deliberate it is possible for them to expand their knowledge and their self-understanding. This is in addition to a collective understanding of what will best serve their communities (Gutman & Thompson, 1997, p41). One way in which this can be facilitated is by eliciting the position of each committee member during discussions on an issue.

In order to investigate if this was the case for CECs involved in the study, participants were requested to indicate whether they agreed or disagreed with the statement that, during committee deliberations, the position of each committee member is elicited. Overall, 67% of study participants (n=128) indicated that they agreed with the statement. 13% of participants indicated that they neither agreed nor disagreed with the statement. Therefore, 20% of respondents indicated that they disagreed that the position of each committee member is elicited. Table 7.11 shows, that a Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 5) and UK participants (Mdn = 5), in the level of agreement with the statement

The study results indicate, that although there was general agreement with the statement (Mdn = 5), 20% of participants disagreed the statement. Thus, the recommendation of the study is that CECs include in guidelines or protocols for meetings that the position

of each member of the committee is elicited in the discussion of issues brought before the committee. This would facilitate the building of a collective understanding on an issue, and thus help in the production of a recommendation or policy that can more successfully withstand critical scrutiny.

iv. The reasons for each committee member's position are elicited

Study participants were requested to indicate whether they agreed or disagreed with the statement that during committee deliberations, 'the reasons or basis for each member's position are elicited'. The importance of the inclusion of this statement is highlighted by Gracia, who asserts that it will often happen that members of a group or committee deliberating on an issue will differ in their final solution. The positive effect of this is that by addressing the reasons for this difference, it may result in a reshaping of the perception of the problem for everyone (Gracia, 2003, p.229). Once again, this is in accordance with key concepts described by clinical pragmatism and hermeneutic methodologies outlined earlier.

Overall, 58% of study participants (n=127) indicated that they agreed with the statement that during committee deliberations, 'the reasons or basis for each member's position are elicited'. 18% of participants indicated that they neither agreed nor disagreed with the statement. Therefore, 24% of respondents indicated that they disagreed that, during committee deliberations, the reasons or basis for each member's position are elicited.
Table 7.11 shows, that a Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 5) and UK participants (Mdn = 5), in the level of agreement with the statement.

Of note from the above results is that although an overall majority of respondents (58%) agreed with the statement, almost one quarter of respondents (24%) did not agree that during committee deliberations, the reasons or basis for each member's position are elicited. In view of the level of disagreement with the statement, the recommendation of the study is that CECs include in guidelines or protocols for meetings that, in addition to the position of each member being elicited in committee deliberations, the reasons for each member's position should also be elicited. As stated previously, the positive effect of this is that by addressing the reasons for this difference, it may result

in a reshaping of the perception of the problem for everyone (Gracia, 2003, p.229). Further, this would facilitate a key feature of a 'perspectives' approach to deliberation, highlighted by Gracia (2003,p.227), that 'Deliberation is the process in which everyone concerned by the decision is considered a valid moral agent, obliged to give reasons for their own points of view, and to listen to the reasons of others.'

v. Discussions marked by a tone of mutuality and respect

In addition to the ideas postulated by the methodologies of Clinical Pragmatism and Hermeneutics described previously, Gutman and Thompson examine, in 'Deliberating about Bioethics', what type of forum best serves bioethical debates. They believe that one answer to this question can be found by looking at political theories of democracy. They conclude that the most promising theories which may be applied to bioethical debates are those that require participants to 'justify any demands for collective action by giving reasons that can be accepted by those who are bound by the action'. According to Gutman and Thompson (1997, p38), this conception has come to be known as 'deliberative democracy.' In cases where there is disagreement, participants should deliberate with one another in an attempt to find moral agreement where possible, and crucially, maintaining mutual respect when such moral agreement is not attainable.

Gutman and Thompson assert that while democracies may not be able to avoid disagreement, parties should be able to deliberate about their disagreements in a manner which contributes to the health of a democratic society. One important purpose of deliberation, described by Gutmann and Thompson, is the promotion of mutually respectful decision-making. This is seen by them as a response to what they consider to be an often neglected source of moral disagreement – incompatible moral values (p40). While deliberation may not be able to make incompatible values compatible, it may assist participants recognise moral merit in the position and claims of those opposed to their position.

In order to investigate this vital element of a deliberative process, participants were asked to indicate whether they agreed or disagreed with the statement that their 'committee discussions are marked by a tone of mutuality and respect'. The majority of

all study participants (n=129) agreed with the statement, with 98% of respondents indicating that this was the case. 1% of respondents indicated that they neither agreed nor disagreed with the statement, meaning that only 1% of all respondents disagreed that their committee discussions are marked by a tone of mutuality and respect. Table 7.11 shows, that a Mann-Whitney test indicated there was a significant difference between Australasian (Mdn = 7) and UK participants (Mdn = 6), U = 1079.00, p= .020, in the level of agreement with the statement, with Australasian participants agreeing more strongly that their committee discussions are marked by a tone of mutuality and respect.

Of note from the above results is that a large majority of respondents (98%) agreed with the statement that their committee discussions are marked by a tone of mutuality and respect. There was little disagreement with the statement, with only 1% of UK respondents (Mdn = 6) and none of the Australasian respondents (Mdn = 7) indicating this to be the case. The conclusion being, quite categorically, that the study participants believed that their committee discussions are marked by a tone of mutuality and respect.

b. Membership Status

Table 7.12. Procedural Characteristics of a Perspectives Approaches to Deliberation: Committee Membership Status

Statement	Committee Membership Status	N	Median	Mean Rank	Mann-Whitney U	p	r
The chairperson encourages members to identify several options and the consequences of each option.	Member	108	6	65.51			
	Chair	20	5	59.05			
	Total	128	6		971.00	.462	.065
Discussions are presented in a manner that encourages all members to express their views.	Member	109	6	66.22			
	Chair	20	6	58.38			
	Total	129	6		957.50	.342	.084
The position of each committee member is elicited	Member	108	5.5	64.72			
	Chair	20	5	63.33			
	Total	128	5		1056.50	.875	.014
The reasons or basis for each member's position are elicited.	Member	107	5	63.46			
	Chair	20	5	66.88			
	Total	127	5		1012.50	.699	.034
Discussions are marked by a tone of mutuality and respect.	Member	109	6	65.52			
	Chair	20	6	62.18			
	Total	129	6		1033.50	.683	.036

Table 7.12 shows, that an analysis of the Procedural characteristics of a Perspectives approach to Deliberation found no statistically significant difference between Chairpersons and Members of participating CECs.

Whilst deliberation based on a perspectives approach is unable to achieve the moral certainty to which some principles based approaches aspire, it is able to create a realm of reflection within the practice of bioethics (Steinkamp and Gordijn, 2003; Boyd, 2005). However, as Steinkamp and Gordijn point out, 'confining oneself in ethical deliberation to understanding and interpretation may prove incomplete. It may amount to blinding out the need to get answers to the questions to what should be done' (Steinkamp and Gordijn, 2003, p.243). Therefore, a broader deliberative process would include a perspectives approach complemented by normative considerations related to the consideration of principles and value conflicts involved in the issue under discussion.

7.3.3. Participation in Committee Deliberations

Section 3, sought to examine the beliefs of respondents regarding aspects of their participation in their committee's deliberations. To this end, participants were asked for their views on three statements; i. I actively participate in committee discussions; ii. My point of view is respected by other committee members; iii. My voice is heard in committee discussions. The theoretical background for many of the questions in this area was presented in chapter 2 (Methodology in Bioethics).

Statistical analysis was undertaken to determine whether there was any significant difference between responses for participants from Australasian and UK CECs. In addition, analysis of responses from CEC chairpersons and committee members was undertaken to investigate any differences between these groups of study participants. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. The Study findings for each of these 3 statements for a. Country of Origin and b. Committee Membership Status are given below.

a. Country of Origin

Table 7.13. Participation in Committee Deliberations: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
I actively participate in committee discussions	Australasia	29	7	71.98			
	UK	100	6	62.98			
	Total	129	6		1247.50	.215	.109
My point of view is respected by other committee members.	Australasia	29	7	77.22			
	UK	100	6	61.46			
	Total	129	6		1095.50	.031	.190
My voice is heard in committee discussions.	Australasia	29	7	73.40			
	UK	100	6	62.57			
	Total	129	6		1206.50	.137	.131

i. I actively participate in committee discussions

As previously stated in chapter 2, regarding 'perspectives' approaches for a CEC's deliberative process, Gutman and Thompson (1997, p.40), contend that 'the number or diversity of voices heard and arguments made is not the only or even most important factor in making deliberations work: the character and will of the deliberators themselves are critical. They must be willing to try and broaden their own perspective in light of what they hear in the deliberative process. They must come to the forum open to changing their own minds as well as to changing the minds of their opponents (Gutman and Thompson, 1997, p.40). One critical factor in achieving this end must surely lie in the willingness of participants to participate in their committee's deliberations. To this end, the policy directive entitled 'Clinical Ethics Processes in NSW Health' NSW Health, 2006), which provides guidance to Public Health Organisations (PHOs) in New South Wales that have chosen to establish a clinical ethics committee, explicitly states that 'Collective membership must have the capacity to deal with complex clinical ethical issues and each member should make a contribution.' On a practical level, in a study by Schick and Moore which presented success factors for healthcare ethics committees from the perspective of members and leaders of 15 such committees in the USA, one of four key personal characteristics of committee members identified was 'participation in the committee discussions' (Schick and Moore, 1998, p.78).

In order to investigate the views of participants in the current study regarding their participation in committee discussions, the participants were asked to indicate whether they agreed or disagreed with the statement that they actively participate in committee discussions. The majority of all study participants (n=129) agreed with the statement, with 96% of respondents indicating that this was the case. 2% of respondents indicated that they neither agreed nor disagreed with the statement, meaning that 2% of all respondents disagreed that they actively participate in committee discussions. Table 7.13 shows, that a Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 7) and UK participants (Mdn = 6), in the level of agreement with the statement.

The above findings clearly show that the majority of respondents (96%) agreed that they actively participate in committee discussions. This finding highlights a positive feature of the deliberative process of participating committees.

ii. My point of view is respected by other committee members

One key component of a 'perspectives' approach to a deliberative process, outlined in chapter 2, was, according to Leder (1994, p.255), the requirement for the process to be able to commence with a 'spirit of dialogic openness'. To be able to truly engage in this manner requires CEC members to be able to respect other members' points of view and to have the expectation that their point of view will be similarly accorded respect by their fellow committee members. This feature of a deliberative process was affirmed by participants in a study by Schick and Moore, which presented success factors for healthcare ethics committees from the perspective of members and leaders of 15 such committees in the USA, who concluded that 'good communication assumes respect for the other person's position; without this respect, shared discourse cannot occur' (Schick and Moore, 1998, p.78).

In order to investigate this component of a deliberative process, study participants were asked to indicate whether they agreed or disagreed with the statement that their point of view is respected by other committee members. The majority of all participants (n=129) agreed with the statement, with 96% of respondents agreeing that this was the case. 2% of respondents indicated that they neither agreed nor disagreed with the statement, meaning that only 2% of all participants responded that they disagreed with the statement that their point of view is respected by other committee members. Table 7.13 shows, that a Mann-Whitney test indicated there was a significant difference between Australasian (Mdn = 7) and UK participants (Mdn = 6), U = 1095.50, p= .031, in the level of agreement with the statement, with Australasian participants showing stronger agreement that their point of view is respected by other committee members.

iii. My voice is heard in committee discussions

Participants in the study were asked to indicate whether they agreed or disagreed with the statement that their voice is heard in committee discussions. The majority of all

study respondents (n=129) indicated that they agreed with the statement, with 95% of respondents indicating that this was the case. 2% of respondents indicated that they neither agreed nor disagreed with the statement. Table 7.13 shows, that a Mann-Whitney test indicated there was no significant difference between Australasian (Mdn = 7) and UK participants (Mdn = 6), in the level of agreement with the statement.

b. Committee Membership Status

Table 7.14. Participation in Committee Deliberations: Committee Membership Status

Statement	Committee Membership Status	N	Median	Mean Rank	Mann-Whitney U	p	r
I actively participate in committee discussions	Member	109	6	64.69			
	Chair	20	6	66.70			
	Total	129	6		1056.00	.810	.021
My point of view is respected by other committee members.	Member	109	6	64.94			
	Chair	20	6	65.35			
	Total	129	6		1083.00	.961	.004
My voice is heard in committee discussions.	Member	109	6	64.79			
	Chair	20	6	66.13			
	Total	129	6		1067.50	.874	.014

Table 7.14 shows, that analysis of Participation in Committee Deliberations found no statistically significant differences between Chairpersons and Members of participating CECs.

7.3.4. Area 2. Summary

In this area of the study a number of aspects of the procedural characteristics of participating committees' deliberative processes were examined. The area was divided into 3 sections, 1. Moral principles and value conflicts, 2. Features of a 'perspectives' approach to deliberation, 3. Participation in committee deliberations.

The key finding of the study in this area being that there was generally a high level of consensus across the items in each section (median of 6 or 7), thus indicating that deliberative processes were being used effectively. The only items with less strong

agreement were those concerning whether each committee member's view and reasons for it were elicited (median 5 or 5.5).

Despite the high level of consensus across the items, a number of statistically significant differences were found between Australasian and UK participants. In section 2, while there was high level of agreement with the statement 'committee discussions were presented in a manner that encourages all members to express their views', a significant difference was found between Australasian (Mdn = 7) and UK participants (Mdn = 6). In similar fashion, for the statement 'committee discussions are marked by a tone of mutuality and respect', it was found that, while only 1% of all respondents disagreed with the statement, there was a significant difference found between Australasian (Mdn = 7) and UK participants (Mdn = 6). In section 3, while only 2% of all participants responded that they disagreed with the statement that their point of view is respected by other committee members, a significant difference was found between Australasian (Mdn = 7) and UK participants (Mdn = 6) in the level of agreement with the statement. Notably, for each of these three statements, Australasian participants had a greater level of agreement than UK participants.

These differences notwithstanding, the conclusion for area 2 was that committees should be commended on the effective use of their deliberative processes.

7.4 Area 3. Committee Deliberation Outcome

The third major area relating to the deliberative process of participating CECs, considered in depth by the study, concerned the outcome of committee deliberations.

According to Benjamin (1995, p.242), agreement among members of clinical ethics committees can take a variety of shapes. For example, at one end of the range is complete agreement on both the substance of a recommendation and its supporting arguments. At the other end of the range is vote-taking, and the committee's sanctioning the will of the majority. Between these two extremes are overlapping consensus and compromise.

In this area of the study, participants were asked to indicate their view on statements

relating to 3 major categories of outcomes of their committee's deliberations

1. Consensus
2. Compromise
3. Majority

Statistical analysis was undertaken to determine whether there was any significant difference between responses for participants from Australasian and UK CECs. In addition, analysis of responses from CEC chairpersons and committee members was undertaken to investigate any differences between these groups of study participants. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant. Each of these outcomes, along with the results obtained from study, is discussed below.

7.4.1 Consensus

The first, and arguably most important area of CEC deliberation outcomes considered in the study concerned consensus. From the literature concerning consensus, with particular reference to CECs, two main types of consensus were identified; namely, 1. Strong substantive consensus and, 2. Weak substantive consensus. In addition to determining the views of study participants on each of these of consensus, the views of participants were also sought regarding the value of building consensus.

7.4.1.1. Strong Substantive Consensus

Strong substantive consensus also referred to as 'complete consensus', can be further sub-divided into two categories; 1.a. pre-deliberatively complete consensus, and, 1.b. complete consensus.

1.a. Pre-deliberatively Complete Consensus

Griffin Trotter (2002a, pp.38-39) defines strong substantive consensus as 'a state of general agreement without coercion.' Thus, strong substantive consensus comes about when an opinion is broadly shared throughout an entire population. For example, it

may be said that strong substantive consensus exists when experts, authorities, and ordinary citizens all share the same opinion (Trotter, 2002a, pp.38-39). Aulisio and Arnold (1999, p.329) expand on a further important feature that defines strong substantive consensus, that it 'is consensus concerning the specific 'thick' first-order values, and the underlying (second-order) reasons, that should determine decision making.' This means, for example, that if members of a clinical ethics committee straight away agree on a recommendation *and* its supporting values or principles, that there is strong substantive consensus, and, according to Benjamin, the consensus would be 'pre-deliberatively' complete (Benjamin, 1995, p.242).

In order to examine the views of the members of the CECs involved in the study regarding pre-deliberatively complete consensus, study participants were requested to indicate whether they agreed or disagreed with the statement that **'**there are occasions where all members of the committee immediately agree on a recommendation and its supporting values or principles i.e. with little or no committee deliberation necessary'.

Overall, 73% of study participants (n=129) indicated that they agreed with the statement. 12% of participants indicated that they neither agreed nor disagreed with the statement. Therefore, 15% of respondents indicated that they disagreed that there are occasions where all members of the committee immediately agree on a recommendation and its supporting values or principles.

Statistical analysis was undertaken to determine whether there were any significant differences between Australasian and UK participants, or between committee chairpersons and committee members, for these statements. The study findings are presented in tables 7.15 and 7.16,

Table 7.15 : Pre-Deliberatively Complete Consensus: Country of Origin

Statement	Country of Origin	N	Median	Mann-Whitney U	p	r
There are occasions where all members of the committee immediately agree on a recommendation and its supporting values or principles	Australasia	29	6			
	UK	100	5			
	Total	129	5	1080.00	<.001	.314

Table 7.15, shows there was a significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 5), U = 1080.00, p= <.001, r = .314, in the level of agreement with the statement, with Australasian participants showing stronger agreement that there are occasions where all members of the committee immediately agree on a recommendation and its supporting values or principles i.e. with little or no committee deliberation necessary. 90% of Australasian respondents (n= 29) compared with 63% of UK respondents (n= 100) agreed with the statement.

Table 7.16: Pre-Deliberatively Complete Consensus: Committee Membership Status

Statement	Committee Membership Status	N	Median	Mann-Whitney U	p	r
There are occasions where all members of the committee immediately agree on a recommendation and its supporting values or principles	Member	109	6			
	Chair	20	6			
	Total	129	6	1029.50	.686	.036

In comparing responses between Chairpersons and Members, table 7.16 shows there to be no significant difference between Members (Mdn = 6) and Chairpersons (Mdn = 6), U = 1029.50, p= .686, r = .036, in the level of agreement with the statement.

These results, indicating agreement with the statement, might be considered to be somewhat surprising since, according to Benjamin (1995, p.242), pre-deliberative complete consensus will be rare because queries regarding ethical issues addressed by clinical ethics committees are typically hotly disputed. Ethics committees are normally brought into being in the first place when society at large is obliged to speak with one voice on complicated ethical questions to which members of society give uncertain or conflicting answers. Matters which would be expected to generate complete consensus at the outset of a committee's deliberation are, as a consequence, not usually directed to ethics committees. Therefore, one interpretation of the study findings might be due to the nature of issues being presented to the participants' CECs not being considered to be contentious by committee members. This question will be addressed more fully in section 1.b., concerning 'complete consensus.'

At another level, according to Benjamin (1995, p.243), ethics committee members normally represent divergent social or ethical viewpoints or dissimilar areas of biomedical, social scientific, or other kinds of expertise, or both. It is partly this heterogeneous and representative structure of such committees that bestows distinct endorsement on whatever agreement that manifests itself from their deliberations. At the same time, this heterogeneity is unlikely to yield pre-deliberative complete consensus. The fact that in the current study none of the Australasian respondents (n=29) and 20% of UK respondents (n=100) disagreed that there were occasions where all members of the committee immediately agree on a recommendation and its supporting values or principles i.e. with little or no committee deliberation necessary, would indicate that, particularly for Australasia, pre-deliberatively complete consensus is a common occurrence. One conclusion to be drawn from this is that the committees in the study lack heterogeneity of membership. Some of the problems associated with homogeneity of committee membership have been discussed previously in Area 1.

Following on from pre-deliberatively complete consensus is complete consensus.

1.b. Complete Consensus

According to Martin Benjamin (1995, p.243), even although it is unlikely that complete consensus occurs at the outset of a committee's deliberations, it frequently develops toward the end. This comes about, according to Benjamin, because often issues arise that are so novel or perplexing that members of a committee have no fixed positions on them to begin with. In such circumstances, 'open-minded, informed, mutually respectful, give and take discussion aimed at well grounded agreement may produce convergence on both reasons and conclusion - complete consensus' (Benjamin, 1995, p.243).

In order to determine the views of the members of CECs involved in the study regarding this form of complete consensus; two statements pertaining to complete consensus were included in section C of study instrument Questionnaire 1.

In the first instance, study participants were asked to indicate whether they agreed or disagreed with the statement that 'issues arise that are so novel that committee

members, at the outset, have no firm positions on them'. 74% of all participants (n=127) agreed with the statement. 9% of respondents indicated that they neither agreed nor disagreed with the statement, meaning that 17% of all participants responded that they disagreed with the statement that issues arise that are so novel that committee members, at the outset, have no firm positions on them.

The second statement relating to complete consensus included in section C of study instrument questionnaire 1, requested study participants to indicate whether they agreed or disagreed with the statement that **'**when novel issues arise, committee deliberation seldom leads to a well grounded agreement which produces convergence on both the reasons and conclusions from all committee members'. Overall, 64% of all study participants (n=123) indicated that they agreed with the statement. 11% of respondents indicated that they neither agreed nor disagreed with the statement. Therefore, 25% of study participants indicated that they disagreed that when novel issues arise, committee deliberation seldom leads to a well grounded agreement which produces convergence on both the reasons and conclusions from all committee members.

Statistical analysis was undertaken to determine whether there were any significant differences between Australasian and UK participants, or between committee chairpersons and committee members, for these statements. The study findings are presented in tables 7.17 and 7.18,

Table 7.17. Complete Consensus: Country of Origin

Statement	Country of Origin	N	Median	Mann-Whitney U	p	r
Issues arise that are so novel that committee members, at the outset, have no firm positions on them	Australasia	29	6			
	UK	98	5			
	Total	127	5	1129.00	.083	.153
When novel issues arise, committee deliberation seldom leads to a well grounded agreement which produces convergence on both the reasons and conclusions from all committee members	Australasia	26	6			
	UK	97	5			
	Total	123	5	891.00	.007	.244

Table 7.18. Complete Consensus: Committee Membership Status

Statement	Committee Membership Status	N	Median	Mann-Whitney U	p	r
Issues arise that are so novel that committee members, at the outset, have no firm positions on them	Member	107	5			
	Chair	20	6			
	Total	127	5	797.00	.062	.166
When novel issues arise, committee deliberation seldom leads to a well grounded agreement which produces convergence on both the reasons and conclusions from all committee members	Member	103	5			
	Chair	20	5			
	Total	123	5	865.50	.248	.104

Table 7.17 shows there was no statistically significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 5), U = 1129.00, p= .083, r = .153, in the level of agreement with the statement 'Issues arise that are so novel that committee members, at the outset, have no firm positions on them'. Similarly, table 7.18 shows there was no statistically significant difference between Members (Mdn = 5) and Chairpersons (Mdn = 6), U = 797.00, p= .062, r = .166, in the level of agreement with the statement 'Issues arise that are so novel that committee members, at the outset, have no firm positions on them'.

The findings of the study would substantiate Benjamin's assertion, stated previously, that ethics committees are normally brought into being in the first place when society at large is obliged to speak with one voice on complicated ethical questions to which members of society give uncertain or conflicting answers (Benjamin, 1995, p.242).

For the statement 'When novel issues arise, committee deliberation seldom leads to a well grounded agreement which produces convergence on both the reasons and conclusions from all committee members', table 7.17 shows there was a statistically significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 5), U = 891.00, p= .007, r = .244, in the level of agreement with the statement. In this case, Australasian participants agreed more strongly with the statement than did U.K. participants. In contrast, table 7.18 shows there was no statistically significant

difference between Members (Mdn = 5) and Chairpersons (Mdn = 5), U = 865.50, p= .248, r = .104, in the level of agreement with the statement 'Issues arise that are so novel that committee members, at the outset, have no firm positions on them'.

The above findings, with the median values showing agreement with the statement, would tend to support Benjamin's assertion that complete consensus will not occur often, since committee members frequently bring conflicting moral outlooks or principles to the deliberations that affect their reasoning or conclusions (Benjamin, 1995, p.243).

However, according to Benjamin, it is still possible for members of an ethics committee to agree in their conclusions, but to have come to these conclusions by dissimilar means. This can arise since 'individuals representing differing areas of expertise are likely to emphasise different aspects of complex, multidimensional questions in their thinking, leading to differing arguments, if not different conclusions' (Benjamin, 1995, p.243). In such cases, the outcome might still be consensus, although not complete consensus.

This leads to the second sub-division of substantive consensus, namely, 'weak substantive consensus.'

7.4.1.2. Weak Substantive Consensus/ Overlapping Consensus

According to Aulisio and Arnold (1999, p.329), 'weak substantive consensus can be reached when parties have differing, but not radically irreconcilable, moral views, and do not see them as beyond compromise.' It can often be the case, according to Jonathan Moreno, that individual members of an ethics committee may reach similar conclusions, but for different reasons. For example, the differences might result from a disparate interpretation or weighting of the same principles; conversely, the differences may result from the selection of completely different principles that, by chance, in this occasion give rise to the same conclusion (Moreno, 1995, p.51).

Aulisio and Arnold contend that it is possible to identify at least two types of weak substantive consensus. These are

1. *Involved parties may come to have the same 'thick' first-order values such that they would make the same choice, but have very different reasons for doing so.*

2. *Involved parties may not actually come to have identical relevant first-order values such that they would choose the same way if faced with the same choice, but rather they may be willing and able to compromise, without the loss of integrity, some of their substantive 'thick' first-order values in reaching an agreement about what should be done* (Aulisio and Arnold, 1999, p.330).

The theoretical underpinning of weak substantive consensus described above by Aulisio and Arnold is derived from the concept of 'overlapping consensus.' The term 'overlapping consensus' was coined by John Rawls in his seminal text 'A Theory of Justice' (Rawls, 1971). According to Kelly (2003, p.349), Rawls's objective was to 'locate within a constitutional democracy the basis for social peace that is neither a fragile Hobbesian political agreement nor the result of an ad hoc negotiating process but a standard or set of standards that is stable over generations.' For Rawls, overlapping consensus was an elaboration of two ideas that are companions to his central idea of 'justice as fairness,' of society as a fair system of cooperation over time, from one generation to the next (Moreno, 1995, p.60). These companion ideas, according to Moreno are

1. The idea of citizens cooperating as free and equal persons.

2. The idea of a society regulated by a political conception of justice, a well ordered society (Moreno, 1995, p.60).

These ideas could then secure the backing of an overlapping consensus, which incorporates, in addition to these ideas:

> *all the reasonable opposing religious, philosophical, and moral doctrines likely to persist over generations and to gain a sizeable body of adherents in a more or less constitutional regime, a regime in which that criterion of justice is the political conception itself* (Rawls, 1981, p.15, cited in Moreno, 1995, p.60).

Therefore, according to the concept of overlapping consensus, it is possible to describe agreement on basic principles of justice among individuals encompassing a plurality of varying, and sometimes incompatible moral, religious, and political viewpoints. Further, since disparate principles can, on occasion, result in the same conclusion, it is possible that seemingly incompatible comprehensive outlooks can endorse the same conception of social justice. In such cases, according to Benjamin, 'there is overlap among those parts of different individuals' comprehensive moral, religious, and philosophical views that include a particular conception of social justice, but not among their moral, religious, and philosophical views as a whole' (Benjamin, 1995, p.243). It is possible, therefore, for one person to place their support for a specific idea of justice within certain religious convictions, while another might find a place for the same idea of justice to be located within a comprehensive secular moral theory, for example, that of Kant or Mill (Benjamin, 1995, p.243). Thus, this kind of overlapping consensus can often be seen in agreement reached by members of an ethics committee, who may frequently formulate both utilitarian and Kantian arguments for the same conclusion.

An example of this type of consensus is given by Stephen Toulmin, who, while acting in his role with the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, noted,

> *When the eleven individual commissioners asked themselves what 'principles' underlay and supposedly justified their adhesion to the consensus, each of them answered in his or her own way: the Catholics appealed to Catholic principles, the Humanists to Humanist principles, and so on. They could agree; they could agree what they were agreeing about; but, apparently, they could not agree why they agreed about it* (Toulmin, 1981, p.32).

From another perspective, Jonathan Moreno contends that it is possible to view principles, such as those found in bioethics, as being objects of an overlapping consensus. He asks us to consider the four principles of Beauchamp and Childress's version of principlism, that is, autonomy, beneficence, nonmaleficence, and justice. Moreno regards justice to be 'already inscribed' in the overlapping consensus as fairness. Autonomy, interpreted as implying freedom and equality, is a necessary requirement the political conception of justice. Nonmaleficence can be seen as 'jointly

implied by a respect for free and equal persons entitled to fair treatment. Beneficence is a more contentful expression of that respect' (Moreno, 1995, p.61).

In order to investigate the views of respondents from CECs involved in the study regarding weak substantive consensus, study participants were requested to indicate whether they agreed or disagreed with the statement that '**i**ndividual committee members arguing from different moral, religious, philosophical and empirical premises may, despite emphasising different aspects of complex issues, reach the same conclusions with respect to positions or policies in clinical ethics'.

Overall, 83% of study participants (n=127) indicated that they agreed with the statement. 13% of participants indicated that they neither agreed nor disagreed with the statement. Therefore, 4% of respondents indicated that they disagreed with the statement.

Statistical analysis was undertaken to determine whether there were any significant differences between Australasian and UK participants, or between committee chairpersons and committee members, for this statement. The study findings are presented in tables 7.19 and 7.20,

Table 7.19. Weak Substantive Consensus: Country of Origin

Statement	Country of Origin	N	Median	Mann-Whitney U	Mean Rank	p	r
Individual committee members arguing from different moral, religious, philosophical and empirical premises may, despite emphasising different aspects of complex issues, reach the same conclusions with respect to positions or policies in clinical ethics	Australasia	28	6		75.89		
	UK	99	6		60.64		
	Total	127	6	1053.00		.041	.181

Table 7.19, shows there was a statistically significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 6), U = 1053.00, p= .041, r = .181, in the level of agreement with the statement that, '**i**ndividual committee members arguing from

different moral, religious, philosophical and empirical premises may, despite emphasising different aspects of complex issues, reach the same conclusions with respect to positions or policies in clinical ethics'. In this instance, although the median values were the same for Australasian and U.K. participants, calculation of the Mean Rank (MR) showed that Australasian participants (MR = 75.89) agreed more strongly with the statement than U.K. participants (MR = 60.64).

Table 7.20. Weak Substantive Consensus: Committee Membership Status

Statement	Committee Membership Status	N	Median	Mann-Whitney U	p	r
Individual committee members arguing from different moral, religious, philosophical and empirical premises may, despite emphasising different aspects of complex issues, reach the same conclusions with respect to positions or policies in clinical ethics	Member	108	6			
	Chair	19	6			
	Total	127	6	974.00	.502	.059

In contrast, table 7.20 shows there was no statistically significant difference between Members (Mdn = 6) and Chairpersons (Mdn = 6), U = 974.00, p= .502, r = .059, in the level of agreement with the statement '**i**ndividual committee members arguing from different moral, religious, philosophical and empirical premises may, despite emphasising different aspects of complex issues, reach the same conclusions with respect to positions or policies in clinical ethics'.

The study findings, that overall 83% of participants agreed with the statement, and the median values obtained, suggest that 'weak substantive consensus' is an outcome of committee deliberations achieved by CECs participating in the study.

7.4.1.3. The Value of Building a Consensus

As the findings of the study have revealed, weak substantive or overlapping consensus is an outcome achieved by CECs involved in the study. The study further sought to

determine the views of participants regarding the value of building a consensus on an issue.

The study investigated the views of study participants regarding the value of building a consensus on an issue by asking participants to indicate whether they agreed or disagreed with the statement that 'the principal value of building a consensus on an issue is its contribution to obtaining external acceptance and implementation of the committee's recommendation'.

Statistical analysis was undertaken to determine whether there were any significant differences between Australasian and UK participants, or between committee chairpersons and committee members, for this statement. The study findings are presented in tables 7.21 and 7.22.

Table 7.21. The Value of Building a Consensus: Country of Origin

Statement	Country of Origin	N	Median	Mann-Whitney U	p	r
The principal value of building a consensus on an issue is its contribution to obtaining external acceptance and implementation of the committee's recommendation.	Australasia	24	5			
	UK	93	5			
	Total	117	5	1259.00	.913	.010

Table 7.21, shows there was no statistically significant difference between Australasian (Mdn = 5) and U.K. participants (Mdn = 5), U = 1259.00, p= .913, r = .010, in the level of agreement with the statement, 'the principal value of building a consensus on an issue is its contribution to obtaining external acceptance and implementation of the committee's recommendation'.

Table 7.22. The Value of Building a Consensus: Committee Membership Status

Statement	Committee Membership Status	N	Median	Mann-Whitney U	p	r
The principal value of building a consensus on an issue is its contribution to obtaining external acceptance and implementation of the committee's recommendation.	Member	108	5			
	Chair	19	5			
	Total	117	5	892.50	.772	.023

Similarly, table 7.22 shows there was no statistically significant difference between Members (Mdn = 5) and Chairpersons (Mdn = 5), U = 892.50, p= .772, r = .023, in the level of agreement with this statement.

Overall, 55% of all study participants (n=117) agreed with the statement. 20% of respondents indicated that they neither agreed nor disagreed with the statement. Therefore, 25% of all respondents disagreed that 'the principal value of building a consensus on an issue is its contribution to obtaining external acceptance and implementation of the committee's recommendation'. One explanation for this result might be that participants hold the view, articulated by Moreno, that while an ethics committee's judgments do not require to be in agreement with the general opinion of society on an issue to have moral authority, their thoroughly articulated judgments cannot justifiably be foisted on the private affairs of persons who embrace incompatible moral views that are themselves consistent with the most general principles of liberal society. For to do so, according to Moreno, would 'jeopardise the framework of the overlapping consensus' (Moreno, 1995, p.70).

According to Benjamin (1995, p.257), the fact that an eclectic, and seemingly knowledgeable clinical ethics committee has achieved consensus on specific recommendation is grounds for giving it careful, but not uncritical consideration. There is the widely held assumption that because such diverse, multidisciplinary committees have scrutinised all the details of a bioethical question characterised by real doubt or reasonable difference of opinion, and after reflection on each and every one of the identified options, they diligently arrive at enlightened, uncoerced, accord on the best position for institutional or social purposes. Benjamin asserts that this, however, is only

a presumption (Benjamin, 1995, p.257). Because of the numerous respects in which a committee's deliberations can go off course, Benjamin asserts that we should 'critically examine the group's reasoning before endorsing its conclusions' (Benjamin, 1995, p.257). Some of the respects in which a CEC's deliberations can go off course have been discussed previously, in area a., in the section regarding 'groupthink'.

Therefore, according to Moreno, 'the scrutiny of the ways in which small groups come to collective opinion is an important part of the study of consensus' (Moreno, 1995, p.70). Further, Moreno asserts, 'the more the inadequacies of small groups as sites of moral consensus processes can be identified, the greater are the opportunities to enhance the prospects for deliberative democracy under the rubric of liberal pluralism' (Moreno, 1995, p.127). A number of factors in the ways in which a CEC comes to a collective opinion were considered in area 2.

7.4.2. Compromise

The second outcome of a CEC's deliberation on an issue brought before it to be considered was that of 'compromise.'

According to Benjamin (1995, p.244), compromise exhibits a number of apparent similarities to consensus, but it is also significantly dissimilar. Fundamental to compromise is the concept of mutual concession for mutual gain. For Jonathan Moreno, the main difference between compromise and consensus is that, in consensus when committee members engage in deliberation they are uncertain about how to resolve the problem, whereas in compromise there is no doubt, other than possibly about the best way of going about making sure that their own viewpoint come out on top (Moreno, 1995, p.116). Individual committee members may, at a later date, attempt to convince other members with whom they are at odds, of the superiority of their initial stance with the intention of it ultimately being re-evaluated and adopted by the entire committee (Benjamin, 1995, p.245). For Moreno, the usefulness of the concept of a procedural consensus is that it gives prominence to the fact that consensus should not merely be seen as a static endpoint, but rather as an important component that characterises the whole deliberative process. According to Moreno (1995, p.41), three distinct points in a deliberative process can be identified

1. The initial situation of the participants which may be termed procedural consensus.
2. The ways in which the participants change their positions.

3. The collective judgment that emerges.

In order to investigate a number of features of the concept of compromise as an outcome of CECs involved in the study, participants were asked for their views on 4 statements pertaining to compromise; i. Our committee seeks to speak with one voice in making and supporting a particular recommendation; ii. At committee meetings, particular matters are often not fully settled, there is no closure, no final harmony; iii. I often find myself, on occasions, in the position of a committee member, supporting a compromise position which is more or less at odds with my personal moral views; iv. I find myself on occasions, in the role of a committee member, making concessions for the sake of agreement on a single recommendation that seems to have some independent value. Statistical analysis was undertaken to determine whether there was any significant difference between responses for participants from Australasian and UK CECs. In addition, analysis of responses from CEC chairpersons and committee members was undertaken to investigate any differences between these groups of study participants. A Mann-Whitney U test was used for statistical analysis and p value less than .05 was considered statistically significant.

The study results are presented below.

Country of Origin

Table 7.23. Compromise: Country of Origin

Statement	Country of Origin	N	Median	Mean Rank	Mann-Whitney U	p	r
Our committee seeks to speak with one voice in making and supporting a particular recommendation.	Australasia	29	6	74.05			
	UK	97	6	60.35			
	Total	126	6		1100.50	.060	.167
At committee meetings, particular matters are often not fully settled, there is no closure, no final harmony.	Australasia	29	6	82.78			
	UK	99	6	59.15			
	Total	128	6		905.50	.002	.278
I find myself on occasions, in the position of a committee member, supporting a compromise position which is more or less at odds with my personal moral views	Australasia	29	2	52.17			
	UK	99	2	68.11			
	Total	128	2		1078.00	.035	.186
I find myself on occasions, in the role of a committee member, making concessions for the sake of agreement on a single recommendation that seems to have some independent value.	Australasia	28	2	53.79			
	UK	95	3	64.42			
	Total	123	2		1100.00	.152	.129

Each of these statements, along with the results obtained from study, is discussed below.

i. Our committee seeks to speak with one voice in making and supporting a particular recommendation

Compromise is similar to consensus by virtue of the fact that, in both cases, an ethics committee, for example, seeks to speak with one voice in formulating and endorsing a specific recommendation on an issue brought before it. In these situations, there is consensus on what position ought to be settled on by the committee (Benjamin, 1995, p.245). According to Moreno, in actual cases of moral disagreement that a clinical ethics committee may be faced with, the participants already share a wide range of beliefs, covering such things as factual medical information through to moral values. This kind of situation illustrates a distinctly ramified background consensus, one that

has ‘widely recognised implications, including agreement on matters of substance as well as procedure,’ and, according to Moreno, ‘without which management of real-world differences would be but a fantasy’ (Moreno, 1995, p.42). In order to investigate this aspect of the deliberative process of the CECs involved in the study, participants were requested to indicate whether they agreed or disagreed with the statement that their ‘committee seeks to speak with one voice in making and supporting a particular recommendation’.

Overall, 84% of all study participants (n=126) indicated that they agreed with the statement. 12% of respondents indicated that they neither agreed nor disagreed with the statement. Therefore, 4% of study participants indicated that they disagreed that their committee seeks to speak with one voice in making and supporting a particular recommendation. Table 7.23 shows, that A Mann-Whitney U test indicated there was no statistically significant difference between Australasian (Mdn = 6) and U.K. participants (Mdn = 6), in the level of agreement with the statement.

Given that the median value (Mdn = 6) shows that participants agreed with the statement, it may be concluded that seeking to speak with one voice in making and supporting a particular recommendation is a goal for the outcome of participating CEC deliberations.

ii. At committee meetings, particular matters are often not fully settled, there is no closure, no final harmony

An important feature of compromise, according to Benjamin, is that in a compromise, the issue is not completely resolved. Benjamin states, that in such cases, ‘there is no closure, no final harmony, no complete or overlapping consensus’ (Benjamin, 1995, p.245). The study sought to determine the views of members of CECs involved in the study on this question of resolution by asking participants to indicate whether they agreed or disagreed with the statement that ‘at committee meetings, particular matters are often not fully settled, there is no closure, no final harmony’.

76% of all study respondents (n=128) indicated that they agreed with the statement. 8% of respondents indicated that they neither agreed nor disagreed with the statement,

meaning that 16% of participants disagreed that at committee meetings, particular matters are often not fully settled. Table 7.23 shows, that A Mann-Whitney U test indicated there was a statistically significant difference between Australasian (Mdn = 6) and U.K. participants (Mdn = 6), U = 905.50, p= .002, in the level of agreement with the statement. Calculation of the Mean Rank (MR), showed that Australasian participants (MR = 82.78) agreed more strongly with the statement than U.K. participants (MR = 59.15). The effect size (r) was .278, indicating a medium effect

Analysis of the responses from participants by country of committee origin showed that 86% of Australasian respondents (n=29) compared with 73% of U.K. respondents (n=99) indicated that they agreed with the statement. After accounting for respondents who indicated that they neither agreed nor disagreed with the statement, it was determined that 7% of Australasian respondents compared with 19% of U.K. respondents disagreed that 'at committee meetings, particular matters are often not fully settled, there is no closure, no final harmony'.

While it can be seen that, overall, 76% of respondents agreed with the statement and 16% of respondents disagreed with the statement, it should be noted that there was a significant difference between Australasian respondents (86%) and UK respondents (73%) agreeing with the statement.

The study findings support Benjamin's assertion that, in a compromise, the issue is not completely resolved.

iii. I often find myself, on occasions, in the position of a committee member, supporting a compromise position which is more or less at odds with my personal moral views

A key difference between compromise and consensus, for Benjamin, is that, by supporting a compromise, an individual committee member may keep hold of personal moral views that may be in conflict with the position they endorse in their role as a committee member (Benjamin, 1995, p.245). In order to assess this aspect of the difference between compromise and consensus, study participants were requested to indicate whether they agreed or disagreed with the statement 'I often find myself, on

occasions, in the position of a committee member, supporting a compromise position which is more or less at odds with my personal moral views.' Overall, 15% of study participants (n=128) indicated that they agreed with the statement. 9% of participants indicated that they neither agreed nor disagreed with the statement. Therefore, 76% of respondents indicated that they disagreed that they often found themselves, on occasions, supporting a compromise position which is more or less at odds with their personal moral views. It can be seen from table 7.23, that a Mann-Whitney U test indicated there was a statistically significant difference between Australasian (Mdn = 2) and U.K. participants (Mdn = 2), U = 1078.00, p= .035, in the level of agreement with the statement. Calculation of the Mean Rank (MR), showed that U.K. participants (MR = 68.11) agreed more strongly with the statement than Australasian participants (MR = 52.17). The effect size (r) was .186, indicating a small effect.

The median values, shown in table 7.23, indicate that study participants disagreed with the statement that they often found themselves, on occasions, supporting a compromise position which is more or less at odds with their personal moral views.

Analysis of the responses from participants by country of committee origin revealed that 17% of Australasian respondents (n=29) and 14% of U.K. respondents (n=99) agreed with the statement. After accounting for participants who indicated that they neither agreed nor disagreed with the statement, it was found that 74% of U.K. participants and 83% of Australasian participants disagreed that they often found themselves, on occasions, supporting a compromise position which is more or less at odds with their personal moral views.

Of note from the above results is that, overall, a relatively small percentage of respondents (15%) agreed with the statement 'I often find myself, on occasions, in the position of a committee member, supporting a compromise position which is more or less at odds with my personal moral views.' Similar results were obtained for Australasian (14%) and UK (17%) respondents. These findings would suggest that the majority of participants in the current study were not prepared to compromise their personal moral views for the sake of reaching some compromise position on an issue brought before their committee, and therefore the results do not support Benjamin's

assertion regarding, what he considers to be, a key difference between compromise and consensus.

iv. I find myself on occasions, in the role of a committee member, making concessions for the sake of agreement on a single recommendation that seems to have some independent value.

According to Benjamin (1995, p.245), all of those involved in supporting a compromise may be required to make concessions in order to achieve agreement on a single recommendation that appears to have some independent validity.

Participants in the study were asked to indicate whether they agreed or disagreed with the statement 'I find myself on occasions, in the role of a committee member, making concessions for the sake of agreement on a single recommendation that seems to have some independent value'. 23% of all study respondents (n=123) indicated that they agreed with the statement. 17% of respondents indicated that they neither agreed nor disagreed with the statement, meaning that a total of 60% of participants disagreed that they found themselves on occasions, making concessions for the sake of agreement on a single recommendation that seems to have some independent value. Table 7.23 shows , that A Mann-Whitney test indicated there was no statistically significant difference between Australasian (Mdn = 2) and U.K. participants (Mdn = 3), in the level of agreement with the statement.

The median values, shown in table 7.23, indicate that study participants disagreed with the statement that they found themselves on occasions, making concessions for the sake of agreement on a single recommendation that seems to have some independent value. This finding does not support Benjamin's assertion that all of those involved in supporting a compromise may be required to make concessions in order to achieve agreement on a single recommendation that appears to have some independent validity.

Committee Membership Status

Table 7.24. Compromise: Committee Membership Status

Statement	Committee Membership Status	N	Median	Mean Rank	Mann-Whitney U	p	r
Our committee seeks to speak with one voice in making and supporting a particular recommendation.	Member	107	6	65.29			
	Chair	19	6	53.42			
	Total	126	6		825.00	.166	.123
At committee meetings, particular matters are often not fully settled, there is no closure, no final harmony.	Member	108	6	64.50			
	Chair	20	5	64.50			
	Total	128	6		1080.00	1.000	0
I find myself on occasions, in the position of a committee member, supporting a compromise position which is more or less at odds with my personal moral views	Member	108	2	64.54			
	Chair	20	2.5	64.28			
	Total	128	2		1075.50	.976	.003
I find myself on occasions, in the role of a committee member, making concessions for the sake of agreement on a single recommendation that seems to have some independent value.	Member	105	2	62.54			
	Chair	18	2	58.83			
	Total	123	2		888.00	.674	.038

Table 7.24, shows that there were no statistically significant differences between responses from Chairpersons and members for any of the statements in this section.

7.4.3 Majority

The third outcome of a CEC's deliberations on issues brought before it to be considered was that of a simple majority of votes.

Periodically, a committee may be incapable of reaching any form of consensus on an issue or of producing an acceptable compromise. It is possible in such cases, that each committee member, in spite of that, would still see it as being preferable for the committee to make either of two recommendations on an issue rather than for the committee not to make a recommendation at all. When this situation arises, it is possible for a consensus to emerge from taking a vote among alternatives, then sanctioning, as a committee, the proposal which receives the majority of votes. For

Aulisio and Arnold, the crucial point is that procedural consensus emphasises who should be permitted to make recommendations, rather than on the substance of the decision itself. Procedural consensus should be viewed as being accord about a response to the essentially political question 'whose values should be reflected in decision making?' (Aulisio and Arnold, 1999, p.330).

In order to investigate the views of members of CECs involved in the study regarding this form of 'majority rule', study participants were asked to indicate whether they agreed or disagreed with the statements, 'If the committee is unable to reach a consensus or satisfactory compromise on an issue, it is acceptable to vote among alternatives, then endorsing as a committee, the recommendations receiving a majority of votes', and 'If the committee is unable to reach a consensus or satisfactory compromise on an issue, all members of the committee must be in agreement that the results of any vote-taking may be attributed to the committee as a whole'.

The study findings for the two statements for Australasian and UK participants are presented in table 7.25, and for committee chairpersons and committee members in table 7.26.

Table 7.25. Majority Rule: Country of Origin

Statement	Country of Origin	N	Median	Mann-Whitney U	p	r
If the committee is unable to reach a consensus or satisfactory compromise on an issue, it is acceptable to vote between alternatives, then endorsing as a committee, the recommendations receiving a majority of votes.	Australasia	20	5			
	UK	83	5			
	Total	103	5	758.50	.090	.167
If the committee is unable to reach a consensus or satisfactory compromise on an issue, all members of the committee must be in agreement that the results of any vote-taking may be attributed to the committee as a whole	Australasia	20	4			
	UK	82	4			
	Total	102	4	810.00	.322	.098

Table 7.26. Majority Rule: Committee Membership Status

Statement	Committee Membership Status	N	Median	Mann-Whitney U	p	r
If the committee is unable to reach a consensus or satisfactory compromise on an issue, it is acceptable to vote between alternatives, then endorsing as a committee, the recommendations receiving a majority of votes	Member	85	5			
	Chair	18	4			
	Total	103	5	590.00	.505	.066
If the committee is unable to reach a consensus or satisfactory compromise on an issue, all members of the committee must be in agreement that the results of any vote-taking may be attributed to the committee as a whole	Member	84	4			
	Chair	18	3			
	Total	102	4	547.00	.189	.130

Overall, 56% of all study participants (n=103) agreed with the statement, 'If the committee is unable to reach a consensus or satisfactory compromise on an issue, it is acceptable to vote between alternatives, then endorsing as a committee, the recommendations receiving a majority of votes'. 17% of respondents indicated that they neither agreed nor disagreed with the statement. Therefore, 27% of all respondents disagreed with the statement. Table 7.25, shows there was no statistically significant difference between Australasian (Mdn = 5) and U.K. participants (Mdn = 5), U = 758.50, p= .090, r = .167, in the level of agreement with the statement. Similarly, table 7.26 shows there was no statistically significant difference between Members (Mdn = 5) and Chairpersons (Mdn = 4), U = 590.00, p= .505, r = .066, in the level of agreement with this statement.

These results show a general level of support for Aulisio and Arnold's views regarding majority vote and procedural consensus.

An important rider for 'majority rule', according to Benjamin, is that in cases where vote-taking has been agreed to by all committee members, the outcome of such vote-taking is sanctioned by and ascribed to the committee as a whole (Benjamin, 1995, p.246). This may be seen to be similar to procedural consensus, which 'is operative when there is agreement about the rules or methods that will be followed in resolving actual or possible conflicts about substantive matters' (Moreno, 1995, p.41). Aulisio and Arnold (1999, p.330) contend that 'procedural consensus is not merely agreement regarding a good procedure for decision making, but also agreement about who is (or are) the authorised decision-makers.'

However, Benjamin (1995, p.246) asserts that it would be unfair to resort to vote-taking without the consent of all of the members of the committee and then attributing the results to the committee as a whole. For Benjamin, 'a majority position, under such conditions, is attributable to only those who voted for that position and not to those who were opposed to settling the matter by vote-taking' (Benjamin, 1995, p.246). This objection to majority rule, according to Moreno, is the concern about the 'tyranny of the majority' and the desire to safeguard those with earnestly held but non-conformist moral values from majority dictates (Moreno, 1995, p.14).

To determine the views of members of CECs involved in the study regarding this aspect of 'majority rule', participants were asked to indicate whether they agreed or disagreed with the statement that 'if the committee is unable to reach a consensus or satisfactory compromise on an issue, all members of the committee must be in agreement that the results of any vote-taking may attributed to the committee as a whole'.

Overall, 46% of all study participants (n=102) agreed with the statement. 11% of respondents indicated that they neither agreed nor disagreed with the statement. Therefore, 43% of all respondents disagreed that if the committee is unable to reach a consensus or satisfactory compromise on an issue, all members of the committee must be in agreement that the results of any vote-taking may attributed to the committee as a whole'. Table 7.25, shows there was no statistically significant difference between Australasian (Mdn = 4) and U.K. participants (Mdn = 4), U = 81.00.00, p= .322, r = .098, in the level of agreement with the statement. Similarly, table 7.26 shows there was no statistically significant difference between Members (Mdn = 4) and Chairpersons (Mdn = 3), U = 547.00, p= .189, r = .130, in the level of agreement with this statement.

Of note from the above study findings was the fact that there were almost equal numbers of respondents who indicated that they agreed or disagreed with the statement. The conclusion which may be drawn from these results is that the outcome of committee deliberations that, 'if the committee is unable to reach a consensus or satisfactory compromise on an issue, all members of the committee must be in agreement that the results of any vote-taking may attributed to the committee as a whole', is controversial.

According to Moreno, on occasions an ethics committee will reluctantly decide that a vote should be taken on an issue. However, should the recommendation only just pass, the committee may decide not to take the recommended action. This is, in part, because it may be seen to be unfitting to insist on a 'mechanical democratic process' where important moral values are involved. It may also be the case that, in such instances, the majority is willing to wave its privileges in order to maintain harmony within the committee (Moreno, 1995, p.13).

7.4.4. Area 3. Summary

In this area of the study, participants were asked to indicate their view on statements relating to 3 major categories of outcomes of their committee's deliberations; 1.Consensus; 2. Compromise; 3. Majority.

The important study findings for this area were,

1. Consensus

Two major categories of consensus were identified; strong substantive consensus and weak substantive consensus. For strong substantive consensus, two further sub-divisions were identified, namely, pre-deliberatively complete consensus and complete consensus.

The finding of the study was that there was general agreement with the items in this area (median 5 or 6). However, there were a number of significant differences found between Australasian and UK participants. These differences are outlined below.

Strong Substantive Consensus

Regarding pre-deliberatively complete consensus, although there was overall agreement, a significant difference was found between Australasian (median 6) and UK (median 5) participants in the level of agreement for the statement, **'**There are occasions where all members of the committee immediately agree on a recommendation and its supporting values or principles i.e. with little or no committee deliberation necessary'. Australasian participants showed stronger agreement with the statement than UK participants.

Similarly, in terms of complete consensus, although there was overall agreement with the statement 'When novel issues arise, committee deliberation seldom leads to a well grounded agreement which produces convergence on both the reasons and conclusions from all committee members', a significant difference was found between Australasian (median 6) and UK (median 5) participants, in the level of agreement with the

statement. Once again Australasian participants showed stronger agreement with the statement.

Weak Substantive Consensus

A significant difference between Australasian and UK participants was found for the statement 'Individual committee members arguing from different moral, religious, philosophical and empirical premises may, despite emphasising different aspects of complex issues, reach the same conclusions with respect to positions or policies in clinical ethics'. Although there was a high level of agreement with the statement with a median value of 6 for both Australasian and UK participants, calculation of the Mean Rank (MR) showed that Australasian participants (MR = 75.89) agreed more strongly with the statement than U.K. participants (MR = 60.64).

2. Compromise

The important study findings for this section were,

There was a high level of consensus (median 6) that committees sought to speak with one voice in making and supporting a particular recommendation. However, there was also a high level of consensus (median 6) that 'At committee meetings, particular matters are often not fully settled; there is no closure, no final harmony'. For this statement, a statistically significant difference was found between Australasian and U.K. participants in the level of agreement with the statement, with the Mean Rank values showing that Australasian (MR 82.78) participants agreed more strongly with the statement than U.K. participants (MR 59.15).

There was also a high level of consensus (median 2 or 3) in disagreeing with the statements, 'I find myself, on occasions, in the position of a committee member, supporting a compromise position which is more or less at odds with my personal moral views.' and, 'I find myself on occasions, in the role of a committee member, making concessions for the sake of agreement on a single recommendation that seems to have some independent value'. A statistically significant difference was found between Australasian and U.K. participants, in the level of agreement with the first of these two

statements. Calculation of the Mean Rank (MR) showed that UK participants (MR 68.11) agreed more strongly with the statement than Australasian participants (52.17).

These findings suggested that there may be some tension in reaching a compromise on an issue. While the goal for committees might be speak with one voice in making a recommendation, often there is no closure or final harmony. The findings also highlighted that participants in the study were not prepared to compromise their personal moral views for the sake of reaching some compromise position on an issue brought before their committee.

3. Majority

The third outcome of a CEC's deliberations on issues brought before it considered in the study was that of a simple majority of votes. The study finding for the statements in this area showed a generally lower level of agreement than for those regarding consensus and compromise.

For the statement, 'If the committee is unable to reach a consensus or satisfactory compromise on an issue, it is acceptable to vote among alternatives, then endorsing as a committee, the recommendations receiving a majority of votes', the median was 5, with 56% of participants agreeing with the statement. There was less strong agreement (median 4) with the statement, 'If the committee is unable to reach a consensus or satisfactory compromise on an issue, all members of the committee must be in agreement that the results of any vote-taking may attributed to the committee as a whole'. In this case, 46% of participants agreed with the statement.

The overall findings for committee deliberation were that reaching a consensus on an issue is the most sought after outcome of deliberations, committees may have some difficulties in reaching a compromise on an issue. Further, a majority decision is the least preferred option for committees.

7.5. Chapter Summary

The analysis of the findings of the study was presented for each of 3 broad areas relating to the deliberative process of participating CECs. These areas being: 1. The Clinical Ethics Committee meeting as a forum for discussing bioethical issues; 2. Procedural characteristics of the deliberative process; and, 3. Committee deliberation outcome. For each of these areas, following discussion on the theoretical underpinnings and connection to the literature, the key study findings and any internal discrepancies in the findings between Australasian and U.K. participants were highlighted and discussed. These results were summarised at the end of each area.

The key findings for each area are shown below.

Area 1.

The key finding of the study was that there was a high level of consensus across the items in each section of this area (median of 6). In light of the study findings, the conclusion from this area of the study is that committee meetings of participating committees provide a useful forum for discussing bioethical issues.

Area 2.

The key finding of the study in this area being that there was generally a high level of consensus across the items in each section (median of 6 or 7), thus indicating that deliberative processes were being used effectively. The only items with less strong agreement were those concerning whether each committee member's view and reasons for it were elicited (median 5 or 5.5). The conclusion for area 2 was that committees should be commended on the effective use of their deliberative processes.

Area 3.

The overall findings for committee deliberation were that reaching a consensus on an issue is the most sought after outcome of deliberations, committees may have some difficulties in reaching a compromise on an issue. Further, a majority decision is the least preferred option for committees.

Chapter 8

Guidelines for Clinical Ethics Committees

8.1. Introduction

A central aim of the study, as stated in chapter 1 (1.3) was to investigate how it might be possible to provide some form of 'quality assurance' that the moral reasoning of CECs. Specifically, one of the study objectives (1.3.4.) was to formulate recommendations which might aid CECs in the evalustion of their performance and help ensure that their moral reasoning meets society's expectations. The study findings in relation to the structure, function, evaluative and deliberative processes have been analysed in depth in chapters 4-7. The aim of this chapter is to highlight and discuss the key study findings from these chapters and present a set of Guidelines for Clinical Ethics Committees. It may be added at this point, that although these guidelines have been formulated for CECs, they may also be of value to other healthcare ethics committees. The guidelines pertaining to deliberative process may be of particular relevance in this regard.

8.2. Study Recommendations

As mentioned above, the study undertook to analyse; 1. The Structure; 2. Functions; 3. Deliberative Processes; and 4. Evaluation Processes, of participating CECs. The study findings and recommendations arising from the findings are gathered together and presented below.

8.2.1. Structure

In terms of recommendations relating to the structure of CECs, the main areas considered were, 1. Committee Size and 2. The Selection Process of Committee members.

8.2.1.1. Committee Size

The number of members serving on each of the participating CECs in the study was selected to be a consideration in the assessment of CEC meeting as a useful forum for discussing bioethical issues. One question pertinent to this issue is whether there might be an optimum size for a CEC in order to best carry out its activities.

As previously stated in Chapter 4, Schick and Guo (2003) , in a study which examined the characteristics of successful CECs, found that larger committees tended to be more successful. They suggested that reasons for this included the fact that larger committees found it easier to form a quorum, and also that larger committees found it easier to divide into sub-committees which may spread the workload. In addition to the above factors larger committees might be considered be more suited to providing a broader diversity of membership, both in terms of representation from professional disciplines and also in representing bioethical perspectives. However, one cautionary note regarding the size of a CEC was put forward by the American Medical Association (AMA) which recommended that care should be taken to ensure the size of any CEC should not be so large as to make it unwieldy (AMA, 2005).

The main finding from the findings of the study (4.2.1), was that in accord with the literature, the large majority of participating CECs have a committee membership of adequate size to ensure the possibility of having sufficient membership from affected stakeholders, in terms of diversity of professions/ disciplines and diversity of bioethical perspectives. The finding of the study was that there was no statistically significant difference between participating committees from Australasia and the U.K. in terms of committee size.

The recommendations of the study arising from the study results are, that, primarily, CECs should be mindful that they have sufficient membership to enable the provision of a broad diversity of representation from the professions/ disciplines and also a broad diversity of bioethical perspectives. CECs should also ensure that they have adequate representation from stakeholders within the general community they represent (1.1.a). The second recommendation with regard to committee size is that CECs should be

aware of the need to be of a sufficient size to facilitate the formation of a quorum and division into sub-committees where necessary (1.1.b).

8.2.1.2. Selection Process of Committee Members

An important structural aspect of CECs investigated by the study concerned the selection of committee members. One of the main problems in the selection of committee members derives from the difficulty of ensuring that the selection process avoids, or at least minimises, bias toward an individual e.g. the hospital CEO or the committee chairperson, the hospital board or management, or any particular bioethical perspective. The danger of such bias being the production of a committee coopted to fulfil the partisan interests of the institution (Benjamin, 1995), individual, or bioethical perspective. Further, should the selection process lead to homogeneity of the membership, then the deliberations of any such committee would be prone to 'groupthink', whereby members' striving for unanimity could override their motivation to realistically appraise alternative courses of action (Janis, 1972).

A conclusion which can be drawn from the study results regarding the selection of committee members (4.2.5) is that, due to the diversity of study results regarding the selection of committee members, there are significant methodological problems facing CECs in determining what might be considered to be the optimal selection process for the selection of committee members.

In light of the study findings, the recommendation to be made pertaining to the selection of CEC members is that problems associated with homogeneity of membership and the dangers associated with groupthink may be alleviated, at least to some extent, by adopting the approach taken whereby professional groups nominate medical, nursing, and allied health representatives. This method of committee member selection should be extended in such a way that lay and specialist positions on the committee be advertised, with the applicants being invited to join the committee following selection by the committee as a whole (1.2.a). However, one disadvantage of this method of selecting lay members of the committee would be that these members would be chosen by non-lay members, thus introducing a source of selection bias. One solution to this problem would be to invite a consumer body, for example the Health Consumers'

Council, to nominate lay members to serve on the committee. This method of selecting committee members, in addition to aiding the minimisation of bias toward any individual, hospital board, or bioethical perspective, would have the added benefit of raising awareness of the CEC among professional groups and the community at large.

8.2.2. Functions

The areas considered, relating to the functions of CECs, were, 1. Education; 2. Policy and Guidelines; and, 3. Case Consultation.

8.2.2.1. Education

In this area, recommendations were made with regard to education for, a. The Hospital Community and b. Committee members.

a. Hospital Community

The study findings presented in Chapter 5 (5.3.2) revealed that 86% (14) of participating committees indicated they provided education for their hospital community, which was understood to include healthcare providers, hospital staff, patients, and the families of patients. No statistically significant difference between UK and Australasian committees was found in this respect.

However, for individual respondents, when asked if they believed that their CEC adequately addresses the bioethical education needs of the hospital community, although there was overall agreement (Mdn=4.5), a significant difference was found between Australasian and UK respondents, with Australasian respondents agreeing more strongly with the statement than their UK counterparts. It was found that 34% of the study participants did not believe that their committee adequately addressed the bioethical educational needs of their hospital community.

Since provision of bioethical education for the hospital community may be seen as deriving importance both from the perspective of inculcating the values and mission of the hospital and also aiding in raising awareness of the committee within the hospital

community, the recommendation arising from the study (2.1.a) is that CECs should actively organise and conduct regular bioethics educational events for the hospital community.

b. Committee Members

The study results showed that 86% (14) of participating committees indicated that they provided education for their members (5.3.2). No statistically significant difference between UK and Australasian committees was found in this regard.

The importance of the provision of education for committee members was highlighted by the findings presented in Chapter 5.3, which revealed that when asked to respond to factors they consider to be major contributing factors to the overall success of a CEC, 87% of participants regarded the provision of education for new and existing members of their committee to be important. Further, from the results presented in Chapter 5.3, it was found that, 69% of participants agreed that the lack of training available for members of the committee would be an obstacle to the successful development and effectiveness of their committee.

The study findings regarding participants views on the provision of education for committee members, showed that when participants were asked to respond to the statement 'our ethics committee adequately addresses the bioethical education needs of its members', although there was overall agreement (Mdn=5), a significant difference was found between Australasian and UK respondents, with Australasian respondents agreeing more strongly with the statement than their UK counterparts. It was found that, overall, 28% of respondents did not believe that their committee adequately addressed the bioethical needs of its members.

Similarly, for the statement, **'**I feel sufficiently prepared for my role on this ethics committee', there was overall agreement with the statement (Mdn=5), However, a significant difference was found between Australasian and UK respondents, with Australasian respondents agreeing more strongly with the statement than their UK counterparts. In this instance, 25% of participants did not feel that they were sufficiently prepared for their role on their clinical ethics committee.

For the statements, ‘Initial qualification training is provided for committee members’, and ‘Ongoing training is provided for committee members’, although no significant difference was found between Australasian and UK respondents for either statement, the overall level of agreement with these statements was less than for the two statements above, with in each case the median being 4. In the case of initial qualification training, 49% of participants indicated that there was no initial qualification training provided for committee members, while 34% of participants disagreed that ongoing training is provided for members of their committee.

In view of the study finding that almost one half of participants indicated that no initial training is provided for committee members, the study recommendation is that CECs should provide training for new committee members, the nature of this training to be documented and included in committee protocols (2.1.b.).

In terms of ongoing training for committee members, it was found from the results presented in Chapter 4.2.3, regarding informal ethics education, that 44% of participants (n=129) stated they had attended Hospital in-service ethics training. There was no significant difference found between Australasian and U.K. participants in this category.

In view of the large number of CEC members who had not attended any Hospital in-service ethics education events, coupled with the study finding that 34% of participants disagreed that ongoing training is provided for committee members, the study recommendation is that CECs should ensure that attention is given to the provision of in-service ethics training events, and that the nature and frequency of these events are documented. It is also desirable that it be included in committee protocols that members attend a specified number of these events, as a form of continuing professional development, thereby ensuring that members are fully cognisant of current bioethical perspectives (2.1.c.).

One aspect pertaining to committee members’ preparation for their role on a CEC considered by the study was that of the nature of any formal ethics education undertaken by committee members. From the results presented in Chapter 4.2.3, fewer than one-half (46%) of all participants indicated they had completed some type of formal ethics education. This, together with the study findings that 49% of participants indicated that

there was no initial qualification training provided for committee members, and 25% of participants did not feel that they were sufficiently prepared for their role on their clinical ethics committee, leads to recommendation that committee protocol should document that new members are enlightened more fully on their role on the committee. This may take the form of an induction process whereby new members are given adequate opportunity to scrutinise committee protocols and procedures, perhaps sitting-in on committee meetings prior to being co-opted on to the committee (2.1.d.).

8.2.2.2. Policy / Guidelines

From the study results presented in chapter 5.2.3, it was found that only one of the committees participating in the study (n=23) indicated they did not undertake Policy and Guidelines development/ review. No statistically significant difference was found between Australasian and U.K. committees in this regard.

One central feature of policy/ guidelines considered by the study was whether participants believed that their CEC's current bioethical policies/ guidelines were consistent with their hospital's mission. As previously stated, the value of this lies in the fact, as cited by Ross (200, p5), that 'a CEC's work should be closely allied to, and justified by, the mission of the institution it serves'. The importance of this in relation to the assessment of a CEC being successful in its activities being that a CEC should be able to pose fundamental questions in relation to the ethical norms of the services its hospital provides (Campbell, 2001).

The study finding, from chapter 5.3, regarding participants views on the statement concerning their CEC's current bioethical policies/ guidelines being consistent with their hospital's mission, showed, that although there was overall agreement (Mdn=6) with the statement, a significant difference was found between Australasian and UK respondents, with Australasian respondents agreeing more strongly with the statement than their UK counterparts. It was found that, 11% of the participants in the study disagreed that current bioethical policies and guidelines were consistent with their hospital's mission. The first recommendation of the study concerning policies and guidelines is that CECs should ensure that bioethical policies/ guidelines and the hospital's mission are consistent with each other.

The study analysed the views of study participants regarding how well they believed their CEC performed in reviewing/ revising policies and also in identifying areas where bioethical policies are required. The study findings, presented in chapter 5.3, regarding participants' views on the statement, 'Our ethics committee adequately deals with revising/ reviewing hospital bioethical policies/ guidelines', showed that, although there was overall agreement (Mdn=5), a significant difference was found between Australasian and UK respondents, with Australasian respondents agreeing more strongly with the statement than their UK counterparts. It was found that, overall, 11% of the study participants believed that their committee did not adequately deal with the revision/ reviewing of hospital bioethical policies/ guidelines.

Similarly, the results for the statement, 'Our ethics committee adequately deals with identifying areas where bioethical policies or guidelines are required', revealed that, although there was overall agreement (Mdn=5) with the statement, a significant difference was found between Australasian and UK respondents, with Australasian respondents agreeing more strongly with the statement than their UK counterparts. In this instance, 15% of participants believed that their committee did not adequately identify areas where bioethical policies or guidelines were required.

Chapter 5.2 also investigated the time spent by CECs on policy review/ revision and policy development. It was found that 57% of participating CECs indicated that they spent 'some' time on policy review/ revision, and, 50% of participating committees spent 'some' time on policy development. No significant difference between Australasian and U.K. committees was found for either category.

The recommendations of the study concerning policies and guidelines are that, CECs should document protocols which clearly state how hospital bioethical policies and guidelines will be reviewed/ revised, and, how areas where bioethical policies/ guidelines are required will be identified (2.2.b).

One salient feature regarding recommendations 2.2.a. and 2.2.b, stated above, investigated by the study, was consideration of whether CECs had sufficient consultation with affected stakeholder groups when developing or revising bioethical policies/ guidelines. It was found there was a much higher level of disagreement that

CECs were successful in these endeavours compared with the other areas regarding policies/guidelines discussed above. To investigate this area, the study sought the views of participants on two statements,

1. 'There is sufficient consultation with affected stakeholder groups when developing bioethical policies or guidelines'. From the results presented in chapter 5.2, it was found that, although there was overall agreement (Mdn=4.5) with the statement, a significant difference was found between Australasian and UK respondents, with Australasian respondents agreeing more strongly with the statement than their UK counterparts. It was also determined that, 28% of participants did not believe that there was sufficient consultation with affected stakeholder groups when developing bioethical policies or guidelines.

2. 'Revisions to bioethical policies/ guidelines are made in consultation with affected stakeholder groups'. From the results presented in chapter 5.2, it was found that, although there was overall agreement (Mdn=5) with the statement, a significant difference was found between Australasian and UK respondents, with Australasian respondents agreeing more strongly with the statement than their UK counterparts. In this instance, 24% of participants disagreed with the above statement relating to revision of bioethical policies/ guidelines.

Given the level of disagreement with these two statements, coupled with one of the study aims, articulated in chapter 1.3, which was to formulate recommendations which might aid CECs in the evaluation of their performance and ensure that their moral reasoning meets society's expectations, the recommendation of the study is that CECs should develop protocols which allow for the identification of all affected stakeholder groups and provide sufficient and appropriate measures to facilitate a consultative process which engages with diverse perspectives (2.2.c.).

Since, according to Gillon (1997) and Harding (1994), a CEC may be seen as aiding the establishment of values and may also be seen to be instrumental in articulating boundaries of conduct which are perceived to determine the 'moral character' of the institution, two further factors studied which could aid in the assessment of a CEC's ability to conduct itself in its dealing with issues relating to policies and guidelines were

analysed. These factors being, 1. How successful participants believed their CEC to be in effectively communicating information on bioethical policies and guidelines to members of the hospital community, and, 2. Whether their CEC assessed the impact of revised policies/ guidelines. To investigate these factors, the study sought the views of participants on two statements,

1. 'Our committee effectively communicates information on bioethical policies and guidelines to members of the hospital community'. From the results presented in chapter 5.2, it was found that there was no overall agreement (Mdn=4) with the statement. A significant difference was found between Australasian and UK respondents, with Australasian respondents agreeing more strongly with the statement than their UK counterparts. It was found that 31% of participants disagreed that there was effective communication of information on bioethical policies/ guidelines to the hospital community.

2. Similarly, for the statement, 'Our committee assesses the impact of revised policies/ guidelines', there was no overall agreement (Mdn=4) with the statement. A significant difference was found between Australasian and UK respondents, with Australasian respondents agreeing more strongly with the statement than their UK counterparts. It was determined that 47% of participants disagreed that their committee assessed the impact of revised policies and guidelines.

Given that the study findings show that a large number of participants perceive their CECs to be poor at communicating with their hospital community, the recommendation of the study is that committees should establish effective channels of communication with their hospital community in order to disseminate information on bioethical policies and guidelines. The nature of such communication channels to be formally documented in committee protocols (2.2.d.). The importance of effective communication with the hospital community derives its importance, not only in helping to determine the 'moral character' of the hospital as mentioned above, but also in raising the profile of the committee and aiding external acceptance of the committee.

A further recommendation pertaining to this area of the study arises from the finding that a considerable percentage of participants disagreed that their CEC assessed the

impact of revised bioethical policies/ guidelines. The recommendation of the study in this regard is that CECs should establish effective feedback loops for assessing the impact of any new, or revised bioethical policies/ guidelines they want implemented within the hospital community. The nature of any feedback loop to be such that it is readily accessible to all members of the hospital community (2.2.e.). In addition to facilitating the assessment of the impact of any bioethical policies/ guidelines the committee implements, any feedback received would also be an aid to the evaluation process of the committee's success in undertaking its activities. This will be discussed more fully in the recommendations for an evaluative process for CECs.

8.2.2.3. Case Consultation

From the study results presented in chapter 5.4, it was shown that 22 (96%) of the committees participating in the study indicated that they undertook case consultation (including retrospective). In this regard, no statistically significant difference between UK and Australasian committees was found.

Case consultation is regarded as one of the principal activities undertaken by CECs, therefore the perceived success by members of their CEC in conducting acute case consultation and retrospective review of cases may be taken as important indicators in assessing a CECs overall success in conducting its activities in this area. The study investigated individual participant's views on 6 statements relating to case consultation; Our committee is successful in its role of conducting acute case consultation; b. Our committee is successful in its role of conducting retrospective review of cases; c. Our committee has an effective procedure/ protocol in place to guide case review/ consultation; d. Case review/ consultation activities are documented; e. A retrospective evaluation of the case review/ consultation process is conducted periodically; f. Case reviews/ consultations are conducted in accordance with established protocols/ procedures. The study findings for each of these statements are discussed, below.

a. Our committee is successful in its role of conducting acute case consultation. The results presented in chapter 5, show that, although there was overall agreement (Mdn=6) with the statement, there was a significant difference between Australasian and UK participants with Australasian participants showing a greater level of agreement with the

statement. It was found that 20% of participants disagreed that their committee was successful in its role of conducting acute case consultation.

b. Our committee is successful in its role of conducting retrospective review of cases. The results presented in chapter 5, show that there was overall agreement (Mdn=6) with the statement, with no significant difference being found between Australasian and UK participants in the level of agreement with the statement. It was also shown that 12% of participants did not believe that their committee was successful in its role of conducting retrospective case consultation.

c. Our committee has an effective procedure/ protocol in place to guide case review/ consultation. The results presented in chapter 5, show that, although there was overall agreement (Mdn=6) with the statement, a significant difference was found between Australasian and UK participants, with Australasian participants showing a greater level of agreement with the statement than the U.K. participants. It was found that 24% of participants responded that they disagreed that their committee had an effective procedure in place to guide case consultation.

d. Case review/ consultation activities are documented. The results presented in chapter 5, show that there was overall agreement (Mdn=6) with the statement, with no significant difference between Australasian and UK participants in the level of agreement with the statement. It was determined that12% of respondents disagreed that case consultation activities were documented.

e. A retrospective evaluation of the case review/ consultation process is conducted periodically. The results presented in chapter 5, show that there was no overall agreement (Mdn=4) with the statement. No significant difference was found between Australasian and UK participants in the level of agreement with this statement. It was shown that 35% of respondents disagreed that a retrospective evaluation of the case review/ consultation process was conducted periodically.

f. Case reviews/ consultations are conducted in accordance with established protocols/ procedures. The results presented in chapter 5, show that there was overall agreement (Mdn=5) with the statement, with no significant difference between Australasian and

UK participants in the level of agreement with the statement. It was determined that 24% of the study participants disagreed that case reviews/ consultations undertaken by their committee were conducted in accordance with established protocols/ procedures.

Clearly, from the findings of the study, a large number of participants (24%) do not believe their committee has effective procedures/ protocols in place to guide case consultation/ review, or that their CEC's case reviews/ consultations are conducted in accordance with established procedures/ protocols.

The study recommendation derived from these findings is that CECs should establish and document appropriate protocols/ procedures to guide any case consultation/ review undertaken by the committee. These protocols/ procedures should be clearly articulated to committee members (2.3.a.). This would be particularly relevant for new committee members, and could be included in the induction process proposed previously in the section relating to education.

The findings indicate quite categorically that a significant number of CECs do not periodically conduct a retrospective review of their case review/ consultation processes. The recommendation of the study arising from this finding are that CECs should establish protocols/ procedures to conduct such retrospective evaluation of their case review/ consultation processes, and, that such evaluation is undertaken periodically by CECs, for example 6 monthly or annually, depending on the case load of the particular committee (2.3.b.).

Further, it may be appropriate to consider the establishment of uniform national norms for evaluation of case review/ consultation processes in order that committees have some benchmarks for assessing their performance.

One of the fundamental questions to be considered as a result of the study findings is whether it is desirable to have CECs regulated by a National structure, perhaps in similar fashion to Research Ethics Committees (REC) in Australia (guidelines by the National Health and Medical Research Council (NHMRC)). Or would it be more appropriate, due to the more complex nature of ethical issues arising in the clinical setting, for individual institutions to formulate their own guidelines?

8.2.3. Deliberative Process

In consideration of the deliberative process of participating CECs, the areas where recommendations were offered by the study were with regard to a. Moral Principles and Value Conflicts; b. Procedural Characteristics of a Perspectives Approach to Deliberation; and, c. Measures to Avoid Groupthink.

a. Moral Principles and Value Conflicts

The study investigated whether moral principles and value conflicts are explicitly articulated during committee deliberation on an issue. Study participants were asked to indicate their beliefs on two statements; i. Moral principles in the topic of discussion are identified, and, ii. A summary description of the value conflicts or other problems leading to the discussion is presented. The study findings for each of these statements are discussed below.

i. Moral principles in the topic of discussion are identified. It was found that, overall, 87% of all study participants (n=125) indicated that they agreed with the statement. 8% of respondents indicated that they neither agreed nor disagreed with the statement. Thus, 5% of study participants who responded to this statement indicated that they disagreed that moral principles in the topic of discussion are identified. No significant difference was found between Australasian (Mdn = 6) and U.K. participants (Mdn = 6), or between Members (Mdn = 6) and Chairpersons (Mdn = 6), in the level of agreement with the statement. The study findings led to the conclusion that, at meetings of CECs involved in the study, the identification of moral principles involved in the topic of discussion would appear to be an integral component of committee deliberations.

ii. A summary description of the value conflicts or other problems leading to the discussion is presented.

Since, according to Gracia (2003, p.230), deliberation endeavours to explore all the intricacies of moral problems, which entails consideration of all the values and principles associated with the issue, and also the circumstances and likely consequences, a summary description of the value conflicts or other problems leading to the discussion might be desirable. The theoretical importance for this area derives from

the discussion in chapter 2, methodology in Bioethics. It was found that, overall, 71% of all participants (n=128) indicated that they agreed with the statement. 15% of respondents answered that they neither agreed nor disagreed with the statement or indicated that it was not applicable. Therefore, 14% of the study participants disagreed that a summary description of the value conflicts or other problems leading to the discussion is presented. No significant difference between Australasian (Mdn = 6) and U.K. participants (Mdn = 6), or between Members (Mdn = 6) and Chairpersons (Mdn = 6), in the level of agreement with the statement. The median values indicate agreement with the statement.

A summary description of value conflicts, in addition to the identification of moral principles in the topic of discussion would be an aid for a CEC in determining all, or at least most, of the possible courses of action possible. Therefore, the recommendations arising from the study findings in this area are that CECs should include in their protocols for their deliberative process, a summary description of value conflicts in the topic of discussion should be presented (3.a.), and, they should identify moral principles in the topic of discussion (3.b.).

b. Procedural Characteristics of a Perspectives Approach to Deliberation.

In chapter 7.3.2, a number of procedural characteristics of a of a 'perspectives' approach to deliberation were eaxamined. The theoretical importance of such an approach to deliberation were discussed in chapter 2. Study participants were asked to indicate their beliefs on five statements; a. Committee members are encouraged to express their views; b. Committee discussions are marked by a tone of mutuality and respect; c. The chairperson encourages members to identify several options and the consequences of each option; d. The position of each committee member is elicited; e. The reasons for each committee member's position are elicited. The study findings for each of these statements are discussed below.

a. Committee members are encouraged to express their views. It was found that 95% of participants agreed that this was the case. 3% of participants indicated that they neither agreed nor disagreed with the statement, meaning that 2% of all participants responded that they disagreed that committee discussions were presented in a manner that

encourages all members to express their views. A significant difference was found between Australasian (Mdn = 7) and UK participants (Mdn = 6) in the level of agreement with the statement, with Australasian participants agreeing more strongly than their U.K. counterparts. No significant difference was found between Members (Md=6) and Chairpersons (Mdn=6) for this statement.

The above results highlighted that very few respondents disagreed with the statement, with 2% of respondents indicating that this was the case. It may be concluded, for participants of CECs involved in the study, that committee discussions were considered, to be presented in a manner that encourages all members to express their views.

b. Committee discussions are marked by a tone of mutuality and respect. It was found that 98% of participants agreed with the statement. 1% of participants indicated that they neither agreed nor disagreed with the statement, meaning that only 1% of all participants disagreed that their committee discussions are marked by a tone of mutuality and respect. A significant difference between Australasian (Mdn = 7) and UK participants (Mdn = 6) was found in the level of agreement with the statement, with Australasian participants agreeing more strongly that their committee discussions are marked by a tone of mutuality and respect. No significant difference was found between Members (Md=6) and Chairpersons (Mdn=6) for this statement.

Of note from the above results is that a large majority of respondents (98%) agreed with the statement that their committee discussions are marked by a tone of mutuality and respect. There was little disagreement with the statement, with only 1% of UK respondents (Mdn = 6) and none of the Australasian respondents (Mdn = 7) indicating this to be the case. The conclusion being, quite categorically, that the study participants believed that their committee discussions are marked by a tone of mutuality and respect.

In reinforcing the findings of the study for statements a and b, the recommendation of the study is that CEC chairpersons should ensure that they promote an atmosphere at meetings of their committee which is conducive to all members feeling they are able to express their views and that committee discussions are marked by a tone of mutuality and respect (3.c.).

c. The chairperson encourages members to identify several options and the consequences of each option.

The study findings for this statement showed that 70% of participants indicated that they agreed with the statement. 10% of participants indicated that they neither agreed nor disagreed with the statement, meaning that a total of 20% of participants disagreed that their committee chairperson encourages members to identify several options and the consequences of each option. No significant difference between Australasian (Mdn = 6) and UK participants (Mdn = 6), or between Members (Md=6) and Chairpersons (Mdn=5) was found in for the level of agreement with the statement

Given the level of agreement with the statement (Mdn = 6), the recommendation of the study is that CECs include in guidelines or protocols for meetings that the committee chairperson encourages members to identify options and the consequences of each option, in order to facilitate the notion of 'bioethics as conversation' (3.d.).

d. The position of each committee member is elicited. The rationale for the inclusion of this statement is, as described by Gutman and Thompson, 'a well-constituted bioethics forum provides an opportunity for advancing both individual and collective understanding. Through the give-and-take of argument, participants can learn from each other, come to recognize their individual and collective misapprehensions, and develop new views and policies that can more successfully withstand critical scrutiny.' When members of a CEC deliberate it is possible for them to expand their knowledge and their self-understanding. This is in addition to a collective understanding of what will best serve their communities (Gutman & Thompson, 1997, p41). One way in which this can be facilitated is by eliciting the position of each committee member during discussions on an issue.

In order to investigate if this was the case for CECs involved in the study, participants were requested to indicate whether they agreed or disagreed with the statement that, during committee deliberations, the position of each committee member is elicited. Overall, 67% of study participants indicated that they agreed with the statement. 13% of participants indicated that they neither agreed nor disagreed with the statement. Therefore, 20% of participants indicated that they disagreed that the position of each committee member is elicited. No significant difference was found between

Australasian (Mdn = 5) and UK participants (Mdn = 5), or between Members (Md=5.5) and Chairpersons (Mdn=5) was found in for the level of agreement with the statement

The study results indicate, that although there was general agreement with the statement (Mdn = 5), 20% of participants disagreed the statement. Thus, the recommendation of the study is that CECs include in guidelines or protocols for meetings that the position of each member of the committee is elicited in the discussion of issues brought before the committee (3.e.). This would facilitate the building of a collective understanding on an issue, and thus help in the production of a recommendation or policy that can more successfully withstand critical scrutiny.

e. The reasons for each committee member's position are elicited. Study participants were requested to indicate whether they agreed or disagreed with the statement that during committee deliberations, 'the reasons or basis for each member's position are elicited'. The importance of the inclusion of this statement is highlighted by Gracia, who asserts that it will often happen that members of a group or committee deliberating on an issue will differ in their final solution. The positive effect of this is that by addressing the reasons for this difference, it may result in a reshaping of the perception of the problem for everyone (Gracia, 2003, p.229). Once again, this is in accordance with key concepts described by clinical pragmatism and hermeneutic methodologies discussed in chapter 2. The study finding was that 58% of study participants indicated that they agreed with the statement, 18% of participants indicated that they neither agreed nor disagreed with the statement, meaning that 24% of participants did not believe that during their committee deliberations, the reasons or basis for each member's position are elicited. No significant difference was found between Australasian (Mdn = 5) and UK participants (Mdn = 5), or between Members (Md=5) and Chairpersons (Mdn=5) was found in the level of agreement with the statement

Of note from the above results is that although an overall majority of respondents (58%) agreed with the statement, almost one quarter of respondents (24%) did not agree that during committee deliberations, the reasons or basis for each member's position are elicited. In view of the level of disagreement with the statement, the recommendation of the study is that CECs include in guidelines or protocols for meetings that, in addition to the position of each member being elicited in committee deliberations, the

reasons for each member's position should also be elicited (3.f.). As stated previously, the positive effect of this is that by addressing the reasons for this difference, it may result in a reshaping of the perception of the problem for everyone (Gracia, 2003, p.229). Further, this would facilitate a key feature of a 'perspectives' approach to deliberation, highlighted by Gracia (2003,p.227), that 'Deliberation is the process in which everyone concerned by the decision is considered a valid moral agent, obliged to give reasons for their own points of view, and to listen to the reasons of others.'

c. Measures to Avoid Groupthink

As discussed in chapter 7.2.3, the study investigated measures employed by CECs to avoid the dangers of Groupthink in their deliberations. Given the importance of being able to recognise and be aware of the dangers associated with Groupthink, the recommendation of the study is that CECs should implement measures to avoid the dangers associated with Groupthink (3.g.). In order to accomplish this, two measured identified in the literature on Groupthink (chapter 7.2.3.), were investigated.

Study participants were asked for their views on two statements pertaining to measures which might be emloyed to help guard against Groupthink; a. The chairperson appoints member(s) to make the case against the majority; b. committee members have sufficient opportunity to scrutinise any second-hand information they receive on issues to be discussed at meetings. The study findings for each of these two statements are presented below.

a. The chairperson appoints member(s) to make the case against the majority. The study results, presented in chapter 7, showed that 7% of study participants indicated that they agreed with the statement. 4% of participants indicated that they neither agreed nor disagreed with the statement, meaning that 89% of participants indicated that they disagreed with the statement. No significant difference between Australasian (Mdn = 1) and UK participants (Mdn = 2), or between Members (Mdn = 1) and Chairpersons (Mdn = 2), was found in the level of agreement with the statement.

The median values indicate that participants disagree that the committee chairperson appoints member(s) to make the case against the majority at CEC meetings.

b. Committee members have sufficient opportunity to scrutinise any second-hand information they receive on issues to be discussed at meetings. The study findings for this statement, indicated that 69% of study participants indicated that they agreed with the statement. 16% of participants indicated that they neither agreed nor disagreed with the statement, meaning that 15% of participants who responded to this statement, disagreed that 'committee members have sufficient opportunity to scrutinise any second-hand information they receive on issues to be discussed at meetings'. A significant difference was found between Australasian (Mdn = 6) and UK participants (Mdn = 6), in the level of agreement with the statement. The Mean Rank values, indicated a greater level of agreement with the statement by Australasian participants. In contrast, no significant difference was found between Members (Mdn = 6) and Chairpersons (Mdn = 5.5), in the level of agreement with the statement.

It is clear from the results of the study that few respondents agreed that the chairperson appoints member(s) to make the case against the majority. The recommendation of the study is that this strategy, which is not currently being widely utilised, should be implemented by CECs in future to help guard against groupthink. The chairperson should either appoint members on a case-by-case basis to make a case against the majority, or make it a particular role for a committee member(s) (3.g.i.).

In addition, CECs should formally ensure that committee members have sufficient opportunity to scrutinise any second-hand information on issues prior to committee meetings (3.g.ii.). As well as being a course of action to aid in avoiding groupthink, as advocated by Benjamin, a further benefit of ensuring that committee members have sufficient opportunity to scrutinise any second-hand information they receive on issues to be discussed at meetings is, quite simply, according to Gutmann and Thompson (1997, p.40), that there are occasions where conflicts arise that do not involve deep disagreement. In such cases, some of these may turn out to be more easily resolved than they first appeared to be as they have arisen as the result of lack of information.

8.2.4. Committee Evaluation

The study findings revealed that, 11 of the 23 committees participating in the study confirmed that they had a formal evaluation process in place. 5 of the 6 Australasian

committees compared with 6 of the 17 U.K. committees indicated that they had such a process in routine use. From the discussion presented in chapter 6, it can be seen that it should considered to be imperative that an evaluative process is required in order to be able to provide a CEC with opportunities to investigate the quality of its work and, where needed, to improve the function of the committee. Given the study findings on the comparatively low number of CECs which actually have an evaluative process in place, the first recommendation of the study in this area is that CECs should ensure that they have a formal evaluation process in place (4).

As discussed in chapter 6.2, approaches to committee evaluation basically divide into two categories, self-assessment and independent audit. Both approaches would appear to have merit. Self-assessment allows a committee to reflect on its performance of the activities it undertakes and provide it with an opportunity to take measures to, as Campbell (2001) suggests, remedy deficiencies in their own procedures. Independent audit has the advantage of being a more objective measure of a committee's performance, and, in addition to providing a committee with formal organisational assessment of its performance, could, as stated by Emmanuel (200), be the most effective form of accountability for a CEC. Given the study findings showing the low number of committees having a formal evaluation process in place and the variety of evaluation processes of those committees having such a process in place, the recommendation of the study is that in addition to ensuring that CECs have a formal evaluation process in place, that such a formal evaluation process should include mechanisms which permit both external and self-assessment (4).

In terms of formulating recommendations for the evaluative process , the study findings regarding, a. The Means of Gathering Information and b. Measures Utilised to Indicate Committee Success, were considered to be the most relevant.

a. Means of Gathering Information

The means by which participating committees which indicated they had an evaluation process gather information for use in such a process was investigated. In addition, all study participants were asked provide their views on what they believed to be effective means of gathering information in order to evaluate their committee. The study

analysed what methods CECs are currently using to gather information and also what individual participants believed would be effective means of gathering information.

In terms of the means by which CECs are currently utlising to gather information, the findings of the study, presented in chapter 6.2.2, showed that, of the eleven participating committees (6 from the U.K. and 5 from Australasia) that indicated they had a formal evaluation process in routine use, there was little uniformity overall among the committees in the methods of information gathering to allow analysis for evaluation. It should be noted, that these findings derived from responses made in questionnaire 2, by CEC chairpersons (or other nominated individual), were taken to represent what obtains for the CEC.

The study findings for individual participants in regard to means of gathering information were determined from responses to 5 statements presented in questionnire 1. These statements were the same as were presented in questionnaire 2. The statements were; 1. Solicited feedback from individuals; 2. Unsolicited feedback from individuals; 3. Solicited feedback from other organisational bodies; 4. Unsolicited feedback from other organisational bodies; 5. Follow-up of case consultation to see whether advice given has been acted upon. The study findings for individual participants showed agreement that each of these five measures would be effective means of gathering information to evaluate the success of their clinical ethics committee. No significant difference was found between Australasian and U.K. participants, or between Chairpersons and Committee members for any of the five statements.. The study results also indicated that each of the five measures put forward had, overall, a median value of 6, thereby indicating that participants agreed these measures to be effective indicators of gathering information for committee evaluation.

These results suggest that the development of a more structured approach to the means by which information is gathered in order to evaluate a CEC, may be beneficial. To this end, the following recommendations regarding the means by which CECs gather information to be used in their evaluation process are offered.

1. CECs, should ensure that 'follow-up of case consultation to see whether advice given has been acted upon' is undertaken and given a position of considerable weight in the gathering of information to be used in the evaluation process (4.1.a.)..

2. Feedback from prominent individuals within the organisation, for example the CEO or chairperson of the hospital board, should be solicited and utilised in the gathering of information to be used in the formal committee evaluation process. In addition, CECs should actively solicit feedback from other organizational bodies with which it has dealings. The importance of this kind of feedback derives from the fact that it provides the opportunity for a CEC to obtain formal comment and opinion on its performance from other bodies within the organisation with which it has dealings e.g. the hospital board, or, committees or groups who have sought advice from the committee (4.1.b.).

This type of feedback, described in 1 and 2, above, could be seen to give a measure of the success of the CEC from those using the committee's services.. In addition, this type of contact with other bodies within the organisation could help to raise the profile of the committee

4. The formal evaluation process of a CEC should have in place mechanisms which allow unsolicited feedback from other organisational bodies to be taken into consideration in evaluating the committee. It is recognised that the potentially sporadic nature of obtaining this kind of feedback means that it may not provide a sufficiently regular flow of feedback required by an effective methodology for gathering information. However, it should not be discounted, since this type of feedback increases the opportunity for a committee to gather feedback from all stakeholders. The formal evaluation process of a CEC should also have in place mechanisms which allow unsolicited feedback from individuals to be taken into consideration in evaluating the committee, thus allowing the possibility of richer, more comprehensive sources of feedback from all stakeholders (4.1.c.).

b. Measures Utilised to Indicate Committee Success

Measures used by participating committees to indicate the success of the committee were investigated. In addition, all study participants were asked to provide their views

on six statements pertaining to measures that they believed might indicate the success of their committee. Once again, the statements were presented in both questionairres 1 and 2. As noted previously that the findings derived from responses made in questionnaire 2, by CEC chairpersons (or other nominated individual), were taken to represent what obtains for the CEC.

The statements included in this section were; 1. For case consultation, continuing or increasing referrals over time; 2. Input into policy/ guideline making formally acknowledged; 3. Documentation of ethical changes to policy/ guidelines that have been applied to practice; 4. Annual (or regular) report to organisation; 5. Documentation of ethics training programs initiated by the committee, and; 6. Ongoing institutional support for the committee.

For participating CECs, the study finding showed that all 11 participating committees which have a formal evuation process, indicated that annual (or regular) report to their organisation was employed as a measure to indicate the success of their committee. 8 (73%) committees stated that ongoing institutional support for the committee was taken as an outcome measure to indicate the success of the committee. For 6 (55%) of the committees, continuing or increasing referrals over time, particularly for case consultation, was an outcome measure used to indicate committee success. Two outcome measures taken to be an indication of the success of their committees for 5 (45%) of the participating committees were the documentation of ethical changes to policy/ guidelines that have been applied to practice, and, input into policy/ guideline being formally acknowledged. In this category, the outcome measure least taken to be a measure of committee success was the documentation of ethics training programs initiated by the committee. In this instance, 3 of the 11 committees (27%) indicated this to be the case. The study findings indicated general agreement between Australasian and U.K. committees in measures used by participating committees to indicate the success of the committee.

In terms of individual participants, no significant difference was found between participants from Australasia and the U.K., or between Chairpersons and Members for any of the six statements regarding measures considered to be effective indicators of the success of their committees. The study findings also indicated that overall, each of

these statements had a median value of 6, thereby indicating that participants agreed that these measures are effective indicators in the measurement of the success of their committee.

The study results showed there little uniformity in the measures were taken to be an indication of success by committees. For example, all 11 participating committees, which have a formal evaluation process in place, indicated that annual (or regular) report to their organisation was employed as a measure to indicate the success of their committee. On the other hand, only 3 committees (2/6 U.K. and 1/5 Australasia) indicated that documentation of ethics training programs initiated by the committee was used in the process of evaluating the success of their committee.

However, in contrast, the study results for individual participants show agreement that each of the six measures postulated would be effective measures to evaluate the success of a clinical ethics committee. These results indicate that, as was the case with the means by which information is gathered in order to evaluate a CEC, the development of a more structured approach to establishing measures to gauge the success of a committee may be beneficial. To this end, the following recommendations are offered.

1. 'Input into policy/ guideline making formally acknowledged' and 'documentation of ethical changes to policy/ guidelines that have been applied to practice', are measures which should be included by CECs in their formal evaluation process. Once again these measures are capable of delivering tangible evidence regarding a committee's performance (4.2.a.).

2. A measure of referrals to the committee over time should be recognised as a key component of the formal evaluation process. This kind of measure can be made quite readily at predetermined intervals, for example annually, and would serve as an excellent measure of indicating the success of a committee, since it affords the committee an opportunity to collect tangible evidence regarding its performance in this area (4.2.b.).

3. Annual (or regular) report to the organisation, should be considered an important measure of a CEC's success, and as such, the recommendation of the study is that CECs

should ensure that such reporting to the organisation is incorporated into the formal evaluative process for their committee (4.2.c.).

4. CECs should be aware that that ongoing institutional support for the committee is an important factor, and as such, consideration of such ongoing support should be a factor incorporated into the formal evaluative process for their committee (4.2.d.).

5. Documentation of ethics training programs initiated by the committee should be included in the formal evaluative process of CECs. The rationale for this being along similar lines to the measure concerning referrals to the committee since,once again, this can be seen as a tangible measure of committee success (4.2.e.).

It is worth highlighting the study finding that, comparatively few committees use the measures, described in recommendation 1, is to some extent unexpected, since as mentioned previously, the Royal College of Physicians (RCP) Working Party Report (2005), recommended that CECs should undergo regular and methodologically sound evaluation of their work and should be able to provide evidence of the central measures of the success of a CEC. These measures included, a measure of satisfaction of those who use the services of the committee including those who are recipients of the committee's policy work, and, a measure of the CEC's success in facilitating development of ethical practice within the institution (RCP, 2005). Further, in the self -assessment by 'Committee Audit' method of assessing CEC's activities, proposed by a number of studies, for example Slowther and Hope, 2000; Szeremeta et al., 2001; Wenger et al., 2002; and, Hofmann, 2001, the self assessment of a CEC by its members with regard to a number of key areas, should include a process for evaluating effectiveness of its policies and guidelines and the development, revision and impact of ethical policies and guidelines for the organisation.

The recommendations arising from the study findings, as articulated in sections 8.2.1, 8.2.2, 8.2.3 and 8.2.4, on how CECs might be structured and function more effectively are presented as a set of guidelines, below.

8.3. Guidelines for Clinical Ethics Committees (CEC)

1. Committee Structure

1.1. Committee Size

1.1.a. CECs should ensure that they have sufficient membership to be able to provide a broad diversity of representation from the professions/ disciplines and also a broad diversity of bioethical perspectives. CECs should also ensure that they have adequate representation from stakeholders within the general community they represent. Typically, this would require a committee membership of at least 10 members.

1.1.b. CECs should be aware of the need to be of a sufficient size to facilitate the formation of a quorum and division into sub-committees where necessary.

1.2. Selection Process of Committee Members

1.2.a. CECs should adopt the approach whereby professional groups nominate medical, nursing, and allied health representatives. This method of committee member selection should be extended in such a way that lay and specialist positions on the committee be advertised, with the applicants being invited to join the committee following selection by the committee as a whole. This method of selecting committee members has the added benefit of raising awareness of the CEC among professional groups and the community at large.

2. Committee Activities

2.1. Education

2.1.a. CECs should actively organise and conduct regular bioethics educational events for the hospital community.

2.1.b. CECs should provide training for new committee members, the nature of this training to be documented and included in committee protocols.

2.1.c. CECs should ensure that attention is given to the provision of in-service ethics training events, and that the nature and frequency of these events are documented. It is also recommended that included in Committee protocols is that members attend a specified number of these events, as a form of continuing professional development, thereby ensuring that members are fully cognisant of current bioethical perspectives.

2.1.d. Committee protocol should document that new members are enlightened more fully on their role on the committee. This may take the form of an induction process whereby new members are given adequate opportunity to scrutinise committee protocols and procedures, perhaps sitting-in on committee meetings prior to being co-opted on to the committee.

2.2. Policy/ Guidelines

2.2.a. CECs should ensure that bioethical policies / guidelines and the hospital's mission are consistent with each other.

2.2.b. CECs should document protocols which clearly state how hospital bioethical policies and guidelines will be reviewed/ revised, and, how areas where bioethical policies/ guidelines are required will be identified.

2.2.c. CECs should develop protocols which allow for the identification of all affected stakeholder groups and provide sufficient and appropriate measures to facilitate a consultative process which engages with diverse perspectives.

2.2.d. CECs should establish effective channels of communication with their hospital community in order to disseminate information on bioethical policies and guidelines. The nature of such communication channels to be formally documented in committee protocols.

2.2.e. CECs should establish effective feedback loops for assessing the impact of any new, or revised bioethical policies/ guidelines they want implemented within the hospital community. The nature of any feedback loop to be such that it is readily accessible to all members of the hospital community.

2.3. Case Consultation

2.3.a. CECs should establish and document appropriate protocols/ procedures to guide any case consultation/ review undertaken by the committee. The protocols/ procedures established to be clearly articulated to committee members.

2.3.b. CECs should establish protocols/ procedures to conduct retrospective evaluation of their case review/ consultation processes, and, that such evaluation is undertaken periodically by CECs, for example 6 monthly or annually, depending on the case load of the particular committee.

3. Committee Deliberative Process

Protocols for a CECs deliberative process should be established and should include,

3.a. A summary description of value conflicts in the topic of discussion should be presented.

3.b. Moral principles in the topic of discussion should be identified.

3.c. CEC chairpersons should ensure that they promote an atmosphere at meetings of their committee which is conducive to all members feeling they are able to express their views and that committee discussions are marked by a tone of mutuality and respect.

3.d. In order to facilitate the notion of 'bioethics as conversation', the committee chairperson should encourage members to identify options and the consequences of each option.

3.e. The position of each member of the committee should be elicited in the discussion of issues brought before the committee.

3.f. In addition to the position of each member being elicited in committee deliberations, the reasons for each member's position should also be elicited.

3.g. CECs should implement measures to avoid the dangers associated with 'groupthink'. These measures should include,

3.g.i. The strategy should be adopted that the committee chairperson appoints member(s) to make the case against the majority in deliberation on a given issue.

3.g.ii. CECs should formally ensure that committee members have sufficient opportunity to scrutinise any second-hand information on issues prior to committee meetings.

In terms of the outcome of committee deliberations, the building of a consensus on an issue brought before it and seeking to speak with one voice in making and supporting a particular recommendation should be a goal. Should this not prove possible then all members of the committee should be in agreement that the results of any vote-taking may attributed to the committee as a whole.

4. Committee Evaluation

CECs should ensure that they have a formal evaluation process in place. Further, this evaluation process should include mechanisms which permit both external and self-assessment. Key components of an evaluative process are 1. The methodology for gathering information to be used in the process, and, 2. The indicators of committee success to be used in the evaluative process.

4.1. Gathering of Information for Evaluation

In terms of the most effective means of gathering of information to be used in committee evaluation,

4.1.a. CECs, should ensure that 'follow-up of case consultation to see whether advice given has been acted upon' is undertaken and given a position of considerable weight in the gathering of information to be used in the evaluation process.

4.1.b. Feedback from prominent individuals within the organisation and also from other organizational bodies with which it has dealings should be solicited and utilised in the gathering of information to be used in the committee evaluation process.

4.1.c. CECs should have in place mechanisms which allow unsolicited feedback from individuals and also from organisational bodies with which it has dealings to be taken into consideration in gathering information for evaluating the committee. This affords the opportunity for feedback and input from all relevant stakeholders.

4.2. Indicators of Committee Success

Indicators of committee success which should be included in the evaluation process

4.2.a. 'Input into policy/ guideline making being formally acknowledged' and 'documentation of ethical changes to policy/ guidelines that have been applied to practice' are measures which are capable of providing tangible evidence regarding a committee's performance, and as such, should be included as indicators of a CEC's success in the evaluation process.

4.2.b. A measure of referrals to the committee over time should be considered to be a key component of the formal evaluation process.

4.2.c. CECs should ensure that annual (or regular) reporting to the organisation is incorporated into the formal evaluative process for their committee.

4.2.d. CECs should ensure that ongoing institutional support for the committee is a factor considered in the evaluative process for their committee.

4.2.e. 'Documentation of ethics training programs initiated by the committee' should be included in the evaluative process of CECs.

8.4. Thesis Summary

The study was undertaken principally because it was identified that there is no apparent consensus on the method required for Clinical Ethics Committees (CECs) in Australasia to competently deal with ethical issues. Further, it was believed that there was a need for some form of 'quality assurance' that the moral reasoning of CECs meets society's expectations.

The specific objectives of the thesis were to

1. Describe the characteristics of Clinical Ethics Committees. In essence, this was an investigation of the structure of participating committees, undertaken in chapter 4 (Structure).

2. Identify the principal activities that CECs are currently engaged in. This area was investigated in chapter 5 (Function).

3. Understand the processes by which CECs come to believe they are making good decisions/ recommendations. These processes were investigated in chapter 6(Evaluation) and chapter 7 (Deliberative process).

4. Provide recommendations as to how CECs might evaluate their performance and ensure their moral reasoning meets society's expectations. The study findings and recommendations were presented in chapters 4-7, and were brought together in chapter 8, culminating in the presentation of a set of guidelines for CECs.

The study was originally designed to investigate Australasian CECs and invite U.K CECs to participate in order to provide some international comparison and highlight, where appropriate, any significant differences between them. However, the reality was that Australasian CECs were more difficult to identify and recruit since, unlike the U.K which has the United Kingdom Clinical Ethics Network (UKCEN), there is no national body for CECs in Australasia. This, coupled with the fact that there are a substantially greater number of committees in the U.K., meant that the majority of CECs which

agreed to participate in the study were from the U.K. This notwithstanding, it is believed the study findings produced useful findings and recommendations for Australasian CECs, and indeed, CECs in general. In addition, aspects of the deliberative processes investigated by the study may be of value for other healthcare ethics committees and human research ethics committees.

This thesis provided a detailed analysis of the structure, functions, and deliberative processes of participating committees, highlighting where appropriate, similarities and significant differences between Australasian and U.K. committees. In addition, the study also sought individual participants' views on a range of issues relating to the structure, activities and deliberative processes of their committee. It was believed that that this type of approach, not previously undertaken, would, by highlighting areas of discord between what currently obtains for CECs and what committee members consider to be best practice, lead to the provision of recommendations which might serve to guide CECs in the evaluation of their performance and ensure that their moral reasoning meets society's expectations. To this end a set of guidelines for CECs was formulated.

Bibliography

Adams, P. D. (1997). *A qualitative analysis of eight hospital ethics committees in Toronto.* Thesis (PhD). University of Toronto.

AHEC. (2003). HRECs and Non-research Ethics Committees. *HREC Bulletin* (11, December), 4.

Allen, G. (1999). *The Sociology of the Family: A Reader*. Oxford: Blackwell Publishing 1999.

AMA. (2005). *E-9.11 Ethics Committees in Health Care Institutions.* Retrieved 7 April, 2005, from http://www.ama-assn.org/ama/pub/category/print/8544.html

Arras, J. D. (1991). Getting Down to Cases. *Journal of Medicine and Philosophy* 16, no. 1: 29-52.

Arras, J.D. (2002). Pragmatism in Bioethics: Been There, Done That. In *Bioethics*, edited by Ellen Frankel Paul, Fred D Miller and Jeffrey Paul. Cambridge: Cambridge University Press.

Aulisio, M., and Arnold, R.M. (1999). Commentary: A Consensus about "Consensus"? *Journal of Law, Medicine & Ethics* 27, no. 4: 328-31.

Bardon, A. (2004). Ethics Education and Value Prioritization among Members of U.S. Hospital Ethics Committees. *Kennedy Institute of Ethics Journal, 14*(4), 395-406.

Batts, C. F. (1998). Making Ethics an Organizational Priority. *Healthcare Forum Journal, 41*(1), 38-42.

Bauer, K. (2004). Book Review: Community as Healing: Pragmatic Ethics in Medical Encounters, D. Micah Hester. *American Journal of Bioethics* 4, no. 1: 62-63.

Beauchamp, T. L. (2003). A Defense of the Common Morality. *Kennedy Institute of Ethics Journal, 13*(3), 259-274.

Beauchamp, T.L., and Childress, J.F. (2001). *Principles of Biomedical Ethics*. 5th ed. New York: Oxford University Press.

Bell, S. E. (2003). Ethical Climate in Managed Care Organizations. *Nursing Administration Quarterly, 27*(2), 133-140.

Benjamin, M. (1995). The Value of Consensus. In *Society's Choices: Social and Ethical Decision Making in Biomedicine*, edited by Ruth Bulger: National Academy (of Sciences) Press.

Benjamin, M. (2002). *Philosophy and This Actual World: An Introduction to Practical Philosophical Inquiry*. Lanham, MD: Rowan & Littlefield.

Bishop, L. J., Cherry, M. N., & Darragh, M. (1999). Organizational Ethics and Health Care: Expanding Bioethics to the Institutional Arena. *Kennedy Institute of Ethics Journal, 9*(2), 189-208.

Boyd, K.M. (2005). Medical Ethics: Principles, Persons, and Perspectives: From Controversy to Conversation. *Journal of Medical Ethics* 31: 481-86.

Brand-Ballard, J. (2003). Consistency, Common Morality, and Reflective Equilibrium. *Kennedy Institute of Ethics Journal, 13*(3), 231-258.

Braunack-Mayer, A. (2001). Casuistry as Bioethical Method: An Empirical Perspective. *Social Science and Medicine* 53: 71-81.

Buchanan, A. (2002). Social Moral Epistemology. In *Bioethics*, edited by Ellen Frankel Paul, Jr. Miller, Fred D. and Jeffrey Paul. Cambridge: Cambridge University Press.

Burton, S. (2004). Surviving Your Thesis. In *Surviving Your Thesis*, edited by Suzan Burton and Peter Steane. London: Routledge.

Callahan, D. (2000). Universalism and Particularism: Fighting to a Draw. *Hastings Centre Report* 30, no. 1: 37-44.

Campbell, A. V. (2001). Clinical governance-watchword or buzzword? *Journal of Medical Ethics, 27*(1), 154-157.

Caws, P. (1991). Committees and Consensus: How Many Heads Are Better Than One? *Journal of Medicine and Philosophy* 16: 375-91.

Charlesworth, M. (1993). *Bioethics in a Liberal Society*. Melbourne: Cambridge University Press.

Cohen, S. (2004). *The Nature of Moral Reasoning: The Framework and Activities of Ethical Deliberation, Argument and Decision-Making*. Melbourne: Oxford University Press.

Collyer, F., & White, K. (2001). *Corporate Control of Healthcare in Australia: Discussion Paper No. 42, October 2001*: The Australia Institute.

Cooke, E. F. (2003). On the Possibility of a Pragmatic Discourse Bioethics: Putnam, Habermas, and the Normative Logic of Bioethical Inquiry. *Journal of Medicine and Philosophy* 28, no. 5-6: 635-53.

Cotton, M. (2006). Developing a Deliberative Process for Ethically Informed Radioactive Waste Management Decision-Making in the Uk. In *Proceedings of Valdor-2006*, edited by K Anderson, 181-89. Stockholm: Congrex.

Crawley, F. P. (2002). European guidelines for auditing independent ethics committees: European forum for good clinical practice. *Applied Clinical Trials, 11*(6), 96-102.

Csikai, E. L. (1995). *The social work role on hospital ethics committees.* Thesis (PhD). University of Pittsburgh.

Cushman, F. R. (1990). *Truth, justice and the institutional ethics committee in American medicine.* Thesis (PhD). University of Virginia.

Daniels, N. (2000). Accountability for Reasonableness. *BMJ, 321*, 1300-1301.

DeGrazia, D. (2003). Common Morality, Coherence, and the Principles of Biomedical Ethics. *Kennedy Institute of Ethics Journal*, *13*(3), 219-230.

Denier, Y. (2005). On Personal Responsibility and the Right to Healthcare. *Cambridge Quarterly of Healthcare Ethics, 14*, 224-234.

Dewey, J. (1991). *How We Think.* Buffalo, New York: Promestheus Press, 1991

Dobbs, R. A. (2000). *Self-assessment of hospital ethics committees in New Mexico: A study in process improvement.* Thesis (PhD). Walden University.

Donabedein, A (1980). *The Definition of Quality and Approaches to its Assessment.* Chicago: Health Administration Press.

Doyal, L. (2001). Clinical ethics committees and the formulation of health care policy. *Journal of Medical Ethics, 27*(suppl 1), i44-i49.

Durante, C. (2008). Bioethics in a Pluralistic Society: Bioethical Methodology in Lieu of Moral Diversity. Downloaded from http://www.springerlink.com/content/m812504pwx1k7111. (accessed 5 July, 2008).

Dwyer, J. (2004, 23/4/1005). *Federating Health Care Would Mend Our Health System.* Retrieved May 3, 2005, from http://www.onlineopinion.com.au/print.asp.article=2194

Emanuel, L. L. (2000). Ethics and the Structures of Healthcare. *Cambridge Quarterly of Healthcare Ethics, 9*, 151-168.

Engelhardt Jr, H.T. (2002a).Consensus Formation: The Creation of an Ideology. *Cambridge Quarterly of Healthcare Ethics* 11 (2002): 7-16.

Engelhardt Jr, H.T. (2002b). Global Bioethics: An Introduction to the Collapse of Consensus. In *Global Bioethics*, edited by H. Tristan Engelhardt Jr. Salem, MA: M&M Scrivener Press 2006.

Fins, J. J., Bacchetta, M.D., and Miller, F.G. (1997). Clinical Pragmatism: A Method of Moral Problem Solving. *Kennedy Institute of Ethics Journal* 7, no. 2:129-43.

Fins, J. J., Miller, F.G. and Bacchetta, M.D. (1998). Cinical Pragmatism: Bridging Theory and Practice. *Kennedy Institute of Ethics Journal* 8, no. 1: 37-42.

Flynn, P. A. (1991). *Moral ordering and the social construction of bioethics.* Thesis (PhD). University of California, San Francisco.

Gadamer, H-G. (2004). *Truth and Method.* 2nd revised ed. London: Continuum Press.

Gallacher, J. A., & Goodstein, J. (2002). Fulfilling Institutional Responsibilities in Healthcare: Organizational Ethics and the Role of Mission Discernment. *Business Ethics Quarterly, 12*(4), 433-450.

Giganti, E. (2004). Organizational Ethics is "Systems Thinking". *Health Progress, 85*(3), 10-11.

Gill, A. W., Saul, P., McPhee, J., & Kerridge, I. H. (2004). Acute clinical ethics consultation: the practicalities. *MJA, 181*(4), 204-206.

Gillon, R. (1997). Clinical ethics committees-pros and cons. *Journal of Medical Ethics, 23*(4), 203-205.

Grace, D., and Cohen, S. (1998). *Business Ethics: Australian Problems and Cases*. 2nd ed. Melbourne: Oxford University Press.

Gracia, D. (2003). Ethical Case Deliberation and Decision Making. *Medicine, Health Care and Philosophy* 6: 227-33.

Gracia, D. (2001). Moral Deliberation: The Role of Methodologies in Clinical Ethics. *Medicine, Health Care and Philosophy* 4, no. 2: 223-32.

Gross, M. L. (1999). Ethics Education and physician morality. *Social Science & Medicine, 49*, 329-342.

Gross, M. L. (2004). Speaking in One Voice or Many? The Language of Community. *Cambridge Quarterly of Healthcare Ethics, 13*, 28-33.

Guo, L., & Schick, I. C. (2003). The Impact of Committee Characteristics on the Success of Healthcare Ethics Committees. *HEC Forum, 15*(3), 287-299.

Gutman, A., and Thompson, D. (1997). Deliberating about Bioethics. *Hastings Center Report 27, no.3: 38-41*.

Harding, J. (1994). The role of organizational ethics committees. *Physician Executive*. Retrieved March 15, 2005, from http://www.findarticles.com/p/articles/mi_m0843/is_n2_v20/ai_14954156

Hare, R. M. (1997). *Sorting Out Ethics*. Oxford: Clarendon Press.

Hester, D. M. (2002). Narrative as Bioethics: The Fact of Social Selves and the Function of Consensus. *Cambridge Quarterly of Healthcare Ethics* 11: 17-26.

Hester, D. M. (2003). Is Pragmatism Well-Suited to Bioethics? *Journal of Medicine and Philosophy* 28, no. 5-6: 545-61.

Hinman, L. M. (2003). *Ethics: A Pluralistic Approach to Moral Theory* (3rd ed.). Belmont CA: Wadsworth Thomson.

Hofmann, P. B. (2001). Improving ethics committee effectiveness. *Healthcare Executive, 16*(1), 58-60.

Hoffmann, D., E. (1993). Evaluating Ethics Committees: A View from the Outside. *The Milbank Quarterly, 71, No. 4., 677-701*

Hollerman, C. E. (1991). Membership of Instituional Ethics Committees. *Physician Executive, 17*(3), 34-37.

Hurst, S., Hull, S., DuVal, G., and Davis, M. (2005). How physicians face clinical diificulties: a qualitative analysis. *Journal of medical Ethics,31(1), 7- 14.*

Janis, I. L (1972). *Victims of Groupthink*. Boston: Houghton Mifflin.

Jansen, L. A. (1998). Assessing Clinical Pragmatism. *Kennedy Institute of Ethics Journal* 8, no. 1: 23-36.

Jones, A. H. (1999). Narrative in Medical Ethics, part 4. *BMJ, 318*, 253-256.

Jonsen, A.R. (1991). Casuistry as Methodology in Clinical Ethics. *Theoretical Medicine* 12: 295-307.

Jonsen, A.R., and Toulmin, S. (1998). *The Abuse of Casuistry*. Berkeley: University of California Press.

Jurchak, M. K. (1996). A Study to Examine the Process of Ethics Case Consultation in End-of-Life Decisions. PhD, Boston College, 1996.

Kaiser, M. (2001). Practical ethics in search of a toolbox: Ethics of science and technology at the crossroads, *2005*. Retrieved March 18, 2005, from http://www.ccels.cardiff.ac.uk/pubs/kaiserpaper.pdf

Kumar, R. (1996). *Research Methodology: A Step-by-Step Guide for Beginners*. South Melbourne, Australia: Longman.

Kekes, J. (1992). Pluralism and Conflict in Morality. *Journal of Value Inquiry* 26: 37-50.

Kekes, J. (1993). *The Morality of Pluralism*. Princeton: Princeton University Press.

Kelly, S. E. (2003). Public Bioethics and Publics: Consensus, Boundaries, and Participation in Biomedical Science Policy. *Science, Technology, & Human Values* 28, no. 3: 339-64.

Kopelman, L.M. (2006). Bioethics as a Second-Order Discipline: Who Is Not a Bioethicist? *Journal of Medicine and Philosophy* 31: 601-28.

Kuczewski, M. (2002). Two Models of Consensus, or What Good Is a Bunch of Bioethicists? *Cambridge Quarterly of Healthcare Ethics* 11: 27-36.

Kvale, S. and Brinkmann, S. (2008). *Interviews: Learning the Craft of Qualitative Research Interviewing*. 2nd ed. London: Sage.

Leavitt, F. (2000). Hospital ethics committees may discourage staff from making own decisions - Letter to the Editor. *BMJ, 321*(1414), 649-650.

Leder, D. (1994). Toward a Hermeneutical Bioethics. In *A Matter of Principles*, edited by E.R. DuBose, R Hamel and L.J. O'Connell. Valley Forge, Pennsylvania: Trinity Press International

Loff, B., & Black, J. (2004). Research ethics committees: what is their contribution? *Medical Journal of Australia, 181*(8), 440 -442.

Mackie, J. L. (1977). *Ethics: Inventing Right And Wrong*. London: Penguin Group.

MacIntyre, A. (1984). *After Virtue*. 2nd ed. Notre Dame, Indiana: University of Notre Dame Press.

Martin, P. A. (1999). Bioethics and the Whole: Pluralism, Consensus, and the Transmutation of Bioethical Methods into Gold. *The Journal of Law, Medicine & Ethics 27,4:316-327.*

McGee, G., Spanogle, J. P., Caplan, A. L., Penny, D., & Asch, D. A. (2002). Successes and Failures of Hospital Ethics Committees: A National Survey of Ethics Committee Chairs. *Cambridge Quarterly of Healthcare Ethics, 11*, 87-93.

McMillan, J. (2002). Ethics and Clinical Ethics Committee Education. *HEC Forum, 14*(1), 45-52.

Mc Neill, P. M. (2001). A Critical Analysis Of Australian Clinical Ethics Committees And The Functions They Serve. *Bioethics, 15*(5/6), 443-460.

Mc Neill, P. M., Berglund, C. A., & Webster, I. W. (1990). Reviewing the reviewers: a survey of institutional ethics committees in Australia. *Med J Aust, 152*, 289-296.

Mc Neill, P. M., Walters, J., & Webster, I. W. (1994a). Ethical Issues in Australian Hospitals. *Med J Aust, 160*, 63-65.

Mc Neill, P. M., Walters, J., & Webster, I. W. (1994b). Ethics Decision Making in Australian Hospitals. *Med J Aust, 161*, 487-488.

Melnick, A., Kaplowitz, L., Lopez, W., Murphy, A.M. and Bernheim, R.G. (Moderator). (2005). Public Health Ethics in Action: Flu Vaccine and Drug Allocation Strategies *Journal of Law, Medicine & Ethics* 33, no. (4 Suppl.): 102-05.

Mitchell, K. R., Kerridge, I. H., & Lovat, T. J. (1996). *Bioethics and Clinical Ethics for Health Care Professionals* (2nd ed.). Wentworth Falls, NSW: Social Science Press.

Moore, T. (2005). How Do Clinical Ethics Committees Measure Outcomes, Success or Value in Hospitals in the Uk? In, http://www.ethics-network.org.uk/reading/evaluate.htm. (accessed 7 November, 2005).

Moreno, J.D. (1995). *Deciding Together: Bioethics and Moral Consensus*. New York: Oxford University Press.

NHMRC. (1993). *Ethical considerations relating to health care resource allocation decisions.* Canberra: NHMRC.

NSW Health (2006). *Clinical Ethics Processes in NSW Health.* Retrieved 10 June, 2006, from http://www.health.nsw.gov.au/policies/pd/2006/PD2006_027.html

O'Donnell, P. (2005). The future of ethics: a European perspective: a recent conference featured debate on the role of research ethics committees. *Applied Clinical Trials, 14*(4), 32-35.

Ozar, D., Berg, J., Werhane Patricia, H., & Emanuel, L. L. (2000). *Organizational Ethics in Healthcare: Toward a Model for Ethical Decison Making by Provider Organizations* (No. 17). Chicago: Institute for Ethics: National Working Group.

Pallant, J. (2005). *Spss Survival Manual: A Step by Step Guide to Data Analysis Using Spss* Crows Nest, NSW: Unwin & Unwin.

Paris, J. J., & Post, S. G. (2000). Manged Care, Cost Control, and the Common Good. *Cambridge Quarterly of Healthcare Ethics, 9,* 182-188.

Park-Ridge-Centre. (2003). *What Is Organizational Ethics?* Retrieved 27 April, 2005, from http://www.parkridgecenter.org/ethics_aprilo3.html

Peirce, A. G. (2004). Some Considerations about Decisions and Decision-Makers in Hospital Ethics Committees., *Online Journal of Health Ethics*. Retrieved 16 June, 2005, from http://ethicsjournal.umc.edu/ojs/printarticle.php?id=15&layout=html

Pinnock, R., & Crosthwaite, J. (2004). The Auckland Hospital Ethics Committee: The first 7 years. *New Zealand Medical Journal, 117* (1205).

Polit, D.F., and Hungler, B.P. (1991). *Nursing Research: Principles and Methods*. Philadelphia: Lippincott.

Posner, R.A. (1992). Legal reasoning from the top down and from the bottom up: The question of unenumerated constitutional rights. *University of Chicago Law Review, 59, 433-450.*

Preston, N. (2007). *Understanding Ethics*. 3rd ed. NSW: The Federation Press.

Raven, C. (2002). *The Intersection of Health Care and Organizational Ethics*. Retrieved 14 March, 2005, from http://www.ethics.org/resources/article_detail.cfm?ID=767

Rawls, John. (1971). *A Theory of Justice*. Revised ed. Cambridge, Massachusetts: The Belknap Press of Harvard University Press.

Rawls, J. (1981). The Idea of an Overlapping Consensus. *Oxford Journal of Legal Studies* 7, no. 1.

RCP. (2005). *Ethics in Practice: Background for recommendations for enhanced support.* (Report of a Working Party). London: Royal College of Physicians.

Rorty, M. V. (2000). Ethics And Economics In Healthcare: The Role Of Organizational Ethics. *HEC Forum, 12*(1), 57-68.

Rorty, M. V., Werhane, P. H., & Mills, A. E. (2004). The 'Rashomon' Effect: Organization Ethics in Health Care. *HEC Forum, 16*(2), 75-94.

Ross, J. W. (2000). Changing The HEC Mission. *HEC Forum, 12*(1), 4-7.

Rudd, P. T. (2002). The Clinical Ethics Committee at the Royal United Hospital - Bath, England. *HEC Forum, 14*(1), 37-44.

Schick, I.C., and Guo, L. (2001). Ethics Committees Identify Success Factors: A National Survey. *HEC Forum* 13, no. 4 : 344-60.

Schick C. I, and Moore F. S. (1998). Ethics committees identify four key factors for success. *HEC Forum, 10 (1): 175–85*.
Self, D. J., & Skeel, J. D. (1998). The Moral Reasoning of HEC Members. *HEC Forum, 10*(1), 43-54.

Schildmann, J., Molewijk, B., Benaroyo, L., et al. (2013). Evaluation of Clinical Ethics Support Services and its Normativity. *J Med Ethics 39: 681-68.*

Silverman, D., and Marvasti, A. (2008). *Doing Qualitative Research: A Comprehensive Guide*. London: Sage.

Slowther, A. (2002). Editor's Introduction: The Development of Healthcare (Clinical) Ethics Committees in the U.K. *HEC Forum, 14*(1), 1-3.

Slowther, A., Bunch, C., Woolnough, B., & Hope, T. (2001b). Clinical ethics support services in the UK: an investigation of the current provision of ethics support to health professionals in the UK. *Journal of Medical Ethics, 27* (2), i2-i8.

Slowther, A., Hill, D., & McMillan, J. (2002). Clinical Ethics Committees: Opportunity or Threat? *HEC Forum, 14*(1), 4-12.

Slowther, A., & Hope, T. (2000). Clinical ethics committees: They can change clinical practice but need evaluation. *BMJ, 321*(16 September), 649-650.

Slowther, A., & Hope, T. (2002). Resource Allocation Decisions in U.K. Healthcare: Do Ethics Committees Have a Role? *HEC Forum, 14*(1), 64-72.

Slowther, A., Hope, T., & Ashcroft, R. (2001a). Clinical ethics committees: A worldwide development. *Journal of Medical Ethics, 27*(1), i1.

Slowther, A., Johnston, C., Goodall, J., & Hope, T. (2004). Development of clinical ethics committees. *BMJ, 328*(17 April), 950-952.

Smith, R., Hiatt, H., Berwick, D., & Tavistock, G. (1999). Shared ethical principles for everybody in health care: a working draft from the Tavistock Group. *BMJ, 318*(7178), 248-251.

Somerville, M. A. (2004). The ethics of clinical ethics services. *MJA, 181*(4), 180-181.

Spike, J.P. (2006). Bioethics Now. *Philosophy Now*, no. 6: 7-8.

Steinkamp, N, and Gordijn, B. (2003). Ethical Case Deliberation on the Ward. A Comparison of Four Methods. *Medicine, Health Care and Philosophy* 6: 235-46.

Stufflebeam, D.L., Shinkfield, A.J. (2007). *Evaluation Theory, Models & Applications.* San Francisco, CA: Jossey-Bass.

Surowiecki, J. (2004). *The Wisdom of Crowds*. London: Abacus.

Szeremeta, M., Dawson, J., Manning, D., Watson, A., Wright, M., Northcutt, W., and Lancaster, R. (2001). Snapshots of five clinical ethics committees in the UK. *Journal of Medical Ethics, 27*(suppl I), i9-i17.

Tollefsen, C. (2000). What Would John Dewey Do? The Promises and Perils of Pragmatic Bioethics. *Journal of Medicine and Philosophy* 25, no. 1: 77-106.

Tong, R. (1997). The Promise and Perils of Pragmatism: Commentary on Fins, Bacchetta, and Miller. *Kennedy Institute of Ethics Journal* 7, no. 2: 147-52.
Toulmin, S. (1981). The Tyranny of Principles. *Hastings Centre Report* 11: 31-39.

Trotter, G. (2002a). Bioethics and Healthcare Reform: A Whig Response to Weak Consensus. *Cambridge Quarterly of Healthcare Ethics* 11: 37-51.

Trotter, G. (2002b). Moral Consensus in Bioethics: Illusive or Just Elusive? *Cambridge Quarterly of Healthcare Ethics* 11: 1-3.

Turner, L. (2003). Bioethics in a Multicultural World: Medicine and Morality in Pluralistic Settings. *Health Care Analysis* 11, no. 2: 99-117.

UKCEN. (2008). Contact Details: Cec Contact Details. In, http://www.ethics-network.org.uk. (accessed 8 January, 2008.

van der Kloot Meijburg, H. H., & ter Meulen, R. H. J. (2001). Developing standards for institutional ethics committees: Lessons from the Netherlands. *Journal of Medical Ethics, 27*(1), 136-141.

Van Der Weyden, M. B. (2003). Australian Healthcare Reform: in Need of Political Courage and Champions. *Med J Aust, 179*(6), 280-281.

Veatch, R. M. (2003). Is there a Common Morality? *Kennedy Institute of Ethics Journal, 13*(3), 189-194.

Wenger, N. S. (2000). The HEC Model Of The Future Builds On Deficiencies Of The Past. *HEC Forum, 12*(1), 33-38.

Wenger, N. S., Golan, O., Shalev, C., & Glick, S. (2002). Hospital ethics committees in Israel: structure, function and heterogeneity in the setting of statutory ethics committees. (Clinical Ethics). *Journal of Medical Ethics, 28*(3), 177-188.

Wenger, N. S., & Lieberman, J. R. (1998). An Assessmant of Orthopaedic Sugeons' Knowledge of Medical Ethics. *Journal of Bone and Joint Surgery, 80*(2), 198-206.
Wildes, K. W. (1997). Institutional Identity, Integrity, and Conscience. *Kennedy Institute of Ethics Journal, 7*(4), 413-419.

Werhane, P. H., & Rorty, M. V. (2000). Organization Ethics in Healthcare. *Cambridge Quarterly of Healthcare Ethics, 9*, 145-146.

Wildes, K.W. (2002). Bioethics as Social Philosophy. In *Bioethics*, edited by Ellen Frankel Paul, Jr. Miller, Fred D. and Jeffrey Paul. Cambridge: Cambridge University Press.

Williams, B. (1985). *Ethics and the Limits of Philosophy*. Cambridge, Massachusetts: Harvard University Press.

Zoloth, L. (2002). Keeping Company: Ethics and the Talk in the Commons. *Cambridge Quarterly of Healthcare Ethics* 11: 52-60.

Appendix 1

Invitation to committee chairperson

THE UNIVERSITY OF
NEW SOUTH WALES

SCHOOL OF PHILOSOPHY

Dear Sir/ Madam

Structure, Function and Deliberative Processes of Australian Clinical Ethics Committees

You are invited to participate in a study of the 'Structure, Function and Deliberative Processes of Australian Clinical Ethics Committees'. In addition to Australian Clinical Ethics Committees, Clinical Ethics Committees identified in the United Kingdom and New Zealand will be invited to participate in the study, in order to provide some international comparison. You were selected as a potential participant in this study because your institution has been identified as having an operational Clinical Ethics Committee.

The specific purposes of the study are to:

1. Describe the characteristics of Australian Clinical Ethics Committees.
2. Identify the current issues that Clinical Ethics Committees are dealing with.
3. Understand the processes by which Clinical Ethics Committees arrive at decisions/ recommendations.

If you agree to participate in this study, I would ask you to do the following things:

1. As chairperson (or other nominated contact) of the committee, complete a self-administered questionnaire on the structure and activities of your committee (*approx. 5-10 minutes).*

2. Complete a self-administered questionnaire relating to your perception of the effectiveness of your committee, and the processes by which your committee arrives at decisions/ recommendations
   (*approx. 15-20 minutes).*

3. Distribute copies of this second questionnaire to all other members of your committee, who will be asked to complete and return the questionnaire directly to the investigator.

In addition, an invitation to participate in a telephone interview (*approx. 30 minutes*) will be extended to all participants. The purpose of the interview will be to gather further data concerning the deliberative process of their committee. Participation in this interview is entirely voluntary.

Any information that is obtained in connection with this study and that can be identified with participants will remain confidential and will be disclosed only with the participant's permission, except as required by law. To ensure privacy, questionnaires will be identified by institution only, by means of a code, and completed questionnaires will be returned directly to the investigator.

The project has been granted approval to proceed by the 'Arts, Humanities & Law Human Research Advisory Panel' of the University of New South Wales (approval no. 05 2 162). Complaints may be directed to the Ethics Secretariat, The University of New South Wales, SYDNEY 2052 AUSTRALIA (phone +61 (2) 9385 4234, fax +61 (2) 9385 6648, email ethics.sec@unsw.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

It is planned that the results will be used to form the basis of a PhD thesis on 'Structure, Function and Deliberative Processes of Australian Clinical Ethics Committees'. In any publication, information will be provided in such a way that study participants cannot be identified. Research records will be stored securely at the School of Philosophy, University of New South Wales. Only the investigator and supervisor will have access to the original records.

Your decision whether or not to participate will not prejudice your future relations with The University of New South Wales. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice.

I would be most happy to answer any questions you might have. Please write or e-mail. My contact details are: Gordon Kennedy, School of Philosophy, UNSW, SYDNEY, NSW 2052, AUSTRALIA Email: g.kennedy@student.unsw.edu.au

Alternatively, if you have any further questions you may contact my supervisor:

Associate Professor Stephen Cohen, Director of Graduate Programs in Professional Ethics, School of Philosophy, UNSW, SYDNEY, NSW 2052, AUSTRALIA
Email s.cohen@unsw.edu.au ; Direct Tel: +61 (2) 9385 2320.

Thank you for your time and your assistance.

Sincerely,

Gordon Kennedy

- -

(Please complete this section, tear off and return in the enclosed envelope)

Structure, Function and Deliberative Processes of Australian Clinical Ethics Committees

You are making a decision whether or not to participate. Your signature indicates that you have decided to take part in the study. A formal statement of consent will be forwarded to you for completion along with other study materials.

Institution Code:

Printed Name of Participant ____

Signature of Participant ________________________________ Date ___________________

Position of Participant __________________________________

Number of members on the committee ______ (for questionnaire number purposes)

Alternatively, if you decide not to participate in the study, please leave this section blank and return (in the enclosed return envelope) to: Gordon Kennedy, School of Philosophy, UNSW, SYDNEY, NSW 2052, AUSTRALIA (to confirm receipt of this letter).

Appendix 2

Introduction from supervisor

THE UNIVERSITY OF
NEW SOUTH WALES

SCHOOL OF PHILOSOPHY

Dear

Re: Gordon Kennedy

I would like to introduce Gordon Kennedy to you, and ask that you participate in his research.

Gordon is writing his PhD thesis in Professional Ethics on the topic, " Structure, Function and Deliberative Processes of Australian Clinical Ethics Committees". Integral to this important research is that he contact a number of ethics committees, and, where permissible, their individual members, to ask about their processes of reaching decisions.

Gordon has received ethics clearance from the University of New South Wales to conduct the research, and will follow prescribed protocols to maintain anonymity of those participating in the research. In his approach to you, he will provide documentation and terms of this clearance for his project; and he will be explicit about the purpose of his research and your proposed role in it. The project itself is not designed to be confrontational. Rather, it is a project about how things are done and whether any generalisations can be made; and it includes some international comparison.

It would be of great benefit to him and to the research if you would participate. I, as his supervisor and as the director of the University's Graduate Programs in Professional Ethics, would be grateful if you would agree to do this.

If you have any questions about the project or about Gordon's engagement in it, please feel welcome to contact me.

Thank you.

Sincerely,

Stephen Cohen

Appendix 3

Letter to participating committees

THE UNIVERSITY OF
NEW SOUTH WALES

SCHOOL OF PHILOSOPHY

Dear Sir/ Madam,

Structure, Function and Deliberative Processes of Australasian Clinical Ethics Committees

Thank you for agreeing to participate in the study.

Please complete and return questionnaires 1 and 2.

I would be grateful if you could distribute the enclosed copies of questionnaire 1 to the other members of your committee. I have also enclosed reply paid envelopes so that committee members may return completed questionnaires directly to me.

If possible, I would appreciate if completed questionnaires could be returned to me by 31 December 2006.

Once again, many thanks for your time and assistance.

Yours Sincerely

Gordon Kennedy

School of Philosophy
UNSW
SYDNEY NSW 2052
AUSTRALIA

Appendix 4

Invitation to committee members

THE UNIVERSITY OF
NEW SOUTH WALES

SCHOOL OF PHILOSOPHY

Date

Dear Committee Member,

Structure, Function and Deliberative Processes of Australasian Clinical Ethics Committees

You are invited to participate in a study of the 'Structure, Function and Deliberative Processes of Australasian Clinical Ethics Committees'. In addition to Australasian Clinical Ethics Committees, Clinical Ethics Committees identified in the United Kingdom have been invited to participate in the study, in order to provide some international comparison. You were selected as a potential participant in this study because your institution has been identified as having an operational Clinical Ethics Committee.

The specific purposes of the study are to:
1. Describe the characteristics of Clinical Ethics Committees.
2. Identify the current issues that Clinical Ethics Committees are dealing with.
3. Understand the processes by which Clinical Ethics Committees arrive at decisions/ recommendations.

If you agree to participate in this study, I would ask you to complete the enclosed self-administered questionnaire relating to your perception of the effectiveness of your committee, and the processes by which your committee arrives at decisions/ recommendations (*approx. 20 -30 minutes).*

In addition, you are invited to participate in a telephone interview (*approx. 20 minutes*). The purpose of the interview is to gather further data concerning the deliberative process of your committee. Participation in this interview is entirely voluntary. You may return your completed questionnaire, leaving the interview invitation blank.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission, except as required by law. To ensure privacy, questionnaires will be identified by institution only, by means of a code, and completed questionnaires will be returned directly to the investigator.

The project has been granted approval to proceed by the 'Arts, Humanities & Law Human Research Advisory Panel' of the University of New South Wales (approval no. 05 2 162). Complaints may be directed to the Ethics Secretariat, The University of New South Wales, SYDNEY 2052 AUSTRALIA (phone +61 (2) 9385 4234, fax +61 (2) 9385 6648, email: ethics.sec@unsw.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

It is planned that the results will be used to form the basis of a PhD thesis on 'Structure, Function and Deliberative Processes of Australasian Clinical Ethics Committees'. In any publication, information will be provided in such a way that study participants cannot be identified. Research records will be stored securely at the School of Philosophy, University of New South Wales. Only the investigator and supervisor will have access to the original records.

I would be most happy to answer any questions you might have. Please write or e-mail. My contact details are:
Gordon Kennedy, School of Philosophy, UNSW, SYDNEY, NSW 2052, AUSTRALIA
Email: g.kennedy@student.unsw.edu.au

Alternatively, if you have any further questions you may contact my supervisor:

Associate Professor Stephen Cohen, Director of Graduate Programs in Professional Ethics, School of Philosophy, UNSW, SYDNEY, NSW 2052, AUSTRALIA
Email s.cohen@unsw.edu.au ; Direct Tel: +61 (2) 9385 2320.

Thank you for your time and your assistance.

Sincerely,

Thank you for your time and your assistance.

Sincerely,

Gordon Kennedy

Appendix 5

Reminder to committee chairperson

THE UNIVERSITY OF
NEW SOUTH WALES

SCHOOL OF PHILOSOPHY

Date

Dear

In August I sent you an invitation to participate in a study of the *'Structure, Function and Deliberative Processes in Australian Clinical Ethics Committees'*. To date I have not received your response.

Since there are relatively few Clinical Ethics Committees currently in existence in Australia, it is extremely important that input from your committee be included in the study for results to accurately represent the practice of Clinical Ethics Committees in Australia.

In the event that you did not receive the invitation, or it has been misplaced, please e-mail me (g.kennedy@student.unsw.edu.au) and I will send you another one.

Yours sincerely,

Gordon Kennedy
School of Philosophy
UNSW
SYDNEY NSW 2052
AUSTRALIA

Appendix 6

Follow-up letter

THE UNIVERSITY OF NEW SOUTH WALES

SCHOOL OF PHILOSOPHY

Date

Dear

Structure, Function and Deliberative Processes of Australasian Clinical Ethics Committees

Thank you very much for your contribution to my study.

I would be grateful if you would pass on my thanks to those members of your committee who have participated in the study.

I note that, to date, I have not received a completed Questionnaire 2 from your committee. I have therefore enclosed another copy in case the original was mislaid or lost in the post.

Since there are relatively few functional Clinical Ethics Committees in existence, it is extremely important that as many responses as possible be included in the study to ensure that the results accurately reflect the procedures followed by such committees.

I would appreciate if you could complete and return this questionnaire to me by the end of March 2008, if possible.

With kind regards

Yours sincerely

Gordon Kennedy
School of Philosophy
UNSW
SYDNEY NSW 2052
AUSTRALIA

Appendix 7

Final letter

THE UNIVERSITY OF
NEW SOUTH WALES

SCHOOL OF PHILOSOPHY

Date

Dear

The Structure, Function and Deliberative Processes of Australasian Clinical Ethics Committees

Thank you very much for participating in my study and providing valuable information regarding your committee's activities. Your input is greatly appreciated.

I would be grateful if you could pass on my sincere thanks to those members of your committee who have contributed.

Members of your committee prepared to participate in the study but who have not already done so may still return questionnaires to me. I would be happy to forward further copies of questionnaires as required.

A number of committee Chairpersons have expressed a wish that their committee's participation in the study be formally acknowledged in any publication of results, while others wish to remain anonymous. Perhaps you could let me know your committee's preference.

Once again, many thanks.

Kind regards

Gordon Kennedy

School of Philosophy
UNSW
SYDNEY NSW 2052
AUSTRALIA

Appendix 8

Questionnaire 1

A STUDY OF THE STRUCTURE, FUNCTION AND DELIBERATIVE PROCESSES OF AUSTRALIAN CLINICAL ETHICS COMMITTEES

Questionnaire 1

General Instructions

The purpose of this questionnaire is to gather information for a study of the 'Structure, Function and Deliberative Processes of Australian Clinical Ethics Committees'. The study, in order to provide some international comparison, includes Clinical Ethics Committees in the United Kingdom and New Zealand

The main objectives of the study are to

4. Describe the characteristics of Australian clinical ethics committees.
5. Identify the current issues that clinical ethics committees are dealing with.
6. Understand the processes by which clinical ethics committees arrive at decisions/ recommendations.

The questionnaire is divided into 4 sections

Section A. Principal Activities of the Committee
The aim of this section is to gather information regarding your view on the success of your committee with regard to its various activities.

B. Success Factors
This section seeks your view on the relative importance of factors which contribute to a successful clinical ethics committee.

C. Deliberative Process
In order to gain insight into committee deliberative processes, this section seeks your view on a number of issues relating to your committee's deliberative process.

D. Respondent Characteristics
In order that some general comparisons can be made, this section seeks some information on your educational background and experience on ethics committees.

Completed questionnaires should be returned (using the reply paid envelope) to

Gordon Kennedy
School of Philosophy
UNSW
SYDNEY, NSW 2052
AUSTRALIA

***If you wish to be informed of the results of the study, please contact me at either the above address or e-mail* g.kennedy@student.unsw.edu.au**

Please use the page at the back of the questionnaire for comments

Section A – Committee Activities

Please indicate your view on each of the following statements concerning your committee's activities (circle one number for each statement).

1= strongly disagree
7= strongly agree
n/a = not applicable

1. Education

Table removed due to Copyright restrictions.

Section A – Committee Activities (continued)

Please indicate your view on each of the following statements concerning your committee's activities (circle one number for each statement).

2. Policy/ Guidelines

1= strongly disagree **7= strongly agree** **n/a = not applicable**

Table removed due to Copyright restrictions.

Section A – Committee Activities (continued)

Please indicate your view on each of the following statements concerning your committee's activities (circle one number for each statement).

1= strongly disagree
7= strongly agree
n/a = not applicable

3. Case Review/ Consultation

Table removed due to Copyright restrictions.

Section A – Committee Activities (continued)

Please indicate your view on each of the following statements concerning your committee's activities (circle one number for each statement).

1= strongly disagree
7= strongly agree
n/a = not applicable

4. Evaluation of Committee Activities

Overall, I believe our ethics committee is successful in its activities. ……	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
I am satisfied with the combination of educational, policy/ guideline involvement, and the case review/ consultation activities pursued by our committee. ……...	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
Our committee periodically evaluates its overall performance. ……..	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
Our committee's performance is measured against established standards/ criteria. ……..	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
Our committee does not receive adequate feedback on whether advice given has been taken or ignored…	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
Our committee lacks credibility within the hospital community. ……	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**

The following would be obstacles to the successful development and effectiveness of your committee

Lack of resources (financial and human)…….	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
Lack of training available for committee members…	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
Lack of appropriate expertise on the committee..……	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
Reluctance of clinicians (particularly doctors) to recognise and use the committee. …….	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
Difficulties in raising the profile of the committee within the hospital community. ……	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
Other (please specify)……								
……								
……	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**

Section A – Committee Activities (continued)

Please indicate your view on each of the following statements concerning your committee's activities (circle one number for each statement).

1= strongly disagree
7= strongly agree
n/a = not applicable

4. Evaluation of Committee Activities (continued)

The following would be effective means of gathering information to evaluate the success of your committee.

Table removed due to Copyright restrictions.

The following outcome measures would be effective indicators of the success of your committee.

Table removed due to Copyright restrictions.

Section B – Success Factors

Please assess the relative importance of the factors listed in the sections below in contributing to the success of your committee. (circle one number for each statement).

1. Leadership

1= unimportant
5= essential

Table removed due to Copyright restrictions.

2. Participation, Communication, Skills

Table removed due to Copyright restrictions.

3. Administrative Support

Table removed due to Copyright restrictions.

Section B – Success Factors

Please assess the relative importance of the factors listed in the sections below in contributing to the success of your committee. (circle one number for each statement).

4. Structure, Function, Process

1= unimportant **5= essential**

Table removed due to Copyright restrictions.

Please assess the relative importance of each of the above four sections in their overall importance to the success of your committee (circle one number for each section)

Table removed due to Copyright restrictions.

Section C – Deliberative Process

Please indicate your view on each of the following statements relating to the deliberative process of your committee (circle one number for each statement).

1= strongly disagree
7= strongly agree
n/a = not applicable

Our committee has sufficient member representation from the professional disciplines. ……..	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
Our committee's membership represents diverse bioethical perspectives. ……..	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
Our committee meetings provide a useful forum for discussing bioethical issues. ……...	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
A summary description of the value conflicts or other problems leading to the discussion is presented. ……	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
Discussions are presented in a manner that encourages all members to express their views. ……	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**
Discussions are marked by a tone of mutuality and respect. ……..	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**n/a**

Text removed due to Copyright restrictions.

Section C – Deliberative Process (continued)

Please indicate your view on each of the following statements relating to the deliberative process of your committee (circle one number for each statement).

1= strongly disagree
7= strongly agree
n/a = not applicable

Table removed due to Copyright restrictions.

Section C – Deliberative Process (continued)

Please indicate your view on each of the following statements relating to the deliberative process of your committee (circle one number for each statement).

1= strongly disagree
7= strongly agree
n/a = not applicable

Table removed due to Copyright restrictions.

Section D – Participant Characteristics

In order that some general comparisons may be made, please answer the following questions about yourself. The data collected is confidential and will not be presented in any form that could enable individual participants to be identified.

Please circle the appropriate answer for each of the following:

Profession/ Discipline

Provider/ Medical Staff	Nursing	Non-medical Administrator
Lay/ Community Representative	Social Services	Clergy/ Pastoral Care
Board Member	Ethicist	

Other (please specify)…….

Additional Degrees

Masters	PhD	Law

Other (please specify)…….

Ethics Education

Have you completed any formal ethics education? **YES NO**

*If **YES,** was it* Degree course Credit course

Have you attended informal ethics training provided in any of the following formats (please circle all that apply)

Local conference/ Seminar	National conference/ seminar
Hospital in-service	Correspondence course
Self study e.g. personal reading	Other (please specify)…….

Committee Membership

Have you <u>ever</u> participated (on any ethics committee) in the following activities?

Ethics policy/ guideline review	**YES**	**NO**
Ethics policy/ guideline development	**YES**	**NO**
Ethics case review (retrospective)	**YES**	**NO**
Ethics case consultation	**YES**	**NO**
Ethics committee self-evaluation	**YES**	**NO**

Section D – Participant Characteristics (continued)

In order that some general comparisons may be made, please answer the following questions about yourself. The data collected is confidential and will not be presented in any form that could enable individual participants to be identified.

Committee Membership (continued). ***Please circle as appropriate***

How long have you been a member of <u>this</u> ethics committee?

0-12 months 13-24 months 25-36 months 37-48 months 49+months

Please indicate the number of <u>this</u> ethics committee's meetings you have attended in the last 12 months

0 1 2 3 4 5 6 7 8+

Please indicate your age group

20-29 30-39 40-49 50-59 60-69 70-79 80+

Please indicate your gender

Female Male

Please indicate your religion

Protestant	Roman Catholic	Jewish	Muslim
Buddhist	Hindu	Agnostic	Atheist

Other (please specify)……………………………………………….

- -

If you are willing to participate in a telephone interview (approx. 30 min), designed to gather further information regarding your committee's deliberative process, please include your contact details below.

Name…………………………………………………….. **Phone** …………………………...

Address………………………………………………………………………………………

…………………………………………………………………………………………………..

E-mail…………………………………………………………………………………......

To preserve anonymity, this section will be detached from the questionnaire and stored separately. <u>If you do not wish to participate in the interview please leave this section blank</u>

THANK YOU VERY MUCH

Appendix 9

Questionnaire 2

A STUDY OF THE STRUCTURE, FUNCTION AND DELIBERATIVE PROCESSES OF AUSTRALIAN CLINICAL ETHICS COMMITTEES

Questionnaire 2

General Instructions

The purpose of this questionnaire is to gather information for a study of the 'Structure, Function and Deliberative Processes of Australian Clinical Ethics Committees'. The study, in order to provide some international comparison, includes Clinical Ethics Committees in the United Kingdom and New Zealand

The main objectives of the study are to

7. Describe the characteristics of Australian clinical ethics committees.
8. Identify the current issues that clinical ethics committees are dealing with.
9. Understand the processes by which clinical ethics committees arrive at decisions/ recommendations.

The questionnaire is divided into 3 sections

Section A. Committee Structure

This section seeks information relating to the structure of your committee.

Section B. Committee Activities

This section seeks information relating to the activities in which your committee participates, with particular reference to case consultation, education, and, policy and guidelines.

Section C. Committee Evaluation

This section seeks to establish whether your committee has a formal evaluation process in routine use, and, where this is the case, the nature of the process

Completed questionnaires should be returned (using the reply paid envelope) to

Gordon Kennedy
School of Philosophy
UNSW
SYDNEY, NSW 2052
AUSTRALIA

***If you wish to be informed of the results of the study, please contact me at either the above address or e-mail* g.kennedy@student.unsw.edu.au**

Please use the page at the back of the questionnaire for comments

SECTION A – COMMITTEE STRUCTURE

Please answer the following questions relating to the structure of your committee (circle the appropriate response).

How long has the committee been in operation?

0-12months 13-24months 25-36months 37-48months 49+months

How many members does the committee have?

0-3 4-6 7-9 10-12 13-15 16-18 19+

Please circle the number of committee members in each category

Provider/ Medical staff (Medical graduate)	0 1 2 3 4 5 6 7 8 9 10+
Nursing	0 1 2 3 4 5 6 7 8 9 10+
Law	0 1 2 3 4 5 6 7 8 9 10+
Ethics	0 1 2 3 4 5 6 7 8 9 10+
Non-medical administrator	0 1 2 3 4 5 6 7 8 9 10+
Lay/ Community representative	0 1 2 3 4 5 6 7 8 9 10+
Social services	0 1 2 3 4 5 6 7 8 9 10+
Clergy/ Pastoral care	0 1 2 3 4 5 6 7 8 9 10+
Board member	0 1 2 3 4 5 6 7 8 9 10+
Other (please specify)…….	0 1 2 3 4 5 6 7 8 9 10+

Who selects members of the committee?

Committee Chairperson Hospital Board Hospital CEO

Other (please specify)……

How many committee meetings are scheduled for 2006?

0 1 2 3 4 5 6 7 8+

What is the occupation of the committee chairperson? .....

How long has the current chairperson been in the chair?

0-6months 7-12months 13-18months 19-24months 25-30months

31-36months 37-42months 43-48months 49-54months 55+months

SECTION A – COMMITTEE STRUCTURE (continued)

Please answer the following questions relating to the structure of your committee (circle the appropriate response).

Does the committee receive administrative support from the hospital?

YES **NO**

Does the committee receive funding from the hospital for-

Education/ training?	**YES**	**NO**
An Ethicist/ Ethics consultant?	**YES**	**NO**
Administration?	**YES**	**NO**

Other? (please specify)……..

SECTION B – COMMITTEE ACTIVITIES

Please answer the following questions relating to the activities of your committee (circle the appropriate response).

Please indicate the activities in which your committee participates

1. Case Consultation (including retrospective)	**YES**	**NO**
2. Ethics Education		
Committee member education	**YES**	**NO**
Hospital staff education	**YES**	**NO**
Community education	**YES**	**NO**
3. Policy and Guidelines development/ review	**YES**	**NO**

4. Other (please specify)……

1. Case Consultation

Please indicate the methods of case consultation in which your committee engages

Acute Retrospective None

How many case consultations has your committee dealt with in the last 12 months?

a) Acute	0	1-3	4-6	7-9	10-12	13+
b) Retrospective	0	1-3	4-6	7-9	10-12	13+

SECTION B – COMMITTEE ACTIVITIES (continued)

Please answer the following questions relating to the activities of your committee (circle the appropriate response).

1. Case Consultation (continued)

Who can request consultation? (circle all that apply)

Attending Physician	Resident Physician	Family member
Nursing staff	Social Worker	Patient/ Surrogate
Any Committee Member	Hospital staff	Outside Agency

Other (please specify)……

Please indicate which of the following issues have been raised in consultations (circle all that apply)

New technologies	Patient autonomy/ competency	Resource allocation
End of life issues	Refusal of intervention	Truth telling
Confidentiality	Problematic proxy	Conflicts of interest
Requests for futile treatment	Uncertainty about the best goal (of treatment)	

Other (please specify)……

Please indicate the outcomes of case consultation (circle all that apply)

Recommendations to physicians and staff	Consultation with risk management
Communication with patient/ family	Publication of case studies
Binding decisions	Arbitration with third parties

Other (please specify)…….

2. Education

Has your committee provided any bioethics education for committee members in the last 12 months?

YES (please give details)……..

NO

SECTION B – COMMITTEE ACTIVITIES (continued)

Please answer the following questions relating to the activities of your committee (circle the appropriate response).

2. Education (continued)

Has your committee provided any bioethics education for the hospital community in the last 12 months?

YES (please give details)……..

NO

Has your committee provided any bioethics education for the general community in the last 12 months?

YES (please give details)……

NO

3. Policy and Guidelines

Please indicate which of the following issues your committee has discussed regarding hospital policy/ guidelines (circle all that apply)

Brain death	DNR orders	Commercial use of tissue
Withdrawal of care	Consent policy	Elective ventilation
Advance directives	Confidentiality issues	Rights of relatives
Consent for DNA testing		Possession of illicit drugs

Other (please specify)…….

SECTION C – COMMITTEE EVALUATION

Please answer the following questions relating to committee evaluation

1. Does your committee have a formal evaluation process in routine use?

YES (go to question 2)

NO (go to question 5)

SECTION C – COMMITTEE EVALUATION (continued)

Please answer the following questions relating to committee evaluation

2. How is information gathered to allow analysis for evaluation? (tick all that apply)

Solicited feedback from individuals e.g. questionnaires, personal contact ___

Unsolicited feedback from individuals ___

Solicited feedback from other organisational bodies e.g. Hospital board, committees or groups who have sought advice from your committee ___

Unsolicited feedback from other organisational bodies ___

Follow up of case consultation to see whether advice given has been acted upon ___

Other (please specify)……

3. What outcome measures are used to indicate the 'success' of the committee (tick all that apply)

For case consultation, continuing or increasing referrals over time ___

Input into policy/ guideline making formally acknowledged ___

Documentation of ethical changes to policy/ guidelines that have been applied to practice ___

Annual (or regular) report to organisation ___

Documentation of ethics training programs initiated by the committee ___

Ongoing institutional support for the committee ___

Other (please specify)……

4. Who is responsible for evaluating the committee?

Committee self-assesses ___

Hospital Board ___

Hospital CEO ___

Other (please specify)……

SECTION C – COMMITTEE EVALUATION (continued)

Please answer the following questions relating to committee evaluation

5. Does your committee have any formal contact with other clinical ethics committees? (circle appropriate response)

YES (please give details)……

…….....

.....

.....

NO

6. In the past 12 months, please estimate the proportion of time that your committee spent performing each of the following activities.

ETHICS EDUCATION					
Committee member education	none	little	some	most	all
Hospital community education	none	little	some	most	all
General community education	none	little	some	most	all
CASE CONSULTATION					
Acute	none	little	some	most	all
Retrospective	none	little	some	most	all
POLICY/ GUIDELINES					
Review/ revision	none	little	some	most	all
Development	none	little	some	most	all
OTHER ACTIVITES (please specify)					
.....	none	little	some	most	all
……..	none	little	some	most	all

THANK YOU VERY MUCH