Nurses' Perspectives of Hospital Ethics Committees

by Holly A. Stadler, John M. Morrissey, Joycelyn E. Tucker, Julie A. Paige, Jo E. McWilliams, Denise Kay, Brian Williams-Rice

The Midwest Bioethics Center (MBC) commissioned a survey of nurses' attitudes and needs regarding Hospital Ethics Committees (HECs) to guide its Ethics Committee Consortium. The survey examined three areas related to nurse utilization of and participation on HECs: 1) perception of HEC role and function; 2) perception of HEC case consultation function; 3) nurses' ethics training and continuing education. Important findings include nurses' reported lack of knowledge regarding HEC policies; a perception that their training in clinical ethics was inadequate; and a strong indication that HECs should be accessible to a wide range of health care professionals.

Nurses wrestle daily with moral and ethical problems in the health care environment; bioethics is a salient component of their professional lives. Some areas in particular elicit distinct ethical concern for nurses, including the allocation of sufficient nursing staff to meet a patient's need, the nurse's right to refuse work in areas he or she feels unprepared for, and the nurse's role in patient care decision making (Haddad 1991). Haddad also noted that with little institutional influence and lack of official acknowledgment of their particular ethical concerns, nurses have become motivated to develop their own nursing ethics committees.

Increasingly, nurses are distinguishing their ethics concerns from those of physicians and other health care disciplines and suggesting the development of an ethical framework that organizes and makes explicit the nursing profession's values and beliefs. Such a framework would enable nurses to recognize ethical dilemmas, clearly articulate their concerns, and plan their responses. Some researchers (e.g., Grundstein-Amado 1992) have suggested that the decision-making process of nurses—the "how" as opposed to the "what"—differs from that of physicians. The patient, however, prefers an integrated response from the health care team to an uncoordinated or inchoate treatment by the various disciplines (Grundstein-Amado 1992).

There are many suggestions in the nursing literature regarding the preparation and training of nurses to become moral agents or competent ethical decision makers in their daily work (e.g., Cassels and Redman 1989; O'Neil 1991; Webb 1990). The literature also points to hospital ethics committees (HECs) as sources of support for nurses (e.g., Curtis 1984; Murphy 1989). HECs encourage the systematic exploration of ethical dilemmas by a range of professionals in the health care system. Not only a forum for case consultation, they also function in the development and promotion of policy and in education of health care providers (Blake 1992). The fact that most hospitals now have ethics committees underscores the great need among persons in health care disciplines for assistance in improving the quality of their ethical decisions (Murphy1989; Gramelspacher 1991). Moreover, HECs are typically multi-disciplinary. National surveys in both the United States (Younger 1983) and Canada (Storch,Greiner and Marshall 1990) have shown that HEC memberships include physicians, nurses, attorneys, social workers, clergy, administrators and lay persons from the community.

Holly A. Stadler, Ph.D., is a Professor of Education and Medicine and Chair of the Division of Counseling Psychology and Counselor education at the University of Missouri-Kansas City. The co-authors are graduate students in that program.

Many professional nurses are attempting to raise ethical issues to the same level of importance as clinical issues. However, there is little empirical research addressing the actual views of nurses regarding their bioethical concerns and the role and function of hospital ethics committees. This study redresses the gap in the literature by investigating nurses' (N=604) perceptions regarding their level of preparation to deal with ethical issues, their knowledge of and attitudes toward the nature and purpose of HECs, their actual participation and utilization of HECs, and their needs and interests in continuing education in ethics.

Methodology

Eight of forty-three hospitals represented on the Midwest Bioethics Center Ethics Committee Consortium were selected for participation in the study. A sample of 2,476 survey participants was randomly selected from the survey the nursing staff rosters of the eight hospitals. To avoid duplication, the rosters of all eight hospitals were cross-checked for multiple hospital affiliations. The results of 604 survey responses reported in this study represent a twenty-four percent return rate.

A twenty-eight-item survey examined three areas: Ethics Training and Continuing Education; Nature and Purpose of HECs; and HEC Case Consultation Function. An Ethics Committee Consortium representative from each hospital was responsible for survey distribution and collection. The survey included instructions and letters of endorsement from the hospital administrator, and the heads of the medical and nursing staffs. To ensure confidentiality, participants returned the survey to the representative in a sealed envelope. The representative delivered the returned surveys to the investigators for data analysis.

Results

Survey respondents were primarily white (92.7%), and female (96.0%), with a mean age of 39.1 years. Respondents varied in degrees held (51.2% bachelors; 33.3% professional diploma; 24.4% associates; 7.6% masters; and 2.0% other). Significant experience in the health care profession was reported (16.3 years), with an average of 7.5 years in the respondent's current position.

Ethics Training and Continuing Education

Respondents indicated that their professional training programs addressed ethics in the following ways: required formal courses (34.0%), elective formal course (12.6%), clinical case discussions (41.4%), bedside teaching rounds (11.6%), and pre-clinical training (19.2%). Of the 604 respondents, 23.6% indicated that their training programs did not address professional ethics. Only 23.7% of the respondents rated their training in addressing ethical issues as exceptional or good, while 41.8% characterized it as poor or inadequate.

Respondents were asked to report the likelihood that they would seek training on various health care issues (see Table 1).

Table 1

Likelihood of Seeking Training on Health Care Issues

A=Very Likely B=Somewhat Likely C=Not Likely

A	60.2%	Legal Issues
A	57.5%	Withdrawal/withholding/forgoing treatment
A	50.7%	Access of health care (e.g., federal government)
A	48.4%	Access to health care
A	45.7%	AIDS/HIV
A	39.9%	Allocation of scarce medical resources
A	37.5%	Physician-assisted suicide
C	43.6%	Genetics
C	37.9%	Maternal/fetal conflict

1. Results given are most frequent responses.

In a second question, nurses reported the likelihood of using various continuing education methods regarding health care ethics (see Table 2).

Table 2

Likelihood of Using Continuing Education Methods

A=Very Likely B=Somewhat Likely C=Not Likely

A	83.2%	Hospital in-service
A	62.7%	Local conference or presentation
A	58. 7%	Informal discussion
A	52.9%	Personal reading
B	39.5%	Formal reading/discussion group
C	52.7%	Session at national or regional convention
C	50.4%	University class
C	47.3%	National or regional conference

1. Results given are most frequent responses.

Nature and Purpose of HEC

Nurses ranked case consultation as the most important HEC function, followed by policy or guideline development, education and retrospective case review. Responding to the question of who should serve on an HEC, nurses most strongly endorsed nursing, medical and pastoral care personnel (see Table 3).

Table 3

Who Should Serve on an HEC?

Medical staff	98.7%	Administration	58.9%
Social services	88.3%	Nursing staff	98.8%
Legal counsel	85.6%	Ethicist	66.4%
Board member	40.7%	Community member	43.8%
Pastoral services	90.5%		
Patient representative (ombudsperson)	37.7%	Mental health services	63.0%
		Other	3.4%
Other clinical staff	37.7%		

1. Respondents indicated all positions that should be included on an HEC.

Respondents described their institutional HECs as impartial (37.4%), a patient advocate (34.7%), a medical staff advocate (15.4%), or an advocate of some other group outside of those listed (3.6%). In contrast to these descriptions, 51.8% of nurses indicated that the HEC in their hospitals *should* be impartial and 40.4% indicated the HEC should be a patient advocate. Asked how HEC case consultation affected their work at their institution, 41.1% of nurses indicated their work was enhanced by this function. Other HEC functions—retrospective case review, policy or guideline development, and education—most often had no effect on respondents' work.

HEC Case Consultation Function

Nurses indicated that they believe the persons listed in Table 4 are authorized to request an HEC case consultation in their hospital (see Table 4). The attending physician was the only position rated over 60%. The survey then asked the nurses who *should* be authorized to request an HEC case consultation in their hospital (see Table 4). With this qualification, only administrative staff and other clinical staff were endorsed by fewer than 70% of the respondents.

Table 4

Who Can Request an HEC Case Consultation and Who Should be Authorized to Request a Consultation?

	Current	Should
Attending physician	60.7%	91.3%
Family/appropriate surrogate/legal guardian	51.3%	86.8%
Attending nurses	50.3%	92.5%
Patient	48.7%	84.6%
Administrative staff	44.6%	66.8%
Don't know	42.0%	8.1%
Other medical staff	41.0%	70.8%
Other clinical staff	35.6%	64.6%
Other	6.4%	8.4%

1. Respondents indicated all positions that could and should be able to request a consultation.

Fifty-two percent of the respondents believe that an HEC case consultation is required in some circumstances at their institutions. Eight percent indicated there were no circumstances in which their hospital required consultation. Forty percent did not know if an HEC consultation was required.

Some respondents (32.1%) considered HEC's case consultation recommendations as advisory, while a small number (2.4%) considered them binding. However, 62.4% of the respondents were unsure if HEC recommendations were advisory or binding. Only 8.3% (n=50) had brought a case before an HEC.

Discussion

HEC Role and Function

Nurses perceive the case consultation function of an HEC to be the most important and enhancing of their work. Other functions such as policy and guideline development, retrospective case review, and education appear to have had no effect on the work of nurses who responded to the survey. While this group of nurses joins others who see case consultations as integral to HECs (Storch et al. 1989), only a small percentage (8.3%) have brought a case to an HEC for consultation. This may be explained by Gramelspacher's (1991) observation that the case consultation function is the one that promotes the most controversy. The survey finding that nurses would likely consult others regarding ethical dilemmas could further explain the limited use of HECs for case consultation purposes. Those consulted could be the nurses' superiors (Hoffman 1991) or peers (Haddad 1991). An additional component of nurses' low rate of utilization of HECs for case consultation is the lack of information about HEC policies and operation. We found that a large percentage of nurses believe that bringing some types of cases to the HEC is mandatory, when, in fact, the participating hospitals' policies do not require case consultations. Moreover, a large percentage of nurses do not know whether consultation recommendations are advisory or binding, whereas in all the hospitals, HEC case recommendations are advisory. Finally, the belief that nurses were not franchised to bring cases to an HEC may have dissuaded some from doing so.

From these findings it appears that HECs must inform members of the nursing staff about both the roles and functions of HECs and about their policies and procedures. This could increase nurse participation on committees as several of the respondents indicated they would gladly serve on such a committee.

In other findings regarding HEC's role and function, we note that the participating nurses were in agreement regarding membership on and access to HECs, echoing the conclusions of Murphy (1989) and Younger (1983). While viewing qualifications for membership on HECs at their institutions as currently being somewhat restrictive, the nurses strongly endorsed including representatives from diverse constituencies on the HEC. The nurses also endorsed enfranchising more groups to bring cases to the HEC than those they believe currently are able to do so. Haddad (1991) has noted how nurses frequently feel "caught in the middle" of ethical controversies. According to Curtis (1984), nurses often find themselves caught between conflicting loyalties to their patients and physicians and other members of the health care team. Indeed, one survey indicated that 34% of the nurse respondents reported that "the most common reason nurses compromise their ethical values is to carry out a physician's request" (Haddad 1991, 61). Haddad says a number of hospitals recently have established nursing ethics committees in an effort to recognize nurses' unique ethical concerns. Our study indicates that extending membership on HECs to a broader range of disciplines, backgrounds, and opinions, and enfranchising more groups

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to bring cases to an HEC for consultation will reduce the triangulation that nurses experience. Moreover, an HEC could build a common ethical ground between nurses and physicians and other health care professionals (Grundstein-Amado 1992).

Murphy (1989) continues to support a nurse advocacy role as do many of our respondents. When asked if an HEC's role should be impartial or a patient advocate, 40.4% of the survey participants chose the latter. The larger percentage (51.8%) endorsing an impartial role for HECs fits Muyskens's (1993) description of the "team player" who moves beyond the "narrow base" of patient advocacy (Muyskens, 11). Nurses' "collective advocacy" to work for "institutional and systemic change" as "collaborators" and "team players" could be acted on in HECs, especially in the area of policy and guideline development.

Ethics Training and Continuing Education

Although nurses in the present study have been exposed to a wide range of ethics education strategies in their training programs, a large percentage of them (41.8%) believe that this training was either poor or inadequate, and nearly a quarter of them reported that ethics was not addressed in their training programs at all. This might further explain their reluctance to bring cases to an HEC for consultation. Nurses participating in this survey expressed interest in furthering their ethics education, particularly with regard to legal issues, withdrawing and withholding treatment, and control of and access to health care. They prefer to pursue these interests through local conferences and presentations, hospital in-services, personal reading, and informal discussion. Rawlins and Bradley (1990) suggest that periodic assessment, such as the present survey, can play an important role in developing HEC goals and designing programs to meet the needs of health care providers. The present study also points to the utility of assessing the ethics training of nurses when developing strategies to meet these needs. A comprehensive strategy would address preferred instructional modalities and topics for continuing education, as well as a structured curriculum to address ethical theory and strategies for recognizing, conceptualizing, and responding to ethical concerns.

Summary

The current study offers HEC members and those institutions anticipating development of an HEC valuable information about nurses' perceptions. The study indicates a particular need for clarity about HEC policies and procedures, as well as an inclusive, enfranchising stance toward qualifications for membership on an HEC. There remains a debate among nurses whether HECs should have an impartial role in health care discussions or whether they should take the role of patient advocate. Finally, the ethics education function of HECs can be carried out through a comprehensive strategy that addresses prior preparation and current needs of nurses.

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