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# EXAMINING ETHICS IN PRACTICE: HEALTH SERVICE PROFESSIONALS' EVALUATIONS OF IN-HOSPITAL ETHICS SEMINARS

*Priscilla Alderson, Bobbie Farsides and Clare Williams*

**Key words:** genetics; haematology; neonatal; prenatal; screening; teaching ethics

This article reviews practitioners' evaluations of in-hospital ethics seminars. A qualitative study included 11 innovative in-hospital ethics seminars, preceded and followed by interviews with most participants. The settings were obstetric, neonatal and haematology units in a teaching hospital and a district general hospital in England. Fifty-six health service staff in obstetric, neonatal, haematology, and related community and management services participated; 12 attended two seminars, giving a total of 68 attendances and 59 follow-up evaluation interviews. The 11 seminars facilitated by an ethicist addressed the key local concerns of staff about the social and ethical consequences of advances in genetics and their impact on professional policies and practice. Seminar agendas were drawn from prior interviews with 70 staff members.

During evaluation interviews, participants commented on general aspects that they had enjoyed, how the sessions could be improved, timing, the mix of participants, the quality of the facilitation, whether sessions should be more challenging, after-effects of sessions, and interest in attending seminars and contacting the ethicist in future. Participants valued the increased interprofessional understanding and coherent discussion of many pressing issues that addressed important though seldom discussed ethical questions. The seminars worked well in the different hospitals and specialities.

## Introduction

Despite the considerable recent increase in health care professionals' knowledge of ethics, there are still gaps between the general and sometimes abstracted knowledge taught in ethics courses and individuals' often isolated attempts to apply the knowledge in their daily work. Most articles concerned with talking about medical ethics with health care staff and students are about teaching

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undergraduates. One exception is a reported course for neonatal practitioners that used realistic cases to help them to bridge gaps between theory and practice.<sup>1</sup> Various reports advise addressing issues that are directly relevant to students,<sup>2</sup> using narrative instead of 'thin' case studies,<sup>3</sup> reflecting critically on power and the political context,<sup>4</sup> working in small groups on problem-based learning,<sup>5</sup> and making closer explicit links between ethics and empirical experience.<sup>6,7</sup> We partly followed these ideas, as described later, but we aimed to move beyond teaching. Instead we initiated practical debates based on practitioners' own experiences, concerns and knowledge, with encouraging guidance by an ethicist.

Another extensive area of the ethics literature concerns the mainly North American models of resident hospital ethicists and clinical ethics committees that advise on specific cases or promote awareness of ethics among staff.<sup>8</sup> These have been adopted or adapted in a few centres in the UK. In one hospital, senior staff introduced a forum for teaching and consulting about ethical problems, developing ethical guidelines, and providing space for ethical reflection outside the acute clinical setting.<sup>9</sup> In contrast, our project involved an 'outsider' ethicist and two research sociologists who visited the hospital to initiate ethics discussions. Our aim was to raise and explore themes illustrated by the practitioners' own experience and examples, but not to discuss specific cases in detail in order to make conclusions about the best course of action to adopt.

Our exploratory ethics seminars aimed to bridge gaps between ethics knowledge and its practical application in three ways by bringing ethics geographically into hospital units, collectively into interdisciplinary team discussions, and substantively into practitioners' daily concerns. The aims of the seminars, as we informed the attenders, were to pilot with health care staff a practical discussion forum, promote interdisciplinary understanding about ethical dilemmas through academically sound and practice-based seminars, and contribute further data to our research about the views of health care staff on genetics and ethics.

We have reported elsewhere the methods used and the topics addressed during the seminar discussions on dilemmas<sup>10</sup> and 'drawing the line' in prenatal screening and testing,<sup>11</sup> on the ambiguous status of the fetus,<sup>12</sup> on contradictions within the aim to give nondirective counselling,<sup>13</sup> and on providing just and equitable services (P Alderson, B Farsides, C Williams, unpublished observations, 2002). This article reports the evaluations of the attenders on how ethics seminars can assist in-hospital discussions about the social and ethical consequences of advances in genetics on health care services. We consider here the range of their responses about the value of the seminars and their reported preferences, to inform readers who may be interested in convening similar groups.

## Methods

The research project that included the seminars was conducted in an inner city teaching hospital and an outer city district general hospital. Research ethics committees approved the research. The disciplines of ethics and sociology complemented one another. The ethicist (BF) ensured that principles and values were at the centre of the discussions, and encouraged attenders to debate critically, to question and probe one another's comments, to examine the logic and structures

underlying common arguments, and to reach 'the deep structure of bioethics'.<sup>14</sup> The discussions were informed by themes from prior in-depth sociological interviews with most of the attenders. Seventy in-depth interviews were held with staff in prenatal, neonatal and haematology departments and in related clinical, scientific, management and community services (by PA and CW). Fifty-six staff members, mainly former interviewees, later took part in the ethics seminars; 12 unexpectedly asked to attend twice, giving a total of 68 attendances. Of 78 people invited, six declined (mainly clergy and GPs), 13 accepted but were not free during the times offered, and three staff members had left the hospital; 23 of 24 invited people attended in the second hospital. We had considered including patients as interviewees and group attenders, but then decided not to do so, partly for time and budget constraints, and partly because we wanted to pilot the seminars with practitioners feeling that they had a 'safe space' to talk freely.

The ethicist, whose basis lay in political philosophy, but who admitted much interest in empirical and social science research, became immersed in the practitioners' own complicated personal and political concerns through reading transcripts of their individual interviews, and by addressing the issues and examples they provided. For example, she opened one seminar by commending the hospital's prenatal screening programme as egalitarian because it was offered to all the women who attended, not to those in certain higher age groups only. The ensuing discussions on equitable universal services and on prenatal screening gradually became more critically reflective about certain integral limitations, difficulties and uncertainties.

New topics were introduced as they grew out of the discussion, or were brought in by the ethicist as a new theme. Her years of experience in teaching masters-level medical ethics courses to multidisciplinary, cross-hierarchy groups of health care practitioners, policy makers, lawyers and people in other related disciplines, were valuable during the seminars, for example, in maintaining a fairly informal and encouraging, yet also challenging, level of discussion. Jargon was avoided. Everyone was invited to join in and to contribute and accept critical debate, but no one was pressed to speak; two (administrative) attenders remained silent, saying afterwards that they had preferred to do so (see later section on 'guided inclusive discussion').

Besides drawing on the sociological data, the seminars provided further useful data on practitioners' shared or contested understandings and values. Before the seminars, the 70 interview transcripts were analysed by content for emergent themes, which were then coded.<sup>15,16</sup> The research team met regularly to check and discuss the data, combining descriptive sociological with normative ethical perspectives when examining, for example, theories about risk, gender and also justice, to enrich and validate the analysis. This article is based on verbatim notes of 59 follow-up evaluations of the seminars, in interviews (conducted by CW) lasting from 5 to 60 minutes (average approximately 20 minutes); some were face-to-face, although most were conducted by telephone. The evaluations were coded by themes based on the interview questions and subthemes that emerged from them when introduced by the attenders.

The participants were given information sheets about the project and about their seminar, which listed: participants' names, disciplines and post; and the aims and agenda of the seminar. The ethicist aimed to encourage and respect everyone

equally, whatever their discipline or grade. Part of this respect included: giving them all a note about confidentiality, asking them not to repeat names outside the meeting; a request that we could tape-record the session; an assurance that names and identifying details would be removed from transcripts and that they could also request that any of their comments should be deleted; a request that participants would take part in a later evaluation; and the researchers' contact details (see later sections for practitioners' views on this, including the section on 'Trust').

The participants included senior and middle managers (many were currently or formerly midwives and included clinical audit managers), obstetricians, paediatricians, neonatologists, haematologists, midwives, neonatal nurses, health visitors, genetic counsellors, psychologists, scientists, chaplains, legal and research ethics committee staff, and midwifery lecturers. To respect anonymity in this article, participants will be given broad titles; 'obstetrician', for example, includes consultants, registrars, research fellows and specialists in fetal medicine.

Much time and many phone calls were needed by the seminar convenor (CW), to confirm dates and give reminders the day before. Several people attended in their free (unpaid) time. About one-third of the attenders were of African or Asian heritage; the white attenders included people from a range of European countries. Some people made international comparisons about health services; some mentioned varying cultural beliefs, and the advantages and complications of treating patients from a similar background to their own (Irish, Catholic, for example). The attenders included people from a wide range of faiths, and their discussions on religion and genetics will be the topic of a future article.

When setting up the seminars, senior staff were easier to contact than junior staff (they have offices, secretaries and formal diaries). When senior staff were interested, it was easier to interest also their junior staff. Some junior staff could hardly find time to discuss whether to join the project. It seemed easiest for out-patient staff to find time to attend. Meetings began at 9.00 a.m., around midday, or at 5.30 p.m., to suit participants' diaries. Snacks and hot drinks were provided and everyone sat round a coffee table on the most comfortable chairs available.

## Participants' views of the seminars

The next sections report participants' follow-up views generally, and specifically on the length of sessions, the mix of people included, quality of the facilitation, whether the session could have been more challenging, whether individuals had reflected on the discussions since the meeting, and if they would like to contact the ethicist or attend regular groups in future. A few participants were not contactable afterwards, so we do not know if these people were critical and dissatisfied with the session.

### General aspects

The participants generally reported interest and enjoyment. 'A good sized group, everyone felt they could take part.' 'Good to know other people's views and what they do.' 'I loved it, it was fantastic to be able to debate the issues about screening and I'd love to attend another group.' 'The best thing I did all week' (senior

manager). 'I think everyone found it enjoyable and pleasant and the ethicist was like a neutral party.'

Many people enjoyed the intellectual challenge. 'I don't think I've ever had a discussion like that.' A few administrative staff tended to speak less but said they liked feeling in touch with clinical practice: 'It was fascinating, valuable, really worth while.' Two obstetricians were critical: '[Ethics is] frustrating, going round in circles with no fixed points, or conclusions.' Two general points especially mentioned were reflection and support.

### *Opportunities to reflect*

Participants valued having time to learn from one another and reflect together. 'It's rare to have the chance to sit and contemplate and seriously discuss issues and hear about other people's thoughts; I don't usually have time.' 'It was nice to chill out and contemplate things.' 'I hadn't realized how the fetal medicine unit differed so much from the antenatal clinic, in allowing women very free choice [about terminations]. It is clearer to me now, very interesting.'

I think the pace of advances in genetics is so fast and there are a whole range of ethical issues we're trying to deal with . . . The ways in which changes in therapies juxtapose with how families are counselled. In groups like that the wider ethical issues could be pointed out. Often genetics focuses on reproductive issues and sometimes misses areas like ours. We're getting a lot of enquiries from families about PIGD [preimplantation genetic diagnosis of embryos] . . . They're pressing issues, but it would also be useful to discuss . . . NHS [National Health Service] changes in clinical governance [and] maintaining standards (haematologist).

An obstetrician saw the seminar as an opportunity to remember 'strict' general principles that may be forgotten during rushed case-by-case practice.

They're issues we all deal with all the time, but we don't discuss them, partly because we think we can't. But this provides time to formulate what you think. It was extremely helpful to me personally to order my thoughts. That helps you to be clearer to patients (obstetrician).

Some participants reconsidered plans and systems that had not been thoroughly thought through.

I think it will change my practice. Very important . . . I always just thought it was a good thing to screen, and a disservice if you don't screen. But things we did in the past as routine we're now finding out [have] problems attached and we're more cautious. The group was excellent in provoking thought. Even though you perhaps can't change things, it makes you more aware (midwife).

Others found time to look ahead and speculate on potential future ethical questions.

As we find more diseases, how will people react? Who is advising the government? The HTA reports [*Health Technology Assessment*, NHS R&D HTA Programme, available at: <http://www.nchta.org>] are very technical; cost analysis seems to be the main issue, and I think the reports are deliberately hard to read. We've got to draw the line somewhere on what we test for, when it is very anxiety making but it doesn't matter or affect the person, otherwise the service will come to a halt (genetic counsellor).

Some senior staff had been students before undergraduate ethics courses were introduced. Several said they were pleasantly surprised by the session.

I'd never really understood about medical ethics; it's made me think I'd like to do an ethics course. It was useful to talk about why we screen for Down's syndrome. The trouble is we're very reactive; we're always running from day to day and we don't reflect; we're just firefighting here and if we talk it is at a very superficial level, so it is really good to sit back and reflect. The rate of TOPs [termination of pregnancy] is very high here; are people terminating for sex? These are very fundamental questions and need broader discussion but this is a start (senior manager).

I was gob-smacked by some of the philosophy, about the different schools of thought. It would have been so interesting to learn more about it. I'm trying to draft an antenatal screening leaflet but now I'm not sure we should be doing it all [laughs]. I really welcomed the chance to reflect (haematologist).

### *Support*

Despite discussion of troubling issues, participants generally found the seminars supportive. 'At times it seemed like a therapeutic group.' 'It was helpful to talk about demarcation and drawing the line when people have to make these terrible decisions.' 'I liked the reassurance of hearing that other people worried about the same issues, and how broad and varying the range of good practice could be, such as on nondirective counselling.' 'Lots of things people said made me feel happier about what I do.' A midwife commented: 'The ambiance was good. I liked the way you welcomed everyone personally and had hot drinks and food, it was done in a leisurely way, around a coffee table. I didn't feel pressured at all.'

An obstetrician implied a sense of being offered a safe supportive forum to air distressing issues:

Sometimes there are things that you don't want to admit that you are having a tricky time with. It's reassuring to know that other people are as uncertain as you are . . . The more you go on doing this the less strict you are, and the more you see every situation as individual . . . We discussed issues which I often try and suppress and it was quite cathartic . . . Normally you just get on and do the job and . . . try not to think about it too much and you're not encouraged to . . . There are so many areas with ethical issues on obs and gynae, fertility issues, and as a junior if you asked questions you were just told 'that's what we're doing'. I think people don't want to discuss them, because the issues can be distressing (obstetrician).

### **Timing**

After the first three groups, the period was extended from 90 minutes to two hours, which worked well. 'I thoroughly enjoyed the afternoon, there was enough time for real discussion. Two hours just flashed by. I think we could have gone on for longer.' 'I'd have liked more time [than 90 minutes]. We were just getting into it when we finished, you need to pussy foot around, begin to feel comfortable and that takes 20 minutes.' 'It wasn't long enough, I felt I was just getting into this new way of thinking and talking, when we had to stop.' A few people said two hours was too long. 'I am so busy. My mind began to wander, we could have done with a break in the middle, and having more people would have been jollier [there were only four participants] but yes I would like to attend these groups one- to three-monthly.'

## Mix of participants

The cross-disciplinary interdepartmental mix was liked by most participants. Members in the one single-specialty group were keen to join a mixed group, hoping for 'less consensus and more challenge'. Some people met colleagues for the first time. Some liked gaining an overview of continuing interdepartmental care, such as 'how women are supported before, during and after TOP by different people'.

Sometimes the mix seemed too broad. A neonatal sister wanted more discussion about the baby's interests during a complicated labour. A few people said too much of the multidisciplinary discussion was irrelevant to them: 'My time is too short.' Conversely, another said:

I felt ignorant and I didn't like to speak on some topics or to ask what the strange terms they used meant, but it was never boring or irrelevant. I didn't speak much but when Bobbie summed up at the end I was there, I felt part of it.

### *Learning from other disciplines*

Participants became more aware of differences between their views and the services they offered. 'People brought in new issues I've never thought about, so it was much more interesting.' '[You had] interesting clashes of viewpoints.' 'Good to hear the diversity.' A haematologist noted the frequently discussed contrast between geneticists offering choice and other clinicians recommending best treatment: 'The neonatal team have to think about best care, whereas in genetics the ethical goal is more informed choice, when you don't impose your view.'

### *Mixing across hierarchies*

Bringing senior and junior staff together had disadvantages. Some people felt awkward when their manager was present: 'I would think about the safety of my job.' 'It would be very difficult to be honest, such as to say if I thought strongly that no one should be offered screening.' 'I felt more comfortable during my interview that I could say exactly what I felt about things and how services could be improved, which I couldn't say in the group [though] I feel very positive about the group.' 'I usually see my manager when something has gone wrong. I don't feel I know her very well.' 'Perhaps senior staff may have been less frank about uncertainties with junior staff there.' But a junior midwife said she felt no constraints because her manager was 'very easy going, so I said everything I wanted to say.' Some people found that others could speak for them. 'I felt rather overpowered by another group member . . . but my colleague who is very good as a public speaker summed up nicely what I thought.' A midwife said she was a bit intimidated at first when a consultant arrived:

We rarely meet, but he was very open and it was easy to talk, and it's really useful to see other people have similar views, things when you're unsure about what you're doing, you realize that you're not out there on your own.

### *Gender mix*

Only 11 of the 56 participants were men; a high proportion of hospital staff, however, are women. The two all-women groups thought they were possibly

more open and friendly but less challenging. 'I think it would have been very different if men had been there; as women we were all empathizing with the women we work with and talking personally as much as professionally.'

## Quality of facilitation

### *Guided inclusive discussion*

The ethicist's personal style and skills and confidence seemed to be very important to the attenders. 'My heart sank when she said she was a facilitator; the only ones I've met have been a waste of time, but she was extremely good.' 'Brilliant, I admire her skills, she's not inclined to give her opinions, very good at summarizing and getting discussion on track.' 'Very thought provoking; she brought people in to talk, very inclusive. She guided us well, she knew when to move on to another topic when we had exhausted one topic.' 'No one ranted, I liked that.' 'She didn't lead or dominate and she wasn't biased. She brought discussion back to the key issues and without having notes. She was very good at getting the group to focus and getting us talking.' A midwife who said little in the group commented: 'Brilliant, she kept including me so that was really good . . . it was very relaxing, everyone's opinion was listened to with no interruptions.' 'I'm mainly a listener and I liked the fact that I felt free to speak or not; she didn't hone in or pick on people.'

### *Free-ranging and academic level of discussion*

Some people were reminded of stimulating sessions they had enjoyed at university. 'All my meetings now are very prescribed, and it's good to wander around, to speculate, I prefer that format.' 'The nearest kinds of meeting are the case conferences but then you get doctors arguing about what to do. This group wasn't necessarily looking at practice, just at our perceptions about what we're doing and provoking thought.' 'I think the topics flowed into each other and if Bobbie had tried to be more directional people might have gone away thinking there were still things they wanted to say.' 'It's not often that you get a conversation that is that free-ranging. I haven't had that style of conversation for a long time; it was nice to revisit it. Thank you very much for asking me to participate.' They generally liked the balance struck between over-directive and too free-ranging discussion.

### *Links to practice*

Expert practitioners were pleased that the ethicist understood their comments quickly while keeping an objectivity and distance.

She saw where we are coming from. But we're so involved in the area we sometimes can't see clearly, whereas Bobbie was able to look at the bigger picture and to draw us back to the topic when we went off at a tangent.

'It was good to have an outsider, someone away from the NHS.' 'She was clever and didn't talk down to us. It was good to be able to talk off the record.' 'She was good. A lay ethicist to be useful needs to understand the practical issues, live in the real world, not just the theoretical world.'

*Trust*

As already mentioned, the participants tended to trust the seminars as safe places for fairly open debate. Contributing factors may have been the care taken to emphasize respectful ground rules. 'It felt safe about confidentiality. I'm confident things won't be repeated.' 'The ground rules were explained well, and I think everyone took them on board. I haven't heard people chatting about names within the group since then.'

The ethicist's confidence also appeared to be important in possibly acting as a kind of reassuring 'container' when quite strong feelings and disagreements were sometimes expressed, while sustaining the interest and goodwill of the whole group. 'I felt the views were very forthright and, although we have similarities in our approaches, we have differences but I don't think anyone felt inhibited in talking about them.' The openness helped some to speak confidently:

I was really surprised that professionals could voice those views . . . about gearing information to different women . . . We say we give the same information to each person, but we don't. [Before the seminar] I would never have dreamt of saying those things, but we all do it.'

We were concerned that having two observing researchers present could be intimidating. Only two people mentioned this. Others spoke of being able to talk openly 'because lay people and outsiders were not there.' Possibly because the observers had previously interviewed them, the staff did not regard them as outsiders.

**Should sessions be more challenging?***Sufficiently challenging*

'It was quite challenging. Bobbie would say, "I'm going to push you here".' 'It was challenging and the ice was broken fairly early on and I think if the group relaxes you could potentially take it on to another level.' 'People, especially midwives, like to test the water first . . . we'd just come together, the tape was on, we were all being nice and polite and only near the end did we start to challenge.' One midwife commented that another midwife 'really challenged [a consultant] and I think that's good, that they know they're not gods.' The midwife mentioned, however, said: 'I felt self-conscious and I challenged him but I don't think we really discussed things, but I felt I can't let that go by . . . There's so little opportunity to talk in terms of practice-based discussion.'

Some thought that a first group should not be too challenging. 'Maybe you could be more challenging in a later group but not at the first meeting. People would clam up and become very cautious; it would change the whole atmosphere in the group.' 'There wasn't much conflict in the group [but] I think Bobbie pitched the right level for a first meeting.'

Bobbie asked questions in a philosophical way and developed a culture of openness, which meant people went into the issues in depth. She was not judgmental, not siding with anyone, not pro or against, but helping people to explore the issues. People didn't have to defend a particular ethical stance. The fact we could express our doubts was very good; it doesn't happen often enough . . . within the culture of your workplace. [Being too challenging] could destabilize and inhibit the group dynamic . . . It would

be valuable to have people with very different values there. But this group, I think, was gathered to explore ethical issues behind ideas and it did achieve that with people going far beyond the level of everyday discussion, and not feeling defensive or guilty (psychologist).

### *Insufficiently challenging*

A few participants made comments such as: 'Yes I wanted to challenge people more, but it is difficult; some people misunderstand and think you're attacking them and not their opinions.' 'We didn't talk about eugenics or Darwin or survival of the fittest. Maybe it is some people's way of coping, to concentrate on the task and not think too deeply.' Some comments implied that greater challenges could have been acceptable:

She was always one step ahead and I liked the way she pushed a bit more in depth [of discussion]. She made very good eye contact and was always watching that everyone felt they could contribute; she could have pushed a bit harder.

### *Doubts about effectiveness of seminars*

The constraints of occasional meetings, sometimes with strangers, made some attenders doubt the impact of the seminars or to see the impact mainly in personal terms. A senior manager said, 'To be honest I don't think these groups will challenge anything dramatically, but I found it invigorating and refreshing . . . In the second group the issues were more personally challenging to me.'

## **Afterthoughts**

### *Ethics to promote good practice*

When asked if they had had time to reflect on the seminar afterwards, the participants referred to ethics in different ways. Some were keen to learn about or apply ethics more. 'It has made me want to go on study days to help me to look at what I do and improve it.' '[The seminar was] a good format to discuss where we're going next in the department, what procedures will be introduced.' 'We discuss patients in depth [at weekly meetings]; ethical issues around cases come up but we don't have a framework in which to work like your group had.'

### *Ethics to question policy and practice*

Some participants linked ethics to critical questioning: 'It made me examine myself. It made me think very carefully about how I react to colleagues' attitudes.' 'I don't think our team has ever sat down and discussed these things in depth [policies on genetic counselling]. We don't have time to talk about our thoughts and feelings' (paediatrician).

Some attenders thought through critical questions to the extent that they considered drawing back from and revoking decisions that they had made earlier and actions they had planned to take. 'We were going to write to all our affected families offering a genetic test, and since the meeting I [decided] to think about things, the potential problems, before we send out a letter (paediatrician).

Several participants thought the seminars had addressed their concerns that

new policies and techniques are introduced without adequate discussion or research evidence.

When I talked about the group to my husband, he's a chemist, he reminded me that a few years ago I used to say [about media reports of scientific innovations] 'that'll never happen' but he knew it would happen and he was right. Since the meeting I've seen things in the [news]papers and thought . . . perhaps it will happen here one day. I'm worried about how some people are overtreated (health visitor).

The health visitor referred to a past method of resolving serious problems in British hospitals by calling in 'three wise men': senior doctors to advise on resolving the problem. She felt that there was now a lack of direction and of clinically-based 'wisdom' in how services should be developed and managed.

Some attenders believed that they had gained new insights. An obstetrician who was an enthusiastic supporter of women's rights and gender equality began to consider how principles of equality could apply to disabled people.

I've thought more about discrimination between handicapped and nonhandicapped people both in and out of utero. I was challenged in the group on that, and I did not mind at all, and I think my conclusion had been flawed (obstetrician).

### Interest in attending future groups

Almost all participants wanted to attend further groups ranging from monthly to annually. 'Great, it's very easy to develop tunnel vision. I went back and told my colleagues and everyone wanted to attend. It would help us to reflect on our practice and see where to improve.' 'It would be excellent if the Trust made it policy.' Several requested more teaching about ethics and law. They valued time to share ideas; some wanted a clearer plan of action to 'formulate ethically balanced policies . . . clarify issues and to develop a consistent attitude . . . to maintain a thoughtful approach.' Some managers wanted seminars to examine a particular clinical issue and promote consensus; others thought the seminars were 'very important' for continuing medical training.

One neonatologist, however, saw less value in the seminars, saying that every case was so unique, crises arose at 3.00 a.m. when no ethics support was available but urgent decisions must be made, and paediatricians turned to their Royal College for guidance.

### Interest in contacting the ethicist in future

The ethicist had invited people to contact her about ethical queries. A range of views were expressed, with more reservations on this than on the other issues. Concern about confidentiality and about seeking advice outside formal channels was mixed with appreciation of the benefits of gaining an impartial 'outsider's' viewpoint.

#### *Questions about relevance and confidentiality*

Some doctors said they relied on their consultants to set ethical standards; some were concerned that without 'a formal link' between the ethicist and the Trust 'it may be a bit *ad hoc* and inconsistent,' or would break confidentiality. 'It wouldn't

have crossed my mind in a million years to do so before. I didn't know such people existed, but now I might contact her.' Many people were interested in contacting the ethicist, and some had already done so, including a consultant, on planning a new screening service.

## Discussion

This final section reviews some of the main issues raised by the participants' evaluations: their validity; whether the seminars met the research aims; contrasting uses of ethics; outstanding questions; and the way forward.

### Validity of the data

Satisfaction surveys are notoriously unreliable, so realistic responses were encouraged in the following ways. The ethicist was not involved in the follow-up, but had invited 'full and frank responses'. Participants were prompted to give critical replies. Most people had taken part in thoughtful interviews besides the seminar, so were likely to be beyond initial polite formalities in speaking with us. They could have said the seminars were irrelevant to their work, or that they were too busy, without losing face by appearing to dismiss ethics generally. This sample may be exceptionally keen, although they described other colleagues as being interested.

### Meeting the research aims

According to the evaluations, the seminars met the research aims to demonstrate that an ethicist can facilitate stimulating multidisciplinary discussions, on crucial but seldom discussed topics, in different types of hospitals (teaching and district). Participants indicated that the seminars promoted understanding about ethics through academically sound and practice-relevant debate, and that methods and frameworks in ethics enabled some to gain valuable new insights into their work. The title 'ethics' warranted wide-ranging discussions from health policies, science, genetic advances and society, to professional practice and relationships, which were welded, as many people mentioned, into coherent discussions. The ethicist's supportive, nonjudgemental, and flexible approach appeared to inspire confidence and frank discussion. More direct sociological research about genetic testing and research using, for example, vignettes, has shown that health professionals, specifically public health doctors, in focus groups tended to be 'defensive or dismissive'.<sup>17</sup> Yet research groups, which, like ours, linked ethics to practitioners' own experiences encouraged debate.<sup>18</sup>

### Contrasting uses of ethics

There can be tensions between using ethics either to go forwards in promoting good practice or to hold back and question activities critically. These two uses are often complementary: good practice is based on critical questioning when planning, carrying out and assessing practices. However, there are also conflict-

ing uses of ethics. Numerous reports that advocate new and expanded activities have brief 'ethics' sessions, which are mainly cost-benefit calculations to justify the plans (e.g. an HTA report by Wald *et al.*<sup>19</sup>). This uncritical and dismissive harnessing of ethics to serve medical or economic agendas may simply claim to consider, or give the appearance of having considered, the ethics thoroughly. In contrast, some participants described during the follow-up and in some seminars how ethical analysis led them to question small and large activities to the extent of wondering if they were efficacious or possibly harmful and should be altered or withdrawn.

## Outstanding questions

This short study of 11 seminars cannot estimate the impact on participants' practice or policy making. It simply provides a promising start towards one multidisciplinary way of addressing dilemmas in everyday health care. The main evidence lies in the interest and need expressed by participants for the seminars, and a few reported effects on practice. It remains to be seen how well the seminars would work with other ethicists and in various clinical specialties. Seminars could fit into routine department meetings.

## The way forward

The prior in-depth sociological interviews enabled the seminars to address participants' practical concerns and showed the value of combining ethics and sociology. Future research could evaluate, instead of a visiting ethicist, using a part-time in-hospital ethicist, and also larger and more cost-effective groups. A hospital trust appointment could resolve problems about confidentiality and consistency, and a series of seminars could develop people's confidence, insights and critical debate. The choice of meeting place and participants, timing and topics would require careful discussion. It would be important that the ethicist routinely observes and talks with staff, plans sessions with them and follows up their concerns, preferably with a sociological colleague to help to connect seminar discussions to everyday practice. Funds would be needed for the ethicist's and participants' time, for a persistent and tactful convenor, and for refreshments.

The profound concerns raised during the sessions, and the participants' own evaluations, suggest that such seminars are a useful format for health trusts to develop. They could be especially helpful in addressing areas of major and rapid change, risk management and clinical governance. The support of fixed professional guidelines and managerial guidance can be complemented by critical reflective discussion during interdisciplinary seminars about the complex practical dilemmas raised by the rapid advance of new genetic knowledge. Seminars offer the means for health care staff to develop their undergraduate knowledge of ethics, or to be introduced to such knowledge, and to apply it to their daily practice. As the participants frequently mentioned, many were relieved to realize how colleagues shared the anxieties and uncertainties they struggled with individually, and they also valued learning from one another's views and experiences.

The seminars appeared to provide a unique forum for enabling health care professionals to share these important concerns.

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