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Education of ethics committee members: experiences from Croatia

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ABSTRACT

Objectives: To study knowledge and attitudes of hospital ethics committee members at the first workshop for ethics committees in Croatia.

Design: Before/after cross-sectional study using a self administered questionnaire.

Setting: Educational workshop for members of hospital ethics committees, Zagreb, 2003.

Main outcome measurements: Knowledge and attitudes of participants before and after the workshop; everyday functioning of hospital ethics committees.

Results: The majority of the respondents came from committees with at least five members. The majority of ethics committees were appointed by the governing bodies of their hospitals. Most committees were founded after the implementation of the law on health protection in 1997. Membership structure (three physicians and two members from other fields) and functions were established on the basis of that law. Analysis of research protocols was the main part of their work. Other important functions—education, case analysis, guidelines formation—were neglected. Members' level of knowledge was not sufficient for the complicated tasks they were supposed to perform. However, it was significantly higher after the workshop. Most respondents felt their knowledge should be improved by additional education. Their views on certain issues and bioethical dilemmas displayed a high level of paternalism and over protectiveness, which did not change after the workshop.

Conclusions: The committees developed according to bureaucratic requirements. Furthermore, there are concerns about members' knowledge levels. More efforts need to be made to use education to improve the quality of the work. Additional research is necessary to explore ethics committees' work in Croatia especially in the hospital setting.

INTRODUCTION

Ethics education is important for the work of ethics committees. Many argue that the main function of ethics committees is to provide ongoing education on ethical issues at every level of health care—for ethics committees themselves and for the general medical community (1). Thus education of members of ethics committees as the first step in fulfilling the educational function of an ethics committee becomes an important issue.

Ethics committees in Croatia are a relatively new phenomenon. (2). Their existence is required by the law on health protection. (3). undertook a survey of the work of ethics committees in Croatia. This looked at number of members; structure of membership; issues that were discussed during the meetings; number of meetings so far, standing orders; working guidelines, and documents related to the work of the committees. The response rate was between 75% and 100%, depending on the type of healthcare institution.

According to the results of this survey 46% of the healthcare institutions in Croatia (excluding pharmacies and homecare institutions) have ethics committee. Eighty nine per cent of ethics committees have five members, three of whom are from medical professions and two of whom come from other fields. Physicians, theologians, hospital lawyers, and nurses were likely candidates for membership of an ethics committee, while philosophers, hospital staff who worked outside of the hospital, and patients' representatives were not. Forty nine per cent of those committees said their main function was the analysis of research protocols. Ethical case analysis was often practised as well. Education was confirmed as an ethics committee's function in only a few cases; the same was true for policy making (2). As a result of those findings, the National Bioethics Committee for Medicine held the first workshop for members of hospital ethics committees in Croatia in 2003. The aim of the workshop was to educate members of the ethics committees and prepare them for their everyday work. Topics covered were: types and functions of ethics committees in the world and Croatia; introduction to the analysis of a research protocol; introduction to case consultations; introduction to biomedical ethics as a discipline, and information about relevant literature. Participants in the workshop were invited to take part in a survey in order to test their knowledge and attitudes before and after the workshop, and to explore in depth their everyday working practices.

METHODS

Participants

Members of hospital ethics committees as well as members of ethics committees at medical and dental schools and research institutes were invited to participate in this workshop. The invitations were sent by post and asked each of the ethics committees to send at least two members. A total of 107 participants attended the workshop, 25 of whom were not members of an ethics committee in a hospital institution. Of 73 hospital institutions (clinical centres, local and regional hospitals, special hospitals, clinics and polyclinics) whose members were invited to the workshop, 52 sent members. The number of members that came from each hospital varied from one to five. Sixty six participants filled in the questionnaire at the beginning of the workshop. Out of these 66, 31 completed the questionnaire at the end of the workshop as well.

The participants from medical schools and research institutes did not participate in the survey.

Instrument

The instrument used for this survey was a questionnaire consisting of four parts. The first part concentrated on obtaining demographic data about the age, sex, and occupation of the respondents; information about the number of members on an ethics committee; possible educational practices in the work of a committee; the frequency of meetings; the issues they dealt with in everyday practice, and the respondents' views on their position in a committee as well as on the work of the committee.

The second part was dedicated to a self assessment of the knowledge of each respondent in the field of biomedical ethics. For this part we adapted the model of self evaluation questionnaire presented by Judith Wilson Ross in her book, *Health Care Ethics Committees—the Next Generation* (1). This second part of the questionnaire consisted of 42 questions. The respondents had to assess their knowledge by using a Likert type scale with grades from one to five: (1 = yes I am familiar with this topic and would feel comfortable teaching others about it; 2 = yes, I am familiar with this topic, but do not think I could answer questions about it; 3 =

yes I am familiar with this topic in a general way, but not any of the specific issues; 4 = no, I do not know much about the topic, and 5 = I have never even heard of this topic).

The third part consisted of 23 questions that tested the participants' knowledge of the field of biomedical ethics.

The fourth and final part of the instrument consisted of 19 statements on different bioethical issues that the respondents could grade by using a Likert type of scale from one to five (1 = I completely disagree, 5 = I completely agree). For this part we adapted the "bioethics consensus statements", also taken from the book by Judith Wilson Ross, *Health Care Ethics Committees—the Next Generation* (1).

Statistical analysis

The results were statistically analysed using the statistical program SPSS version 11.5. Descriptive statistics, non-parametric tests (Mann-Whitney, Wilcoxon Signed Ranks Test), and Spearman's ρ were used for data analysis.

RESULTS

Hospital ethics committees: structure and function

The mean age of the respondents was 48.65 (95% CI = 46.25–51.04). There were 27 male and 39 female respondents. Fifty one of the respondents were physicians; three were pharmacists; three were psychologists; four were nurses with a higher education degree; two were lawyers; one was a sociologist, and three did not state their profession. Structure, everyday work, and functions of hospital ethics committees can be seen from table 1. Respondents were also asked a few questions regarding their views on their work as a member of an ethics committee. The majority of the respondents (64) felt their views were respected in the everyday work of the committee. Fifty seven respondents felt the views of the members of their committees reflected the views of Croatian society. Forty nine respondents felt that so far the work of their ethics committee had been efficient.

Table 1 – Data on the structure, functions and everyday work of ethics committees according to the respondents answers

Year started	1991-2003	
Median number of months of committee existence	24 (interquartile range 45)	
Structure		
Number of members	1- 9 members 5 members on average	
Members' occupation	All committees had physician (median 3, interquartile range 1)	
	theologian	49
	lawyer not employed by the hospital	26
	nurse	20
	hospital lawyer	8
	social worker	5
	member of hospital executive board	5
	local official	1
	hospital administration official	1
	No patient representatives, philosophers or ethicists as members.	
Functions		
Analysis and approval of research protocols *	56	
	*(Median time spent on the analysis of a research protocol was 2 hours (interquartile range 2))	
Education of the members of the ethics committees and hospital staff	12	
Policies and guidelines formation	11	
Ethical case analysis	37	
Review of complaints made by patients and physicians	35	
Everyday work		
Most frequent issues dealt with in everyday practice		
	clinical research	48
	informed consent	28
	communication problems between patients and physicians	28
	communication problems among hospital staff	26
	confidentiality of medical data	26
	principles of ethical decision making	25
	patients' rights	24
	assessing the competency of patients	21
Median number of annual meetings	4 (interquartile range 6)	
Total number of annual meetings	7.5 (interquartile range 16)	
Decision making process	consensus formation	37
	public voting	22
	secret voting	1

Average grade of influence on decision making process of hospital 3.27 (95% CI = 3.00- 3.55)

Average grade of work that committee performed so far 3.44 (95% CI = 3.20-3.70)

Ethics committee members' knowledge

Fifty four respondents felt competent to be a member of an ethics committee; only 13 had attended special educational courses and conferences related to bioethical issues. However, 61 respondents felt they needed additional education in the field of bioethics. We tested how the respondents themselves assessed their knowledge of different bioethical issues (table 2).

Table 2 - Level of self-assessment of respondents' knowledge about different bioethical issues (tested on 66 respondents before the workshop; 1= yes, I am familiar with this topic and would feel comfortable teaching others about it; 2= yes, I am familiar with this topic , but do not think I could answer questions about it, 3= yes, I am familiar with this topic in a general way, but not with any of the specific issues; 4= no, I do not know much about the topic; 5= I have never heard of this topic).

FIELD	C ± Q
procreation and genetics	3.00 ± 0.88
transplantation	3.00 ± 1.00
research	2.00 ± 1.00
ethics committees	3.00 ± 1.00
resource allocation	3.00 ± 1.00
patients' rights	2.50 ± 1.13
end-of-life issues	3.10 ± 1.00
legal provisions	2.72 ± 1.07

How respondents self assessed the level of their knowledge of different bioethical issues before and after the workshop was also tested (table 3). We found significant difference ($p = 0.011$ Wilcoxon Signed Ranks Test; $C \pm Q$ before = 2.6 ± 0.87 ; $C \pm Q$ after = 2.68 ± 0.7) between the self evaluation of knowledge results before and after the workshop. No significant correlation was found between self evaluation of knowledge results and sex

Table 3 - Level of self-assessment of respondents' knowledge before and after the workshops about different bioethical issues (n =31) (1= yes, I am familiar with this topic and would feel comfortable teaching others about it; 2= yes, I am familiar with this topic , but do not think I could answer questions about it, 3= yes, I am familiar with this topic in a general way, but not with any of the specific issues; 4= no, I do not know much about the topic; 5= I have never heard of this topic).

FIELD	BEFORE C ± Q	p*	AFTER C ± Q
procreation and genetics	3.13 ± 0.69	0.517	3.00 ± 0.56
transplantation	3.00 ± 1.00	0.564	3.00 ± 1.33
research	3.00 ± 1.00	0.040	2.00 ± 1.00
ethics committees	3.00 ± 1.00	0.021	2.33 ± 1.00
resource allocation	3.00 ± 1.00	0.019	3.00 ± 0.50
patients' rights	2.75 ± 0.63	0.132	2.63 ± 0.94
end-of-life issues	3.30 ± 1.05	0.004	2.90 ± 0.65
legal provisions	2.72 ± 1.14	0.001	2.43 ± 0.86

*Wilcoxon Signed Ranks Test

The level of knowledge of the respondents was also tested. The highest number of correct answers, 68% and higher, was obtained on the questions that dealt with functions, work, and types of ethics committees and patients' rights issues. The level of correct answers to questions related to research issues was a bit confusing. On the one hand almost all of the respondents knew about the Declaration of Helsinki, however, less than one per cent of respondents gave the right answers to the question related to informed consent. The level of knowledge regarding other ethical issues, especially legal provisions regulating those issues in Croatia and the world, was not that high (less than 68% on average) and incomplete.

We found significant difference ($p = 0.001$ Wilcoxon Signed Ranks Test) between the level of knowledge before and after the workshop ($C \pm Q$ before = 0.47 ± 0.17 ; $C \pm Q$ after = 0.61 ± 0.09). The level of the respondents' knowledge before and after the workshops was tested on 31 respondents. No significant correlation was found between level of knowledge and sex or age of the respondents.

Attitudes of ethics committee members toward bioethical issues

Respondents' agreement or disagreement with certain statements regarding bioethical issues is shown in table 4.

Table 4– Level of agreement with statements regarding bioethical issues (tested on 66 respondents before the workshop) (1 = I completely disagree, 5 = I completely agree)

STATEMENT	C ± Q
The goals of medical care are to cure disease, restore function, eliminate suffering and prevent illness.	5.00 ± 0.00
In spite of highly developed technological achievements, today's modern medicine cannot always be successful because it cannot always help to cure disease, restore function, eliminate suffering and prevent illness.	5.00 ± 1.00
The competent and informed patient has the right to refuse any form of treatment, regardless of whether he or she is terminally ill.	5.00 ± 1.00
A diagnosis of mental illness does not by itself justify a judgment that the patient lacks decision-making capacity.	2.00 ± 2.50
The physician has a duty to recommend the course of treatment that in his or her judgment reflects the patient's best interest.	5.00 ± 0.00
The physician should not respect the patient's refusal of a certain medical treatment if this, according to the judgment of the physician, could lead to serious consequences for the patient's health.	3.00 ± 2.00
If a patient lacks decision-making capacity, a family member or significant other may act as the patient's surrogate.	5.00 ± 1.00
If the patient's wishes about a medical treatment are known they should be respected.	5.00 ± 1.00
If the patient's wishes about a medical treatment are not known an attempt should be made to determine what the patient would probably have wanted.	4.00 ± 2.00
Any quality of life consideration is to be assessed from the patient's perspective (for example, the patient's perceived experience of burden and benefit).	4.00 ± 1.00
Parents have the right and duty to make treatment decisions for their children and may be presumed to be acting in their child's best interests.	4.00 ± 1.00
Similar medical cases should be treated similarly.	4.00 ± 0.50
There is a psychological and moral difference between withholding and withdrawing treatment under the same circumstances.	4.00 ± 1.00
It is more reasonable to withhold treatment on the grounds that it might not achieve the patient's desired goals than to try a treatment and then stop if the treatment does not achieve the patient's desired goals.	4.00 ± 2.00
Treatment recommendations should clearly articulate the goals of the treatment so that patients/ surrogates can be clear as to whether the treatment meets their desired goals.	5.00 ± 1.00
Advanced directives are not helpful in encouraging dialogue among patient, family and physician about the patient's values and preferences with respect to the treatment until such time as they are no longer able to make decisions.	3.00 ± 2.00
The rationing of healthcare (decisions about limiting availability of medical care to individual patients) should be explicitly addressed at the policy level, whether at the institutional, professional or governmental level.	4.00 ± 1.00
Rationing decisions in the healthcare system should be made by individual physicians for	2.00 ± 2.00

individual patients	
Patients may want to use economic factors in making their own decisions but surrogates' use of economic factors in making decisions for others is controversial.	4.00 ±2.00

Wilcoxon Signed Ranks Test

We found no significant difference ($p = 0.37$ Wilcoxon Signed Ranks Test $C \pm Q$ before = 3.86 ± 0.25 ; $C \pm Q$ after = 3.89 ± 0.32) between the level of agreement or disagreement with statements regarding bioethical issues before and after the workshop and no significant correlation was found either with sex or age of the respondents.

DISCUSSION

The current survey provides more detailed insights into the everyday work of ethics committees and their position within the hospital structures. According to the literature, members of ethics committees have identified four key factors for success: (a) support from the administration; (b) committee composition; (c) committee leadership, and (d) committee structure, function, and process. The level of administrative support should be good but a good working relationship implies that the administration will not attempt to control the committee and that committee is autonomous in its work. Multidisciplinary and diverse membership is also important for the success of an ethics committee in a hospital institution, together with strong leadership, which guarantees equality and creates a good atmosphere for the committee's work. Clarity of purpose, regular meetings, an emphasis on the committee's functions, especially the educational one, with a clear recognition of the importance of self evaluation orientation, is the fourth factor identified as important for ethics committees' success (4).

Administrative support for ethics committees and their members was not lacking in our case, according to the data obtained. The respondents were quite satisfied with the committee's influence on the hospital's decision making practices and with the overall work of their committees. The committees were founded after the implementation on the law on health protection in 1997. Membership structure (three physicians and two members from other fields) and functions were based on those legal provisions. The same pattern regarding the formation of ethics committees was also observed in a 2002/2003 survey carried out by the National Bioethics Committee (2). However, this raises the concern that the implementation of

ethics committees in the hospital system in Croatia is not a "grass root" process, as it has been in the USA (1), but has, instead, been prompted by the bureaucratic behaviour of the hospital administration, as can be observed in other European countries in transition (5). Further evidence for this is suggested by the fact that the majority of the members of ethics committees were appointed by the management of their hospitals, and some committees have hospital administration employees as members. The reasons for this require further investigation.

Multidisciplinarity of the membership of the committees was present to some extent. However, as in the survey carried out by the National Bioethics Committee in 2002/2003, physicians, theologians, hospital lawyers, and nurses were likely candidates for membership for an ethics committee, while philosophers, hospital staff who worked outside of the hospital, and patients' representatives were not. The reason for this can probably be found in the perceived social value of different professions in the Croatian society. However, one might wonder whether every theologian and lawyer, and in some cases, as we have found out in our survey, even every hospital lawyer, is a suitable candidate for the membership of a hospital ethics committee (6, 7). In our opinion it is highly unlikely that just because someone is a member of a certain profession they are therefore going to be suitable candidates for membership of a hospital ethics committee. We feel that expertise and competency in the field of bioethics should be the prime criterion for membership of an ethics committee, taking also into consideration the criterion of multidisciplinarity of its membership (8).

The notion of equality and the significance of a good atmosphere in the committee's work were perceived by respondents. Committee members were satisfied with their position as members of the committee and they felt their views were well respected. The positive perception of the committees' work is related to the age of the respondents and the length of time spent on the committee, as well as to the profession of the members (theologians, nurses, and physicians rated the success of their committees very highly) (9). Since the average age of our respondents was 48.65 years and the majority of them were either nurses, physicians, or theologians the high satisfaction rate was not unexpected. Also the role of ethics committees is often not well perceived in a hospital environment (10, 11). However, the respondents were quite satisfied with the committee's influence on the hospital's decision making practices.

Research protocol analysis was a dominant function of the committees. Ethical case analysis was often practised as well. Education was confirmed as an ethics committee's function only in 12 cases, and policy making in only 11. This feature of prioritisation of the research protocol analysis in the work of ethics committees can be observed in the committees of mixed type (those combining functions of an IRB and HEC) such as Belgian ethics committees (12). Croatian ethics committees are of the mixed type. In countries such as the UK and Australia, where ethics committees do not combine the functions of IRBs and HECs, policy formation seems to be the dominant function of hospital ethics committees (13, 14).

A high proportion of ethics committee members were confident about the level of their knowledge and their level of competency. This is probably the reason why they did not attend a lot of educational workshops or lectures that could help them in their work. However, the results of knowledge self assessment and the results of actual knowledge level in our study show a different picture. The average level of self assessed knowledge before the workshop was three, meaning: "yes, I am familiar with this topic in a general way, but not with any of the specific issues". This level significantly improved after the workshop. The level of knowledge before the workshop was less than satisfactory, especially in regard to issues such as informed consent, research ethics, transplantation, and legal provisions in Croatia and other countries. This level significantly improved after the workshop as well. However, the majority of respondents felt that they needed additional education for their work as members of an ethics committee. Self education and self assessment constitute the corner stone of the work of a successful ethics committee (8,15). Educational efforts are important and can improve the knowledge level of ethics committee members (16). There is, however, a need for further investigation into the influence of education on the moral reasoning, moral competency, and moral development of medical professionals and ethics committee members (17,18).

The attitudes of members of ethics committees in our survey did not change much after the educational workshop. The respondents were, so to say, paternalistic in their approach to the patient. They would overrule a patient's refusal of a treatment if they regarded the treatment as beneficial for the patient. Moreover, patients who were mentally ill were regarded as incompetent. They found a moral difference in favour of withholding treatment as opposed to discontinuing the ongoing treatment of a patient. Attitudes and behavioural dimensions are important for ethics education and thus are important for the education of ethics committee members. It is not easy, however, to change attitudes and behaviours via education (19).

One should, however, be cautious in interpreting the data we have presented: it is evident that our survey presents only snapshots regarding the work of ethics committees in hospitals in Croatia. The participants were those members that were officially delegated to come. Thus, they were either selected by their committees as more versed in the subject or were highly motivated to come as this was a field that interested them. A more detailed analysis, including a larger number of members, should be carried out. Moreover, one can see that any real follow up of the workshop cannot be carried out because only 31 participants filled in the questionnaire both before and after the workshop. Thus, this survey cannot prove for certain whether the educational workshop was successful or not. This was just, one might say, a short pilot test in anticipation of further investigations in this field in Croatia. We feel that such investigations are important because quality control should be implemented in this area of hospital work (20, 21), Croatia should follow any recommendations arising from further investigations in order to improve quality control within the hospital setting.

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