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Proposal for a Hospital Ethics Committee at the Hacettepe University Hospitals, Turkey: A Mixed Method Study

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Abstract

Introduction: Hospital Ethics Committees (HECs) were established to solve the ethical dilemmas experienced by health personnel in clinics. However, HECs also provide training on ethics, and develop ethics guidelines and institutional policies. HECs first appeared in the USA in the 1960s and had become widespread in Europe by the 1990s. In Turkey, the introduction of HECs is relatively recent and the number of committees is limited. The aim of this study was to identify the need for a HEC at the Hacettepe University Hospitals (HUHs) and to develop an appropriate model for the HEC.

Methods: Both qualitative and quantitative research methods were used. As a part of the qualitative research, focus group interviews were conducted with physicians in the intensive care unit of the HUHs. Survey forms were prepared, with reference to the data, which were collected during these interviews. The quantitative research was conducted by distributing survey forms to all physicians working at the HUHs. Data were evaluated using SPSS v.11.5 software.

Results: In total, 250 surveys were completed (participation ratio 25%). Physicians who participated in the research confirmed the need for an organization to provide training on ethics, to prepare ethics guidelines and to help solve ethical dilemmas.

Conclusion: Here a model for a HEC is proposed, with reference to the needs and suggestions of the physicians who work at the HUHs.

Keywords: Medical ethics, clinical ethics committee, hospital ethics committee, ethics consultation.

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Introduction

Hospital (or Clinical) Ethics Committees (HECs), are institutions which help healthcare professionals to solve the ethical dilemmas they encounter during their work, organize training on ethical awareness and develop hospital policies and ethical guidelines. HECs provide guidance to healthcare professionals and contribute to the development of patient-centred service without intervening in the physician–patient relationship (1). In general, HECs are not established on the basis of a legislative framework but are set up to meet the requirements of physicians and medical institutions (2, 3). However, there is much debate on the need for HECs, their organization and membership and mechanisms of decision-making.

Developments of HECs from Different Countries

The first HECs were established in the USA in the 1960s and similar organizations appeared in Europe in the 1980s (2, 4). Development of HEC in England coincides with the beginning of 1990's. There were 20 ethics committees in 2000. And this number increased to 57 by January 2004 (5). In Japan example, ethics committees were established voluntarily within medical faculties of 80 universities across the country in 1992. These ethics committees in universities in Japan review the research protocols as well as playing a role in development of policies necessary for the institutions (6). In a research published in 2008 within the scope of a project, 17 educators working in biomedical ethics field have conducted a clinical ethics and support activity. The results obtained from the review of the one-year activity of consultancy service carried out by this small group which was considered as the first application in this field were found positive (7). In Norway example on the other hand, Ethics Center started a project in 1993 with the support of Ministry of Health. Within the scope of the project, HECs were established in 3 different structures chosen amongst the hospitals at national, municipal and district levels. Committees established with respect to the project would be supported by the hospital administration, would act as multi-disciplinary structures, would serve as consultants and would be regulated in accordance with the requirements of Norway. Members of the committee have attended two seminars a year held by the Ethics Center in order to improve their medical ethics and ethical reasoning skills. It was found out as a result of the evaluation that these institutions could

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be beneficial in conducting fact analysis, composing ethics guides in special areas and developing policies for the hospitals (8). There are HECs in Norway since 1996. As of 2008, there is one ethics committee in each hospital (9). In an article in which USA, England, France and Canada were compared, it can be seen that each country has established its own structure and there is no particular standard (10). As it's observed in the examples around the world, there is no particular standard for HECs and they have been formed in accordance with the requirements of related countries.

Situation in Turkey

The process of establishing ethics committees in Turkey started in 1993 with the Regulations on Drug Trials (11). Ethics committees became widespread in Turkey with this legal regulation. Most common bioethics committee type in Turkey is the research ethics committees. HECs on the other hand are the structures which take place in a few hospitals and which are generally not known about by the healthcare professionals. Within this context, the studies conducted about HECs are significantly limited in our country.

Only four doctorate studies have been carried out in Turkey about HECs (12-15). The fourth thesis is the thesis of the first writer of this article which was made in 2011 with the title. When the literature examples of HECs structuring in Turkey are reviewed, it's seen that such structuring is a relatively new concept. Within this context, it gains more importance to present the need for hospital ethics committees in Hacettepe University and to make an effort to suggest a model through the doctorate thesis which is subject to this article. This thesis also includes the only qualitative study made about HECs.

When the contents of the thesis done in such field are reviewed, it can be seen that Karakaya and Dogan theoretically discuss the structuring of HECs (12, 13). Karlikaya on the other hand has gathered the views of the doctors and nurses about ethics consultancy services through a survey. This study was carried out in 2007 and 76,7% of the doctors and 75,3% of the nurses working in university hospitals stated that they wanted to benefit from ethics consultancy services. The doctors who have participated in the study believed that ethics consultation would lessen the conscientious and legal responsibility and the likelihood of occurrence of problems among the teams (14). In a study which was conducted in 2011 in 3 universities with the participation of 270 doctors, 90,4% of the doctors stated that that they would like to receive ethics consultation (16). In a study carried out with the participation of doctors working at HUHs, it was found out that the doctors in general had knowledge about ethical values while young doctors had relatively higher ethics knowledge and awareness. The writers attribute this result to the fact that young doctors had more education on ethics (17). This study emphasizes the importance of establishment of the HECs which also have the duty of giving ethics awareness education.

A 2010 study of university hospitals in Turkey (18) identified ten HECs, and two of them were working together with Research Ethics Committee. However, most did not function efficiently. HECs are not widespread in Turkey and the existing organizations have been established through personal efforts. Currently, there is no legal regulation regarding HECs. In certain hospitals, case-specific commissions are established temporarily (ad hoc committees) and then dispersed, but these are not institutionalized committees. Cases are usually investigated clinically, without any ethical evaluation.

The first aim of the present study was to identify the needs of physicians for a HEC in the Hacettepe University Hospitals (HUHs). There are three hospitals affiliated to Hacettepe University, with approximately 1040 inpatient beds in total: adult hospital, children's hospital, oncology hospital and physical therapy and rehabilitation hospital (19). The HUHs have multi-disciplinary committees that have been established for specific purposes. These include the Commission for the Evaluation of Sexual Identity Problems; inter-disciplinary case-specific meetings, which are conducted at Hacettepe University Oncology Hospital; the Neuro-oncology Council and Tumor (Surgery) Council that has been meeting since 1973; three different councils that convene once every week and involve all departments of the Children's Hospital; and biweekly meetings of the Department of Child Psychiatry and the Department of Pediatrics. All these meetings focus on clinical decisions and do not generally address ethical issues. Therefore, there are no HECs in the HUHs, at least in line with the definition of ethics committees documented in the literature.

The second aim of this article was to propose a model for a HEC based on the methods physicians use for solving ethical dilemmas and the issues for which they need consultancy and training. The final aim was to gather the opinions they have about the organization of HECs.

Methods

The research for the present study was complementary to a PhD thesis that has been prepared by the Department of History of Medicine and Medical Ethics at the Hacettepe University Faculty of Medicine. Since not enough information could be achieved about the HECs in Turkey during the thesis, firstly, a survey study aiming to present the situation in Turkey was conducted (18). Afterwards, a study using qualitative and quantitative methods together was conducted in order to study the ethics awareness of the doctors working in HUHs, their methods to solve the ethical dilemmas they encounter and their thoughts about the role of HECs in solution processes. Researching the situation in Turkey, the study showed that HECs and research ethics committees were mixed and HECs were not commonly known. Therefore, it was planned to receive the opinions of the doctors through a qualitative study as a beginning and to generate the survey questions according to them. The survey consisted of three sections. The doctors were asked about the dilemmas they encounter and the ways of solution in the first section, their thoughts about the HECs in the second section and their views about the end of life ethical decision making process over two case evaluations in the last section. In this article, Hacettepe University Hospitals' HEC model suggestion based upon the views of the doctors about HECs will be presented.

Qualitative research

In the qualitative first phase of the study, intensive care physicians were selected for the focus group interviews because they frequently encounter ethical dilemmas (20) and are involved in end-of-life decisions (14). There are nine intensive care units (ICU) in the HUHs. These include Thoracic and Cardiovascular Surgery ICU, Brain and Nerve Surgery ICU, Anesthesia ICU, Internal Diseases ICU, General Surgery ICU, Neurology ICU, Coronary ICU, Neonatology ICU, and Pediatric ICU.

The General Surgery and Brain and Nerve Surgery ICUs were excluded from this study because there are no autonomous intensive care workers who make decisions regarding the patients in these units. Four groups, each including six participants, were established. Because the ideal number of participants in focus group interviews are 6-9 (21).

The researcher conducted face-to-face discussions with intensive care personnel to inform them about the content of the study and to ask if they were prepared to participate in focus group interviews. A meeting time was arranged for the physicians who agreed to participate. In the meetings, which lasted approximately one hour, physicians were asked about the ethical problems they experienced, the methods they used to solve those problems and their opinions about HECs.

Approval for participations were obtained verbally. Audio recordings of the discussions were made, and these records were erased after they had been transcribed. No information about the identity of the participants was retained. The qualitative part of the survey was completed between June and July 2009.

Quantitative research

The quantitative second phase of the study involved a survey that was based on the findings of the first phase. In the focus group interviews, it was noted that assistants do not hold themselves responsible for the solution of ethical dilemmas because they are not in a position to make decisions. Therefore, in the survey, physicians were asked whether they felt they were in a position to make decisions about diagnosis and treatment. Question 13 of the survey, which asked about the frequency of encounters with ethical dilemmas, the options to address communication problems, the lack of legal regulations and problems with administration, was added because physicians insisted on these points in the focus group interviews.

The population in the second phase of the study included all of the physicians working at the HUHs. The survey form was composed of three sections and a total of 21 questions. The first section contained questions on the participant demographics. The second section focused on the ethical dilemmas, solutions and opinions about HECs. The third section covered case evaluations. A pilot study using the survey was conducted with 22 physicians from various hospitals. After the pilot study, the questions were reviewed, new answer options were added and an additional question on whether the participant had ever worked in an ICU was included. The revised survey forms were distributed in a closed envelope to all of the physicians that were employed by the HUHs. Of the total of 1030 physicians, 987 received the survey form. The form could not be delivered to 43 physicians for reasons including being on vacation or on sick leave. Physicians were asked to pass the completed forms to the department secretaries. The forms were then collected from the secretaries by

the researcher. One month after the surveys were distributed, reminder e-mails were sent to the physicians who had not completed the forms. Digital copies of the survey form were then sent on two occasions 15 days apart.

Information about the research was provided on the cover of the survey form. The survey was completed anonymously. The data collection of quantitative part of the survey was completed between January and June 2010.

Data were evaluated using SPSS v.11.5 software. The findings of the survey were evaluated as percentages.

Ethical Approval

This research was approved by the Medical Research Local Ethics Committee of the Hacettepe University Faculty of Medicine on 10 April 2009 (number LUT 09/10-59). The permission to include physicians in the study was given by the General Directorate of HUHs.

Results

Qualitative research

Open-ended and semi structured questions asked during the focus group interviews are configured as below: (22)

1. Genders, ages, working years, areas of expertise of the group members and whether they have received ethics education or not
2. What are the ethical dilemmas you experience in practice?
3. How do you solve such dilemmas?
4. Would you like to receive ethics consultation?
5. What are the functions of Hospital Ethics Committees?
6. How do you think this committee should work?
7. Who do you think should take place in this committee?
8. How should education, one of the functions of this committee, be given? Subjects, ways of teaching, duration, etc.
9. One of the functions of this committee is to develop an ethics guide. For which subjects do you need ethical guidance?
10. Do you think this committee would be beneficial for clinicians?

First interview was conducted with the physician associates working in anesthesia intensive care unit (ICU). The group consisted of 3 women and 3 men and the average of age was 32,5 ± 3,39 years. Working experiences of 3 persons were between 0 and 4, 1 person was between 5 and 9 and 1 person was over 10 years (22).

The second focus group interview was made with 3 assistants from cardiovascular surgery and 1 physician associate from cardiology department. The participants were all males since the number of women working in this department was low. 2 participants couldn't attend the interview due to health problems. Average of age of the group was 28,5 ± 5,69 years. Working experiences of the 3 of the participants were between 0 and 4 while working experience of 1 participant was over 10 years (22).

The third focus group interview was made with 3 employees working in internal diseases ICU and 3 employees from neurology ICU. 3 men and 3 women participate in the study. Average of age of the group was 37,5 ± 9,46 years. Working experiences of the 2 participants were between 0 and 4, 1 participant was between 5 and 9 years and 3 participants were over 10 years (22).

The number of the doctors in newborn and pediatric ICU was insufficient to form a group of 6 persons which was planned for the fourth focus group interview. Therefore, doctors as newborn and pediatric ICU from children's hospital clinicians, hematology, genetics, emergency service doctors who frequently encounter ethical dilemmas were included in the interview. Since the fact that most of the employees working in the children's hospital were woman was reflected by the group as well, the interview was made with 4 women and 2 men doctors. The average of age was 34,8 ± 5,18 years. Working experiences of 2 participants were between 5 and 9 years and 4 participants were over 10 years (22).

As a result of the interviews made with 4 focus groups formed with doctors working in ICU, the resident physician associates stated that they have nothing to do during the treatments even though they realize ethical problems since they are not the final decision makers. They stated that they have problems in telling the medical facts to the patients and informing them since their professors are the primer doctors of the patient. The doctors indicated that they didn't know about the regulations and their rights. The doctors who were in the decision maker position on the other hand mentioned that they live problems in decisions with regard to beginning

and end of life and in needless treatment decisions. They stated that they generally consulted with their superiors and friends to solve ethical problems. It was determined that the doctors didn't know about ethics consultation concept and had difficulties in understanding it even after the concept was explained to them. They stated that they believed such service wouldn't work within the system even though it was thought to be theoretically beneficial. The doctors stated that as research ethics committees, they thought the HECs would also be the institutions which would hinder the processes and which would operate slowly due to the work-load. The importance of continuous ethics education starting from undergraduate period and continuing during on the job training was emphasized. It was mentioned that it would be beneficial to give trainings in dramatized, interactive ways as forms of problem-oriented case analysis which gives tangible data. It was also suggested to give the trainings in interdisciplinary and forum forms. The doctors also stated that giving certificates after the trainings, making the trainings compulsory activities and employees being granted leave of absence would increase the participation. Developing ethics guidelines and hospital policies wasn't accepted since they weren't conceptually known and they couldn't be interpreted even after their definitions were made. Medical ethics expert, psychologist or psychiatrist, an experienced doctor, social service specialist, legist, an experienced nurse, forensic science expert and all related parties were counted as the persons who should be the members of the committee. However, it was suggested that the committee should consist of a maximum five persons' skeleton crew since such wide membered committees could not be able to give decisions rapidly. It was emphasized that it was difficult for the HECs to work in current health system but one shouldn't be hopeless about that. It was also stated that hospital ethics committees supporting the doctors would be beneficial in terms of sharing responsibilities (22).

The expression of one of the doctors who have participated in focus group interview about the HECs continuing as *"it would be good to have one but it's not an absolute must, things go without it as well…"* is very appropriate to see how the subject is perceived (22). The survey questions and answer alternatives were developed based on these qualitative research data.

Quantitative research

Of the 987 physicians who had received survey forms, 250 participated in the study to determine the need for a HEC at (250/987; response rate 25.3%). Clinicians do not want to fill in the questionnaires due to heavy workloads. The average age of the participants was 37.1 years (SD, 10.6), and 48.2% of the participants were female. The areas of expertise and academic titles are presented in Table 1.

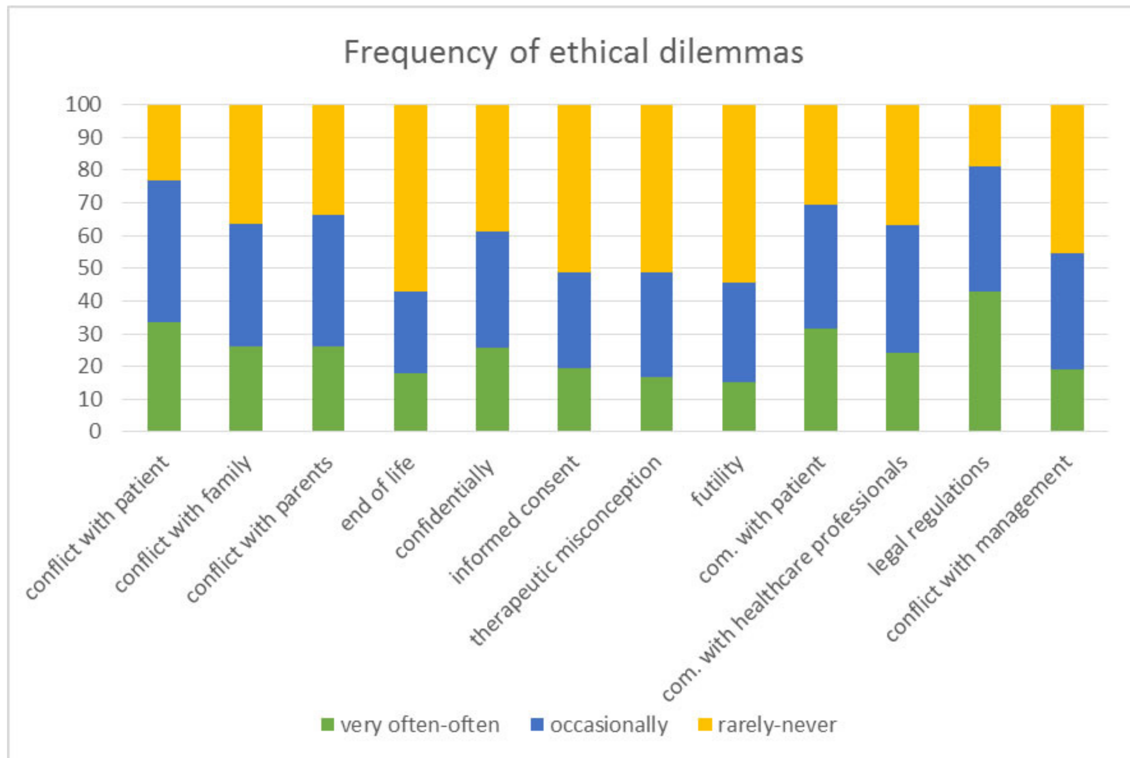
Table 1. Areas of expertise and academic titles of the physicians.

Area of Expertise	Number	%
Internal Departments	82	32.8
Surgical Departments	123	49.2
Paediatrics	45	18
Academic Title		
Professor	46	18.5
Assoc. Professor	34	13.7
Assist. Professor	14	5.6
Instructor / Specialist	31	12.4
Assistant (Resident)	124	49.8

The doctors were asked about the frequencies of encountering ethical dilemmas (see Graph 1). Problems associated with lack of information about legal regulations and problems with administration were also included in the alternatives to the question even though they don't constitute an ethical dilemma since they come into prominence in qualitative study. Indeed, lack of information about legal regulations was reported as the mostly encountered problem 42.8% of the doctors stated that they frequently encounter such problem while 38.3% stated that they occasionally encounter and 19.8% stated that they never encountered.

The second most commonly encountered problem is the conflict between the patient/patient's relatives and the healthcare professionals in conscious patient situations. 43.3% of the doctors stated that they occasionally faced the conflict between the patient/patient's relatives and the healthcare professionals about conscious patients. The rate of the doctors who have stated that they frequently faced such ethical problem was 33.6% and the rate of the doctors who have stated that they never encountered such problem was 23%.

The third problem is communication problems with the patients. When doctors were asked about how often they live communication problems with other healthcare professionals, 39% of the doctors marked the occasionally option. The rate of the doctors who have stated that they frequently faced was 24% and the rate of the doctors who have stated that they never encountered such problem was 37%.



Graph 1. Frequency of ethical dilemmas.

In this study when asked regarding the methods used to solve ethical dilemmas, physicians chose an average of two options. These were consult to a superior (75.1%) and solve it myself (54.3%) which are given Table 2.

Table 2. Methods used to solve ethical dilemmas.

Methods to solve ethical dilemmas	Number	% of all answers	% of all physicians (n = 245)
Solve it myself	133	29.2	**54.3**
Consult a superior	184	40.4	**75.1**
Consult my chief	41	9.0	16.7
Consult a friend	61	13.4	24.9
Take ethical consul-tancy	29	6.4	11.8
Leave it to time	8	1.8	3.3
Total	456	100.0	186.1

When we asked the needs of physicians for HEC functions, preparing guideline (31.8%) and giving training (30.1%) had come forward which are given in Graph 2.

Ethical Training from HECs

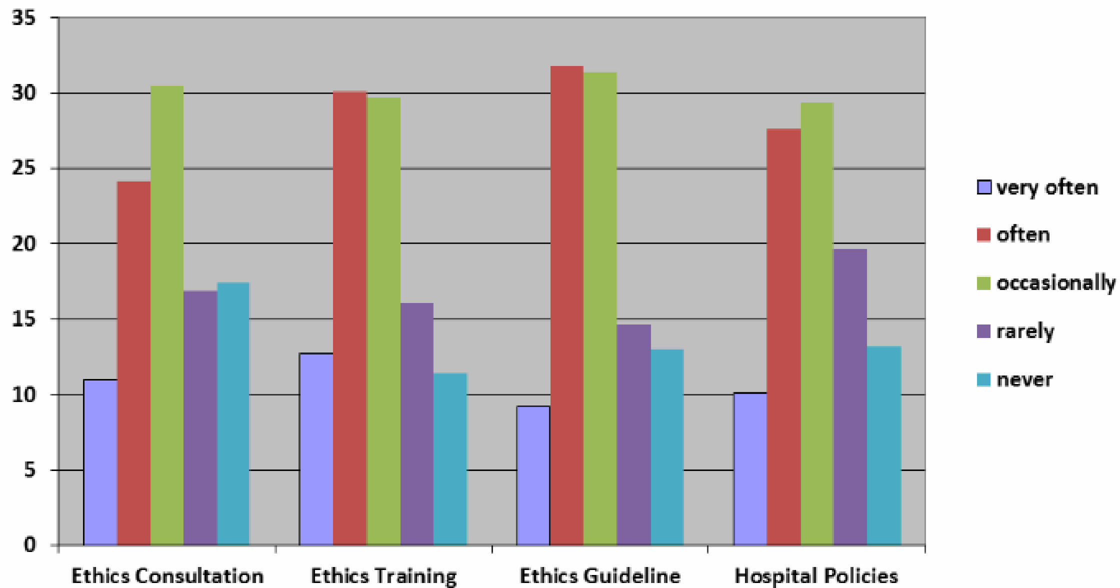
Participant physicians were asked to suggest three subjects for which they would like to receive ethical training. As expected, the most common answer (68.5%) was training on legal regulations regarding malpractice. The second was training on basic concepts of ethics (55.6%). Training on the regulations on informed consent and 'do not resuscitate' (DNR) orders were both suggested by 29.3% of physicians.

Ethical Guidelines Prepared by HECs

In response to the question regarding the subjects that should be covered by HEC guidelines, participants marked three answers on an average. These were guidelines related to end-of-life decisions (DNR orders, withholding and withdrawing treatment, vegetative state, brain death, futile treatments, etc.; 85.4%), poor prognosis and telling truth (72.1%) and conflict between the family and healthcare professionals in making decisions for unconscious patients (62.3%).

Opinions of Physicians on HECs

In response to the question on whether HECs would help with the ethical dilemmas encountered in practice, 69.2% of the physicians answered positively. While 28.7% of the physicians said that HECs would be partially useful, only 1.6% of the participants gave a negative answer.



Graph 2. The needs of physicians for HEC functions.

Physicians Opinions on the Role of HECs in Solving Ethical Dilemmas

In response to the proposition that there is no need for a specific organization for the solution of ethical dilemmas, 77.9% of physicians disagreed and 12.5% were uncertain. On the other hand, 66.0% of the physicians disagreed with the proposition that a committee is not necessary and that problems can be solved with individual ethics consultations, whereas 24.8% were uncertain. The majority (83.6%) of the participants agreed that HECs are absolutely necessary. In the focus group interviews, the most widely stated reason given by physicians who opposed HECs was that HECs would not work in the existing healthcare system. However, in the survey, 48.0% of physicians disagreed with this and 37.1% were uncertain (see Table 3).

Who do Physicians Expect to See as Members of a HEC

In response to the question regarding appropriate members of a HEC, physicians mentioned nine groups. These were medical ethics experts (84.6%), lawyers (75.6%), physicians who work in ICU (67.1%), specialist physicians (63.8%), chief physicians (61.4%), social work experts (60.6%), nurses (58.5%), heads of departments (55.7%) and psychiatrists (54.9%).

Discussion

In Turkey, the concept of HECs as organizations to help physicians solve ethical dilemmas is relatively new. The HUHs are among the pioneering institutions in Turkey in terms of the quality of service they provide. In that sense, the establishment of a HEC for the HUHs would be an important step.

In the UNESCO guideline titled 'Establishing Bioethics Committees', it is stated that HECs should be composed of 15–25 members (1). The literature on HECs also mentions examples in which there is a core group, which comes together with members from distinct fields of expertise to constitute a committee in situations of need (2, 23, 24). Because communication within and outside a committee is easier in a small structure, the functioning of such committees is relatively easier (25).

Considering these reasons and the findings of the survey, the model HEC for HUHs should initially be based on a core group. To be accepted by the parent institution, the HEC should be flexible, and it should produce rapid concrete results. However, small committees are often criticized for their inability to reflect the viewpoints of all parties (2). Therefore, following its development and acceptance by the personnel of the institution, the HEC should evolve towards the format defined in the UNESCO guidelines. Following that, sub-committees could be established to enable flexibility and quick decision-making.

Our survey results on the membership profile of HECs show that physicians expect to see physicians who are employed as administrative personnel, such as heads

Table 3. Physicians Opinions on the Role of HECs

Would a HEC be beneficial for Clinicians?	Number	%
Yes, it would	171	**69.2**
It might be partially useful	71	28.7
No, it would not	4	1.6
No opinion	1	0.4
Total	247	100.0
No need for a separate unit		
I agree	23	9.6
I'm not sure	30	12.5
I don't agree	187	**77.9**
Total	240	100.0
Ethical consultancy is sufficient		
I agree	22	9.2
I'm not sure	59	24.8
I don't agree	157	**66.0**
Total	238	100.0
HEC is absolutely necessary		
I agree	204	**83.6**
I'm not sure	21	8.6
I don't agree	19	7.8
Total	244	100.0
HEC won't work in this system		
I agree	33	14.9
I'm not sure	82	37.1
I don't agree	106	**48.0**
Total	221	100.0

of departments or chief physicians, involved in HECs. However, physicians in administrative positions may not suitable committee members because they may influence the opinion of the committee in a certain way using their position of authority. Furthermore, administrative personnel might be unable to devote the necessary time and commitment to the committee (26). The composition of the core group is an important issue for discussion. An ideal core group would be composed of six members, including an experienced physician and nurse who have worked in ICU, a lawyer or forensic expert who understands the legal framework, an expert on medical ethics, a psychiatrist or psychologist and a social worker. UNESCO's Bioethics Committees Guide No. 3 focuses extensively on the education of the members of bioethics committees. After planning their own training program, HEC members should prepare training for physicians and other healthcare professionals on gaining sensitivity to ethics. In addition, an orientation program should be prepared for every new member of the committee. HEC members, who have different occupations, require training to ensure effective communication with each other and to produce ethical justification during consultation (27, 28).

The results of the our survey show that physicians identify the legal regulation of medical malpractice, the basic concepts of ethics and legal regulations on informed consent and DNR orders as key subjects for training by HECs. Lack of information about legal regulations which was reported as the most commonly faced problem also shows parallelism within the context of the trainings they have requested. According to previous research conducted in Turkey, the most common problems physicians encounter are rejection of treatment, communication problems and lack of knowledge in legal regulations (14). In a study conducted in England, the most common issues taken to HECs were competence, consent and withholding and withdrawing treatment (29). Therefore, the findings of the present study agree with reports in the literature.

According to a study of cases brought to HECs for consultation between 1996 and 2002 in Norway, the most common concerns were the amount of information given to the patient, the quality of this information and the timing and method of informing the patient (30). In another study, the most common reasons for ethical consultation were conflict and communication problems with family and the patient or trustee, problems in decision making and planning of care and emotional triggers. These emotional triggers were defined as facing patients who experience threat, fear, disappointment, uncertainty or pain (31). The issues addressed in these studies tended to be communication problems rather than ethical dilemmas (32). Additionally, in our study the third common problem the physicians encounter is communication Therefore, it would be appropriate to add medical communication and communicative abilities to the above-mentioned training subjects to be provided by a HEC.

The model HEC proposed in this study would develop ethical guidelines on end-of-life decisions, informing patients about poor prognosis and conflict with the relatives of unconscious patients' issues, according to the opinions of the physicians. The flow chart on end-of-life healthcare, which was developed by the General Medical Council in England, provides a good example. In this guideline designed for physicians, there are several topics such as respect for human life, the situation of adults who are able or unable to make decisions, the situation of child patients and the evaluation of competence in decision-making. In addition to written text, this guideline provides visual materials, videos and examples from different cases (33). A model HEC could design new flow charts and guidelines based on these examples, taking into consideration the particular requirements and conditions of the country involved.

Informing the patient about poor prognosis is a subject taught in medical school before graduation. At the HUHs, education on this subject is provided to third semester students as a part of a Good Medical Practices course under the topic of communicative abilities. However, the results of the survey indicate that more training on this topic is required after graduation. There are certain means of communication that have been developed to solve problems experienced while informing patients about end-of-life decisions (the 7 Step Pathway) (34). This approach enables the sharing of information and experience about these cases, allows for discussion of the solutions and support among fellow physicians during the training meetings that are organized by HECs.

Another issue physicians felt required guidelines was conflict with the relatives of unconscious patients. Conflict between relatives and healthcare professionals has reached a critical stage in Turkey and violence towards healthcare workers is increasingly common. The only regulation about making decisions in the name of incompetent patients is the 9th article of the Convention on Human Rights and Biomedicine (35). This article states that previously expressed wishes of the patient about medical intervention should be considered when making decisions about the patient's fitness for expressing wishes at the time of intervention. An appropriate guide, which would be prepared by the model HEC, should provide detailed information about these subjects. In addition to the guidelines, physicians should be trained about the decision-making process for unconscious patients, advanced directives and living wills.

If the most important duty of the HEC is to provide ethics consultation, then this should be delivered with a model suitable to the particular institution (trainer, consultant, pleader, arbitrator, etc.) (36). Ethics committees function more successfully when they can coexist with the parent institution for longer periods (37). Once the decision to provide an ethics consultation service is made, a pilot study could be conducted in the ICU. In this pilot study, joint studies could be conducted to monitor and observe the situation and to familiarize the personnel with the idea of ethics consultation. Constant evaluation of service outcomes and regular feedback is important for the quality of service (1).

While a single consultant model could also be applied if a sufficiently competent consultant is available, it would also be possible to provide consultancy services through a sub-committee working under the HEC or through the entire committee.

Currently, physicians who work in the HUHs try to solve the ethical problems they experience by themselves or by consulting with their superiors. Therefore, there is a need for an organization that can provide consultancy for the solution of ethical dilemmas. A model HEC should be developed based on observations on distinct requirements and experiences.

To provide an ethics consultation service, a HEC should be accepted by healthcare professionals and it should meet the needs of the specific demands of consultancy. The HUHs are educational and research components of the faculty of medicine. Therefore, the membership profile of the committee should be

designed to avoid the influence of the hierarchical structure.

Conclusion

The model HEC proposed for HUHs is that a core group of six members should be established in the first step with the primary function of training its members and healthcare professionals. This committee should then prepare ethical guidelines and contribute to the efforts for establishing institutional policies. After completing the process of development, the size of the committee should be expanded to reflect the opinion of all parties in the institution and eventually the committee should reach a stage where it is capable of planning ethics consultation.

Hacettepe University is the first public institution in Turkey to provide health care services in conformity with Joint Commission International (JCI) standards (19). In accordance with the requirements of JCI accreditation and under the leadership of medical ethics department and also this study, HEC establishment at HUHs has been initiated. Draft directive of HEC have been established by the contributions of Department of History of Medicine and Medical Ethics, Board of Health Care Units and Physician-in-Chiefs. The directive of HEC is awaited approval of the Hacettepe University Senate.

Limitations

Participation in this research was limited to the physicians of the HUHs; thus, the findings cannot be generalized to Turkey. Rather than sampling, researchers tried to reach at the entire cohort of physicians at the HUHs. However, only 25% of the physicians participated in the survey. After sending reminders via e-mails, the departments with very few rates of responds to the survey were determined. These departments were met and the permission for the physician associates to redistribute the survey in training hours was obtained. Despite all efforts, the total collected number of surveys remained at 250 due to time lag reasons of the clinician doctors working in our hospital and their reluctance to answer the survey questions. Therefore, this study might not be able to address all the requirements of physicians regarding HECs. HUHs which offer health care services to 1,000,000 outpatients and 50,000 inpatients, perform 35,000 surgeries approximately on an annual basis in addition to providing 24-hour emergency services, are tertiary hospitals and important for Turkey (19). Therefore, despite the low rate of participation, researchers think that the survey results are considered to be significant.

Authors' Contribution

This paper is the part of first author's PhD thesis. The second author is the mentor of the PhD thesis. Both of MD and NOB have equally made substantial contributions to conception, design, acquisition and interpretation of references; have been involved in drafting the manuscript and revising it critically for important intellectual content; and have given final approval of the version to be published. This research was supported by the Hacettepe University Scientific Research Unit (HUBAB 09 T05 101 001).

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