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CLINICAL ETHICS COMMITTEES: RELEVANCE AND NEED

Obstetrics & Gynaecology

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ABSTRACT

Background: A Clinical ethics committee (CEC) is established by a healthcare institution and assigned to consider, debate, study, take action on, or report ethical issues that arise in patient care. The objective of this study was to identify various ethical dilemmas faced in clinical practice, the perceived need for provision of CECs in our healthcare institutions, challenges faced therein, their structure and functions and to find ways to develop ethical competence among healthcare providers. **Methods:** A questionnaire-based study involving 45 participants comprising of clinicians from various specialities, ethicists and hospital administrators at a tertiary care, teaching hospital in Mumbai, India. **Results:** Key ethical issues dealt with revolved around patient autonomy, privacy, confidentiality and consent. There was a consensus that CECs are essential in our hospitals and should have multidisciplinary membership. The tripartite functions of CECs, namely case consultation, institutional policy review and development and ethics education were pointed out by our participants. Lack of financial and human resources, clinicians' reluctance to recognize ethical issues and seek ethics consultation, ignorance about CECs and their functions were identified as limitations to the functioning of CECs. Our results also highlight the need for dedicated ethics training programs for healthcare providers in India. **Conclusion:** CECs are helpful in facilitating moral deliberation and building consensus in the face of value conflict. There is need for further research addressing the real gaps and institutional challenges of CECs and evaluating the functions of CECs.

KEYWORDS

Clinical ethics committees, ethics consultation, hospital ethics committees.

INTRODUCTION:

Expansion of modern medicine and development of new techniques such as organ transplantation, assisted reproduction and advanced life support systems offer treatment opportunities but stimulate ethical debate about their application. There are perpetual concerns about the appropriate resource allocation in the face of inequalities in global healthcare distribution. With increasing recognition of patients' rights and their subjective experience of the healthcare journey, a there is a greater need to involve patients as partners in their own healthcare. Transparency and accountability and ethically sound clinical decision-making have become critical.

Clinical ethics support (CES) describes the provision of advice and support on ethical issues arising from clinical practice and patient care within a healthcare organisation. In the west, initially, models of CES focused on provision of advice to health professionals in hospitals, usually through a hospital ethics committee (HEC) or ethicists. More recently models of CES have developed to also include support for patients and their kin and to provide support across institutions, for example, area-wide ethics committees supporting primary and secondary care trusts [1]. The title “hospital ethics committee” is used interchangeably with “patient care advisory committee”, "healthcare ethics committee" and "clinical ethics committee" [2,3]. HECs still do not exist or have not been appropriately established in developing countries like India and few studies have been performed in this regard in these countries. Hence the need to conduct studies that can provide guidelines for the establishment and operation of HECs.

Aims And Objectives :

1. To identify ethical dilemmas in various clinical specialities & sub-specialities and how they are addressed in daily practice.
2. To investigate the perceived need for provision of Clinical Ethics Committee (CEC) /clinical ethics consultation services among ethicists, hospital administrators and clinicians.
3. To describe the envisaged structure and function of CECs and challenges in CEC functions according to ethicists, hospital administrators and clinicians.

METHODS:

A cross-sectional study was conducted at Seth GS Medical College & KEM Hospital, Mumbai, from December 2021 to July 2022.

Sample size: Participants comprising of clinicians from various clinical and para -clinical branches, key informants (administrators) and ethicists were included by purposive sampling. Validated questionnaire was sent through a link to a Google form by an email to individuals who met the inclusion criteria, out of whom 45 consented and answered the questionnaire. Responses to the questions were analysed for each category of respondent groups.

Inclusion Criteria:

1. Faculty members from departments of various clinical and para - clinical branches.
2. Administrative officers (Key informants) responsible for provision of resources
3. Ethicists

Data Collection And Statistical Analysis:

i. Questionnaire for consultants: Focus was on any prior training in clinical and research ethics, the ethical dilemmas in their clinical practice and how they tackled the same.
ii. Questionnaire for hospital administrators: Focussed on legal and social support requests from clinicians and clients regarding patient management and how they are dealt with; existing institutional guidelines and standard operative procedures for ethical issues, existing training programmes in ethics at their institute and need for training in clinical ethics. Consultants and administrators were asked about their perception of need for CECs and inclination to have CECs at their institution.
iii. Questionnaire for ethicists: included questions about their training, involvement in CECs, ethical problems referred to them from different specialities, the composition and nature of functioning of CECs and challenges faced by them. Ethicists' suggestions for establishment and effective functioning of CECs in our healthcare setting were sought along with desirable inclusive composition and training.

While analysing opinions and perceptions, commonly used terminologies were picked up and their frequency noted. Participants were asked to record their responses to some questions using a 5- point Likert-scale.

RESULTS

Sample size was meant to be 66. 66 questionnaires were sent, out of which 45 responses were obtained. This included responses from 5 ethicists,4 administrators (key informants) and 36 consultants.

Ethicists'-responses:

Experience of the 5 ethicists ranged from 10 to 30 years. One ethicist with formal training in Medical Law and Ethics and Bioethics and others with experience as members of ethics committees, short courses and interaction with peers and seniors.

According to them training in the following forms and domains is required to gain expertise as an ethicist :

- Part-time or full-time training in Bioethics, Research Ethics or Ethics and Law
- Intensive training of a week or more, depending on one's background and knowledge.
- Case discussions using an ethics lens or case-based projects.
- Experiential training in ethics committees

4 ethicists were in favour of certificate course in medical ethics with end of course assessment.

According to ethicists, for appointment to a CEC, members should meet following criteria:
- No conflict of interest,
- demonstrated interest
- experience in clinical ethics consultation and training ,
- adequate research experience.
- Commitment to independence and autonomy of CEC.

Frequency of meetings: Two ethicists suggested it should be at least 4 times a year and one suggested it should be monthly. In addition, one ethicist laid stress that CEC should be able to meet at short notice, for issues demanding urgent consultation.

Monthly, as suggested by all consultants as well as key informants . 2 CECs meeting fortnightly for large institutes as suggested additionally by 1 consultant.

An ethicist suggested that if there are no cases, the meetings should be used for training, discussion of other difficult cases and creation of policy based on emerging needs, accreditation standards or legislation. Only half of the key informants opined that a CEC should also be available to resolve ethical issues arising in patient care due to systemic institutional deficiencies.

Remuneration:
- Sitting fees fixed in consultation with HR of the institute and considering faculty expectations.
- It is voluntary work but must be adjusted in the workload of the individuals at the institution and should reimburse cost of participation (travel, food etc) and provide modest honorarium or sitting allowance.
- Key informants and consultants were of the opinion that remuneration is not required for hospital employees. Travelling allowance and dearness allowance for external members.

Support: The institution should provide secretarial and legal support.

Funds allotment: 4 ethicists suggested separate institutional budget for its Clinical/Research ethics committees - on the basis of the workload, number of meetings and the cost of functioning secretariat.

1 ethicist suggested funding solely from processing fees charged by the CEC.

Key informants as well as most clinicians suggested that the funding should be institutional, from processing fees of cases.

Training responsibility- suggestions of ethicists:
- Members may be sent for specific training such as conflict resolution, end of life and palliation seminars where available with the institution funding it.
- Training by experts in bioethics and clinical ethics.
- The Chair and secretary should have responsibility to organise training of members of the CEC with the institution funding it.
- In addition the CEC should conduct ethics training of clinical staff at different levels on regular basis and promote regular ethics grand rounds to discuss clinical ethics cases.

As per consultants and key informants, training should be done by ethicists, institutional senior faculty trained in ethics.

Functions:
- Review of cases brought to the committee, conflict resolution, advocacy for better care protocols, ethics training of staff, capacity building of members.
- In the absence of legal mandate, the committee will have consultative function on cases of clinical ethics challenges/ dilemmas.
- It may have more prominent and definitive function in devising the clinical ethics policies of the institution if the institution authorises it.
- Training and sensitization of staff and students.

All the ethicists agreed that proceedings of a CEC should be recorded in detail and all healthcare providers (HCPs) should undergo routine clinical & research ethics training.

Limitations to the functioning of CECs:
- Lack of training, conflict of interest, pressure from colleagues or management.
- Lack of awareness among HCPs regarding ethical issues in their work and lack of perceived need for ethics consultation, unwillingness to implement CEC's advice.
- Lack of institutional responsiveness to CEC recommended policies.
- Lack of institutional funding and infrastructural support.
- No punitive powers to CEC.

Indemnity:
- Two ethicists felt that there should be legal indemnity for CEC members , 2 opined that such indemnity is not really required. 1 ethicist pointed out that since the CEC acts on behalf of the hospital, the hospital needs to be indemnified.

Most common ethical issues dealt with by CECs:
- Withdrawal of life support
- patients or caretakers insisting on/refusal of certain treatment
- patients' inability to meet expenses once treatment is started
- violation of patient's privacy
- perceived bad/rude behaviour of healthcare staff
- inter-departmental conflicts
- fraudulent activities in the institution
- excessive hospital charges, corruption
- harassment from seniors
- Research ethics issues

Current practice of communication of CEC with the stakeholders :
- Social worker, counsellor talk to patient. Chairperson talks to management.
- Direct conversation with them as a committee or by some CEC members.
- Written communication.

Challenges in the work of CEC in a government-run/public/teaching hospital:
- Large number of cases brought to the CEC.
- Less awareness about the role of CEC in such hospitals.
- Bureaucratic and political interference.
- Hierarchy
- Confusion between ethics & law.
- Financial and time constraints.
- Institutional apathy.

Challenges in the work of CECs in a private hospital:
- Interference of the administration, investors/trustees.
- Lack of transparency , confusion between ethics & law
- Reliability of the members on the CEC.

Conflict of interest of CEC members is a challenge in both scenarios.

Key informants-responses:
4 key informants responded to the questionnaire.
As administrators, following requests regarding patient management had been received:
- priority of surgery, or early discharge
- non-indicated treatment/procedure
- requests that limit resource availability for other patients

3 key informants said that there was a Transplant Co-ordination Committee in their institute and 2 of them were unaware of its composition. One of them was not sure but guessed the coordinator was the Director of the Regional cum State Organ and Tissue Transplant Organisation.

On being asked if their institute had any guidelines for organ and tissue retrieval for transplant, the responses obtained were as shown in table 1.

Table 1: Guidelines For Organ And Tissue Retrieval For Transplant In The Institute.

Guidelines / Practice	Yes N (%)	No N (%)	Don't know N (%)
National guidelines for organ and tissue retrieval	3 (75)	0	1 (25)
Guidelines for unclaimed body/ fetus disposal	2 (50)	0	2 (50)
Guidelines for research use of unclaimed body/ fetus	2 (50)	2 (50)	0
SOPs / Guidelines for DNR	0	2 (50)	2 (50)
Institutional initiatives for postgraduate students' sensitization about ethics	2 (50)	1 (25)	1 (25)
structured programs at their institute imparted undergraduate training in bioethical principles	4 (100)	0	0

All the key informants replied that following are structured programs imparted at their institute:
- Bioethical principles
- Patients' rights
- Documentation
- Organ donation
- Research ethics
- Common ethical issues in clinical practice.

Consultants-responses:

36 consultants responded to the questionnaire. 15 (41.7%) of them had more than 10 years of clinical experience (senior consultants) and 21 (58.3%) were junior consultants.

22 (61.1%) consultants were from surgical specialities and super specialities, 1 each (2.7%) from anesthesia and forensic medicine & toxicology , 9 (25%) belonged to a medical specialities and super specialities, 3 (8.3%) were from paraclinical and laboratory medicine. 23 (63.9%) consultants had received training in clinical ethics and 27 (75%) in research ethics.

Consultants were asked at what stage of their career did they receive training in ethics,for which responses were obtained as depicted in table 2.

Table 2: Stage At Which Ethics Training Was Received By Consultants.

Stage	Training in clinical ethics N (%)	Training in research ethics N (%)
Undergraduate studies	1 (2.8%)	2 (5.5%)
Postgraduate studies	9 (25%)	12 (33.3%)
After postgraduation	2 (5.5%)	5 (13.9%)
In service	11 (30.5%)	8 (22.2%)

Other ethics-related training was received by 12 (33.3%) consultants. Out of them, 10 had received training after postgraduate studies.

11 of these consultants found it relevant for the following reasons:
- etter awareness regarding different facets of ethics including research.
- Knowing the rights of patients and importance of patients' autonomy better.
- Improved communication with patients and
- Understanding approach to ethical dilemma and consequences of clinical complications.
- Changed approach towards any clinical question on how it can be supported by research evidence.

21(58.3%) consultants were of the opinion that ethics issues differ in the various specialities in tertiary care institutes. Following examples were cited by them:
- Medical branches: Decisions regarding terminally ill patients, withdrawal of life support, etc
- Neurology: Need for video recording consent.
- Pathology: postmortem. Respect for dead bodies. Rights or access to tissues.
- Surgery: Operating on an unknown and unaccompanied patient, in emergency.
- paraclinical branches: Different perspective of clinician and supporting branches.
- Obstetricians: Maternal safety considerations vis-a-vis fetal life, confidentiality of patients for eg: cases of sexual assault, teenage pregnancy, STIs., consent of minors, unwed mothers, counselling, indication and time of termination of pregnancy vis-a vis rights of the unborn, adoption, surrogacy, decision between expectant management, medical, surgical or radical treatment in Gynaecology.
- Distributive justice in face of shortages.
- Privileged communication and patient autonomy.
- Anaesthesia: Unavailability of ICU postoperatively.
- Research: Intervention and surgical trials have different ethics than drug studies.

13 consultants opined that there are special or different ethical issues in their practice,16 consultants did not think so and 7 consultants chose to rather not comment on the same.

8 (22.2%) consultants said that there were guidelines published by professional bodies in their branch of medicine on ethics issues,6 (16.7%) consultants said that there weren't such guidelines and 22 (61.1%) consultants were unaware of the same.

Consultants were aware of the following guidelines dealing with clinical ethics:
- Related to organ retrieval and donation, euthanasia, Jehovah's witnesses for surgery.
- Perinatal viability, neonatal resuscitation in extremely premature babies.
- Reproductive rights of women.
- General code of conduct by the World Confederation of Physiotherapy and the Indian Association of Physiotherapists.

Following ethical dilemmas had been faced in practice by the consultants and their colleagues:
- viability and neonatal resuscitation at extreme prematurity and treatment towards end of life
- Not having the best therapeutic option/ or requested modality due to resource limitations
- Decision regarding surgery in a high risk patient or unoptimised patient.
- Certain treatment options not offered to patient due to doctor's personal preference
- Patients having less chances of survival and entirely ventilator-dependent bring forth the question of euthanasia
- Refusal of treatment by patient/family due to lack of finances or poor comprehension of the illness.
- Use of scarce resources like blood on patients who have little chance of survival
- Disclosure of own/ own unit's /colleague's management error.
- Triage in scarce resources
- Decision to continue versus step-down or even discontinue treatment in moribund patients with poor chance of survival.
- Disclosure of privileged communication.
- Ethical dilemmas related to organ donation.
- Liability of cases operated by other units
- Multidisciplinary decision-making and management optimisation with conflicting opinions.
- Intraoperative consent in due to unexpected/ new intraoperative findings
- Discharge against medical advice.
- Radiological investigation asked by clinician but not indicated according to radiologist.
- Relatives requesting not to reveal bad news such as intrauterine foetal demise to a patient.

The consultants said that they try to resolve such ethical issues by shared decision making with patients, discussion with seniors and by joint counselling of patient and family with colleagues 0from other specialities involved in a case.

Sources of information, advice, counsel on ethical dilemmas in clinical practice: Majority of the consultants- 28 (77.8%) consulted their seniors and 25 (69.4%) followed guidelines issued by authoritative agencies. 18 (50%) consultants referred to published material/ YouTube videos/ podcasts/other sites on the internet.

7 (19.4%) consultants sought advice from their colleagues and 3 (8.3%) consulted ethicists.1 (2.8%) consultant believed that communication with patients itself is a key to resolve such dilemmas. 10 (27.8%) believed that nursing members should also be involved in decision -making in such cases.

Following ethical mishaps had been witnessed by the consultants:
- Withholding or misrepresenting information in violation of patient's right to make informed choices in their healthcare.
- Poor documentation of patient's condition, responses or other information leading to complications during treatment.
- COVID inappropriate behaviour putting colleagues and patients at risk.
- Surgery without consent or on the wrong side.
- Insensitive way of explanation of complications, breaking bad news leading to misunderstanding and dispute.
- Intrusion of patient autonomy, especially in elderly and women.

Following responses (Table 3) were obtained from the key informants and consultants when they were asked about the consequences of ethical mishaps noted by them.

Table 3: Consequences Of Ethical Mishaps Noted By Respondents.

Responses	Key informants N (%)	Consultants N (%)
Dissatisfaction of patients / patients' or family's distress / loss	2 (50)	17 (47.2)
Moral distress experienced by health care providers	2 (50)	26 (72.2)
Bad reputation to the institute	1 (25)	12 (33.3)
Legal issues	1 (25)	13 (36.1)
I would rather not comment	2 (50)	5 (13.8)

One consultant said that it leaves the healthcare providing team, administration and nursing staff with an "unclear state of mind" for want of guidelines, reviews/ audits of such mishaps; and suggested that such cases be referred to for training staff in dealing with ethical issues.

24 consultants agreed that ethical or medical mishaps should be disclosed to the affected patients and their families.4 consultants said that they need not be disclosed and 8 consultants chose to not comment.

20 consultants knew of an existing CEC and 16 did not.

All consultants agreed that if the institute they work at were to have a CEC, they would consult the CEC.

Following responses were obtained when participants were asked their suggestions regarding the composition and chairperson of an ideal CEC (Table 4).

Table 4: Suggested Composition And Chairperson Of An Ideal CEC.

Member	Ethicists' suggestions N (%)	Key informants' suggestions N (%)	Consultants' suggestions N (%)
Physicians	4 (80%)	4 (100%)	36 (100%)
Nursing staff	3 (60%)	2 (50%)	34 (94.4%)
Social worker	4 (80%)	3 (75%)	30 (83.3%)
Religious leaders (chaplains)	2 (40%)	0	7 (19.4%)
Hospital administrators	3 (60%)	3 (75%)	32 (88.9%)
Ethicist as well as Legal expert	4 (80%)	3 (75%)	Ethicist :28 (77.8%) Legal expert: 34 (94.4%)
Lay person from community	3 (60%)	3 (75%)	20 (55.5%)
Social scientist	1 (20%)	0	0
Patients' rights group representatives; public health expert	1 (20%)	0	0
Surgeon and Anesthetist/ Experts from various specialities	1 (20%)	4(100%)	2 (5.5%)
Chairperson of a CEC:			
Chairperson	**key informants' suggestions N (%)**	**Chairperson**	**consultants' suggestions N (%)**
Physician	2 (50%)	Physician	22 (61.1%)
Dean	1 (25%)	Dean	1 (2.8%)
Surgeon	1 (25%)	Member with experience of working in CEC	1 (2.8%)
External member	1 (25%)	External member	5 (13.9%)
		Any person elected by majority of the committee members	7 (19.4%)
Ethicists' unanimous agreement was that chairperson of a CEC should be a clinician (physician/surgeon) or an administrator.			

The consensus was that a CEC should have members from diverse backgrounds in terms of gender, caste and religion.

80% of the ethicists, 75% of key informants and 72.2% of consultants in our study considered that the most important function of CECs would be ensuring ethical practices by all members of the hospital teams.

All the ethicists, 75% of key informants and 66.67% of consultants opined that resolving ethical dilemmas is the most important function. 20% ethicists, 25% key informants and 41.67% consultants felt that helping manage legal cases filed against hospital and staff is the most important function.

There was a consensus among all respondents that a CEC as a responsible body for holding discussions on and settling ethical dilemmas as well as appropriately detecting and penalising unethical practice in every institute is much necessary.

DISCUSSION

A clinical ethics committee is characterized as a body of persons established by a hospital or health care institution and assigned to consider, debate, study, take action on, or report on ethical issues that arise in patient care [1]. Over time, HECs have moved toward democratic processes of discussion by which ethical processes are advocated with the consideration of the benefit of patients, their families and healthcare team members [4]. HECs have made considerable progress, being first established in the USA and European nations in the 1970s and 1980s respectively [5] and are now well established in many other countries [6,7].

Core Competencies For CECs:

In contrast to research ethics committees, there is neither formal legal or regulatory governance framework for many CECs, nor specification of core competencies for their members [8].

Though CEC members may acquire skills by exposure to conflict cases and ethical dilemmas, it is believed that training is necessary to acquire basic competencies [9].

Some ways to gain skills are self-directed and group-directed learning within the committee such as training workshops; ethics conferences, grand rounds, short courses, modular education programmes and degree programmes which provide advanced skills and knowledge [9,10]. Similar suggestions were obtained from our ethicist participants.

Composition Of CECs:

CECs in the UK generally comprise of 6 to 26 members. Size and composition of CECs depends on their intended functions. Acute review of cases may be accomplished by small groups [10], but for more complex issues a larger membership may be desirable. The chairperson is elected by members of the CEC and majority of CECs have a clinician as chair, facilitating access by clinicians to the committee. Committees meet on average once a month for one to two hours [11].

Wider inclusion of disciplines in the CEC helps a holistic examination of a patient's or their family's ethically complex issues [12].

Membership of CECs in UK NHS trusts usually includes doctors, nurses, other healthcare professionals e.g. dieticians, speech therapists, lay members, lawyer, a religious leader, a user of the service, an ethicist or philosopher. In our study, in addition to the above, some participants suggested inclusion of hospital administrators, a social scientist, patients' rights group representatives and public health expert. Diversity in members' culture, skills, experiences and knowledge inspires debates to obtain new information and consider alternative ideas, which is as a prerequisite to culturally safe and ethically sound discussions [13]. CEC members should be inclined to learn about clinical ethics, receptive to various ideas and able to deal with emotionally charged topics and interpersonal disagreements [14]. Some members should be recruited from outside the institution,to avoid parochialism [15].

Institutional Position Of CECs:

In the UK, CECs have supportive, educational and consultative functions that are advisory rather than prescriptive or quasi judicial [15]. They are more concerned with values rather than their compatibility with the law [16]. There is no obligation to request clinical ethics consultation by a CEC or to follow its recommendations,but evidence suggests that those who seek advice would be likely to take it.This contrasts with the 'top-down' approach to ethics consultations and CECs in the USA that has been driven by court recommendations and hospital accreditation requirements [17,18].

Functions Of Existing CECs

i) Contribution to the generation of guidelines for ethical practice [19,20] :

- Development of local ethical guidelines compatible with national or professional guidance.These are ratified by institutional clinicians and administrators.
- Providing an ethical input to policies and procedures developed by other groups within the organization.
- Guidelines and policy issues addressed by CECs include: Do not resuscitate (DNR) guidelines, consent policy, advance directives, rights and duties of relatives, confidentiality, withholding and withdrawing of treatment, guidelines relating to HIV, policy for dealing with the media, commercial use of tissue, use of restraints, elective ventilation.

ii) Facilitating education in ethics for healthcare professionals [17,21] :

- Providing healthcare professionals with the formal competencies to make ethically difficult decisions.
- Educational initiatives by CECs include grand rounds, seminars ,workshops, educational document on consent,ethics newsletters, inclusion of ethics in postgraduate seminar programme, biannual study days in ethics on diverse topics. Similar activities were suggested by our ethicist participants.

iii) Multidisciplinary, confidential analysis and discussion of cases and topics :

Case discussion, analysis and the provision of an ethical opinion as to the right course of action. CECs receive requests for ethical review either in a resolved case (retrospective analysis) or current cases before critical decisions (prospective analysis or acute cases). The process helps to resolve disputes within disciplines and separate ethical from technical or scientific issues. It is argued that the prospective approach may- fail to respect the autonomy of clinicians; erode doctor-patient relationships; increase inter-professional dissent, and reduce time available for patient care [22]. Rarely, urgent cases may require rapid response [23].

iv) If research ethics committees (RECs) and HECs, both share members, reflective and analytical research into the cases may help to integrate scientific arguments and conclusions into policy making [24].

Complex ethical dilemmas faced by the consultants in their practice included issues such as consent, withdrawal/withholding treatment, patient/family refusal of treatment, resource allocation/access to care, palliative care, assisted dying, cultural and religious affiliations and preferences, disclosure of patient information, decision-making for incompetent patients, innovative treatment, protection of staff, error disclosure, interdepartmental disagreement, organisational ethics; which are similar to issues pointed out by the clinicians in other studies and formed the basis of ethics consultation requests [15,17,21].

In all three groups the largest number of respondents felt that the most critical CEC functions were ensuring ethical practices by all members of the hospital teams and addressing ethical dilemmas . A small number thought that CECs should help manage legal cases filed against hospital and staff.

Limitations To The Functioning Of CECs:

Lack of financial and trained human resources, reluctance of clinicians to recognize ethical issues and consult CECs were pointed out by the participants. The ignorance of some participants about a CEC and its functions, as well as the mistaken idea of their role and overshadowing of CECs by RECs due to greater awareness and interest in the latter as evidenced by participants' responses could be additional limitations to development of CECs. Similar limitations have been identified in studies from the UK [21], Canada [25], Africa [26] and Brazil [27].

LIMITATIONS:

This study was carried out in a local context with a small sample size. Therefore, the results cannot be generalized to a national stage.

CONCLUSION

Healthcare professionals are witnessing a rising trend of ethically sensitive and complex situations.Public sector consultants have divergent ethics issues, hence the public sector institutions should consider development of clinical ethics consultation services.

Our results also highlight that all HCPs should have a strong grounding in ethics during their undergraduate training. Postgraduate training and continuing education should regularly include ethics in their programmes. Also, there is a need for ethics training programs to incorporate multidisciplinary perspectives into their curricula. Finally, it is desirable that there be common understanding of the role and composition of such committees and opportunity to share expertise and experience gained in their work.

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