Information about this resource and others can be accessed via the Manitoba Provincial Health Ethics Network (MB-PHEN) website at www.mb-phen.ca.

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This toolkit was originally developed in 2009-2010 as an initiative of the WRHA Ethics Council for the benefit of Winnipeg health ethics committees and teams. In 2011, it was adapted so that it might also benefit health ethics committees and teams in other Manitoba RHAs.
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PURPOSE AND OVERVIEW

This toolkit is designed to help you with the exciting and challenging endeavor of establishing and integrating a Health Ethics Committee (HEC) in your site, program or region. It is intended as a resource and organizational tool to provide information on the role, goals and structures of HECs and to contribute to their continued growth, development and consistency across and within Manitoba.

The toolkit is divided into two parts:

Part One: Getting Started focuses on the initial development of an effective HEC.

1. Why create a Health Ethics Committee (HEC)?
2. What does a modern Health Ethics Committee look like?
4. Health Ethics Committee Resources

Part Two: Ethics Consultation provides essential information for a HEC that has established its committee processes and membership core competencies as outlined in Part One and is about to develop an ethics consultation process.

FEEDBACK

Any feedback or suggestions about this Toolkit are welcome. Email ethics@wrha.mb.ca with “HEC Toolkit” as the subject line.
HOW TO USE THIS TOOLKIT

This Health Ethics Committee Toolkit – Part One: Getting Started is intended as a resource and organizational tool for those responsible for the development of Health Ethics Committees. We suggest the following process for the use of this toolkit:

♦ Begin by reviewing the contents to get a sense of the type of information included in it.

♦ Read Section 1 and Section 2 and think about what a modern HEC might look like in your particular health care context.

♦ Review Section 3 to develop a sense of the process for HEC development. If your HEC is already established, you can use the information provided in this Toolkit to help you identify any gaps in your current structure. If you are establishing a new HEC, we suggest that you work systematically through the steps outlined in the Toolkit. Do not rush the process, as the education and competency building of your HEC membership is an important goal to address early in your HEC’s development. Education and capacity building will be ongoing as the functions of your HEC evolve. Building a proactive, integrated and accountable committee takes patience, dedication, preparation and vision. It is well worth the effort.

♦ Suggestion: Store your Health Ethics Committee Toolkit in a binder with all the pertinent paperwork your committee will generate. Create tabs to label:

1. Terms of Reference
2. Membership
3. Agendas and Minutes
4. Work Plan
5. Resources (place this Toolkit in the Resources tab).

Add your own resources and articles as your committee evolves. Make this your central location for the storing of your HEC documents.

ACKNOWLEDGEMENT

We wish to thank Alberta’s Provincial Health Ethics Network which served as a significant resource and inspiration for this toolkit!
WHY CREATE A HEALTH ETHICS COMMITTEE (HEC?)

INTEGRATIVE ETHICS

Ethics is concerned with the value dynamics in human relationships. Everyone has a role to play in fostering an ethical climate in healthcare.

There is a strong movement across North America away from isolated ethics committee structures and towards the integration of ethics throughout the health care system(s). Integrative ethics is a central theme in the organizational ethics literature, a major expectation in the Accreditation Canada standards and the guiding philosophy of Manitoba’s Provincial Health Ethics Network (MB-PHEN). Integrative ethics initiatives rely for their success on elements such as:

- Board and Senior Management commitment, support and engagement;
- Dedicated staffing;
- Strategic planning to address key ethics priorities;
- Purposeful integration of ethics into health care processes, policies and clinical/service practices, and decision-making;
- Ethics-capacity building initiatives through ethics education, staff engagement, networking and communication; and
- Attention to advancements in health ethics both nationally and internationally.

A Health Ethics Committee has a key role to play in Integrative Ethics initiatives. Tips to help integrate ethics...

- Think ethics (accessible, relevant), not ETHICS (intimidating, obscure)
- Think preventive, not reactive
- Be purposeful and strategic. Develop a Work Plan and communicate results
Why Create a Health Ethics Committee (HEC)?

- Learn about ethics and the many resources and strategies available. Share what you have learned by engaging others in discussions and activities.
- Encourage others to consciously consider ethics every day, not only when exceptional situations arise.

Did you know?

WRHA Ethics Services and MB-PHEN Staff offer presentations and workshops on integrative ethics. Call 204-926-1312.
**What Does a Modern Health Ethics Committee (HEC) Look Like?**

**Introduction**

In North America, the concept of a health ethics committee (HEC) has grown out of a number of developments in the areas of healthcare research and treatment. If we are to fully understand the role of the modern HEC, it is helpful to begin with an overview of how health ethics committees have evolved within and alongside the changing landscape of bioethics in the United States and Canada.  

In the Western world, we have lengthy experience in thinking about the ethical dimensions of the healthcare professionals. The *Hippocratic Oath*, for example, dating from approximately the fourth century B.C.E., served as the physician’s ethical guide for proper relationships with patients. These guidelines required physicians to act to benefit patients and to refrain from causing harm or injustice to patients or their families. These guidelines seemed sufficient until the mid-20th century, when a number of very significant developments in healthcare research and treatment sparked debate about challenging healthcare ethics issues and the adequacy of the frameworks being used to address them.

**Traditional Health Ethics Committees**

Changes in the physician-patient relationship in North America in the 1960s and 1970s occurred due to a number of influences in the areas of healthcare research, technological development and societal change. Research conducted on unwilling captives by German and Japanese doctors publicized throughout the world after WWII seemed to set the stage for public concerns about ethical research practice. Contributing to this rising public awareness, Dr. Henry Beecher published an article in the New England Journal of Medicine in 1966 describing 22 examples of unethical experiments conducted within the United States. Later, in 1972, the public learned that a study of untreated syphilis had been conducted for four decades on a group of inadequately informed and unwilling black men in rural Alabama. Responding to intense publicity surrounding disclosure of the unethical

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research practice in this study, United States Congress established the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The intent of this Research Commission was to formulate basic ethical principles to guide research with human subjects, to study areas of ethical controversy and to recommend steps to protect the rights of research subjects. Respect for persons, beneficence and justice principles were emphasized and a system of “peer review” of research was endorsed. This led to the development of one common federal system, the Institutional Review Board (IRB), which became the new system for research subject approval. These new boards examined each research proposal to determine conformity to ethical principles and ensure thorough review to ensure that research participants were respected. The membership composition of these IRBs included individuals who were neither research scientists nor institutional employees. It has been proposed by some authors that the health ethics committee is indeed a descendant of the IRB since the composition and mandates are similar (Hackler and Hester 2008 p. 2-3).

Here in Canada, the commitment to promote the ethical conduct of research involving human subjects was first expressed in the late 1970’s, but an international summit on bioethics held in Ottawa 1987 was particularly important in that it recommended the establishment of a forum devoted to issues arising in research with human subjects. Work on a joint policy was started by the formation of the Tri-Council Working Group in 1994. The 1998 Tri-Council Statement: Ethical Conduct for Research Involving Humans describes the policies of the Medical Research Council (MRC), the Natural Sciences and Engineering Research Council (NSERC), and the Social Sciences and Humanities Research Council (SSHRC). This joint policy has the stated aim of promoting the ethical conduct of research involving human subjects. ²

Ethics committees have other possible roots/influences worthy of consideration. The new technologies which evolved within the context of medical practice beginning in the 1960’s gave rise to new ethical dilemmas. Heart transplantation, for example, challenged traditional definitions of death. New life prolonging technologies emerged such as kidney dialysis which was scarce and costly. This created allocation questions about who should live and, ultimately, who should die. To deal with these emerging questions, a committee or a series of committees was formed to make important decisions in situations where conflicting values meant that no clear consensus was apparent. These early traditional ethics committees had as their membership, “elite” decision-makers, whose primary role was to dispense ethical wisdom. They had authority to make decisions in their particular situations and each committee was comprised of members who had been selected because of their particular expertise. The institutions relied upon these “experts” to make substantive decisions. An example of such

early traditional models were the legal commissions formed to confirm prognosis during the *Karen Ann Quinlan* case (1976) (Wilson, R.J. et al, 1993).³

In 1983, in response to public concerns on how such decisions were being made, the *President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (President’s Commission)* published the influential report “Deciding to Forego Life-Sustaining Treatment”. Although the previously mentioned *Research Commission* and this *President’s Commission* were established to address different areas of concern, there was a similarity in their results. The *President’s Commission* issued a number of influential reports on topics related to defining death, forgoing life-sustaining treatment and making general healthcare decisions. It also, following the *Research Commission* suggested that hospitals establish interdisciplinary committees to provide guidance in difficult treatment decisions. It supported the establishment of these committees to help educate personnel about ethical issues, formulate policies or guidelines and review or aid in making decisions about the care of individual patients. In making its recommendation, the *President’s Commission* endorsed the approach the New Jersey Supreme Court took to decision making for incapacitated patients in the *Quinlan* case, leaving the decision to the patient’s guardians in consultation with the “ethics committee” (Hackler and Hester, 2008, 4). A large number of organizations representing hospitals, physicians, nurses, and patient advocacy groups quickly endorsed institutional ethics committees to facilitate discussion of ethical issues. At the same time, several controversial cases focused national attention on the limitation of treatment for newborns with disabilities and accelerated the momentum of these committees. The “Baby Doe” cases in 1982 and 1983 signaled the turning point for the practical and widespread use of such committees.⁴ These early committees are examples of the precursors to our modern Health Ethics Committee

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³ The rise of institutional ethics committees is linked to the growth of the bioethics movement, but the New Jersey Supreme Court decision in the Karen Ann Quinlan case is often referred to as a pivotal decision which led to the growth of ethics committees in healthcare institutions. The court held that Quinlan’s respirator could be disconnected as requested by her guardian if her physician consulted with a hospital ethics committee. The ethics committee or “prognosis committee” as it was called, had to agree with the physician’s prognosis in order for the respirator to be unplugged. The court urged hospitals to develop prognosis committees to review patient cases and to provide assistance and safeguards for patients and their medical caregivers. After Quinlan, other state courts disputed both the effectiveness and the legitimacy of ethics committees in resolving ethical dilemmas, but it was not until the early 1980’s that the option of the New Jersey court began to have national impact.

⁴ The primary case was a 1982 incident involving “Baby Doe”, a Bloomington, Indiana baby with Down’s Syndrome whose parents declined surgery to fix *esophageal atresia* with *tracheoesophageal fistula*. A similar situation in 1983 involving a “Baby Jane Doe”, again brought the issue of withholding treatment for newborns with disabilities to public attention. In this case, “Baby Jane Doe” was born with *spina bifida*, an abnormally small had, and *hydrocephaly*. © MB-PHEN
What Does a Modern Health Ethics Committee (HEC) Look Like?  

(HEC). Certainly care of the dying in Canada has generated its own professional and government position papers and has been the object of legal cases and decisions.⁵

As Nuala Kenny (2003) observes, Canada’s proximity to the United States and “cross border fertilization of academic sensitivity” has meant that theoretical perspectives have closely paralleled U.S. thought. She notes that case-based and principle based perspectives have dominated, yet there are still distinctive Canadian perspectives on many issues that have been enriched by francophone philosophers and ethicists rooted in Continental philosophy. Canadian thinkers, she adds, have provided a critique of what is seen as a “U.S. autonomy-dominated bioethics” and have contributed to the development of a more distinctive Canadian literature (9). The Canadian Charter of Rights and Freedoms (1982) has also had a significant effect on the interpretation of ethical and legal obligation in the context of healthcare and medical decision making.⁶ Another contributor to the “distinctly Canadian” health context is the 1984 Canada Health Act. The Act’s principles of comprehensiveness, universality, accessibility, portability – across all Canadian provinces – and public administration and provincial jurisdiction over health care are distinctive of Canadian Health Care (Taylor, 1987).

The committees that arose in Canada and in the United States in the 1980’s “signaled a change in the function of ethics committees”. Rather than bodies established only to handle predetermined issues of ethical tension, these committees were developed as a way of addressing multiple ongoing ethical concerns. (Jiwani, 2001, p.13). These early (traditional) institutional ethics committees differ from today’s HECs in two important ways...

♦️ These earlier committees had the authority to make decisions in their particular situations.

♦️ These earlier committees were comprised of members who had been selected only because of their particular expertise.

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⁵ An example of withdrawal and withholding of care was highlighted in the 1992 case of Nancy B, a 25-year-old woman with Guillain Barre Syndrome who successfully petitioned to have her respirator disconnected. Her autonomous decision to refuse care was respected.

⁶ Cases that demonstrate this relationship are the landmark 1980 decision Reibel vs. Hughes which moved the standard for patient consent from what a reasonable physician would disclose to what a reasonable patient would want to know in order to refuse treatment. In 1983 Dawson emphasized the ethical significance of accurate medical information in life and death decisions, in 1986 Eve followed mid 70’s and 80’s debates on contraceptive sterilization for the mentally disabled, declaring that sterilization would never be authorized for non-therapeutic reasons.
MODERN HEALTH ETHICS COMMITTEES

Modern HECs usually have little or no decision-making authority; instead, they serve as advisory boards or forums for discussion. Today’s HECs are interprofessional and represent a broad set of views or perspectives. Their purpose is to engage in thorough discussion and debate. Unlike earlier institutional ethics committees, modern HECs are comprised of individuals from diverse backgrounds, including physicians, nurses, allied health professionals, administrators, spiritual healthcare providers, lawyers and individuals from the lay community.

This change in structure and mandate is due to a number of factors. One influential factor has been the shift that has taken place in Western society’s values which puts greater weight on personal autonomy. The idea of a group of “moral experts” making pronouncements is not necessary nor is it desired in our current societal context. It has become clear that almost every aspect of the creation, implementation and evaluation of health and health care delivery systems has important ethical dimensions and implications. Bodies such as ethics committees can promote examination of these systemic issues in addition to providing support and facilitation on case-by-case basis (Wilson Ross, J. et al, 1993).

Major growth of HECs occurred in the 1980’s and 1990’s in university teaching hospitals, larger community hospitals and health centers. The American Hospital Association (1986) and the American Medical Association (Ethical and Judicial Council, 1985) and the Joint Commission on the Accreditation of Healthcare Organizations (Joint Commission or JCAHO) which began in 1992, fully endorsed the concept of Health Care Ethics Committees (HECs) as a mechanism to assure that ethical issues in patient care were addressed in an effective fashion. While the Joint Commission did not mandate the formation of these committees, the result was nevertheless a rapid increase in the number of HECs in hospitals of all sizes. It was during this time that the emergence of “Ethics Committee Networks” in Canada and the United States occurred. Peter Allatt was a pioneer in both the founding and development of the Toronto and Southwestern Ontario Ethics Committee Network. Al-Noor Nenshi Nathoo and Bashir Jiwani also engaged in excellent pioneering work in Alberta where the Provincial Health Ethics Network (PHEN) began in 1995.

During the 1990’s there was also a growing interest in ethics committees in many smaller health care facilities and health care agencies. Professional associations both in and outside health care established their own ethics/bioethics committees, such as the committees of the Canadian Medical Association and the Canadian Nurses Association. In the late 1990’s and the early part of the 21st century, there has been a significant commitment to develop HECs in those provinces that have established health authorities. The expansion in the number of HECs

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can be attributed to a growing interest in ethics and HECs amongst health care professionals as well as external expectations of accreditation processes and professional/regulatory bodies that ethical issues be addressed in a more intentional and deliberate manner.

It has been asserted that “HECs exist for the purpose of enhancing the care of patients by enhancing the ethics of professional caregivers and the care giving organization” (Blake, 2000). According to Neil Wenger (2000), “a classic, reactive HEC is inadequate”. He observes that “[w]hile the patient level issues persist and grow in complexity, the major ethical issues gnawing at healthcare facilities today are conflicts between departments and between institutional values. ...This requires integration of the ethics system into the administrative decision-making mechanism that is much different from the traditional HEC”.

Placement of the HEC in the administrative structure has the potential to permit direct interaction with institutional stakeholders and potentially integrate ethics activities with the administrative appendages in which core ethical issues arise such as: admissions and transfers, marketing, contracting, corporate relations, and legal (33). It is clear that almost every aspect of the creation, implementation and evaluation of health care delivery systems has important ethical implications. Modern HECs can promote exploration of these systemic issues, in addition to providing support and facilitation on a case-by-case basis. In order to foster an ethical climate in their sites, programs and regions, modern HECs should aim to be strong, purposeful, effective and accountable. According to David C. Blake (2000) the “Next Generation” HEC should be: “proactive and not just reactive, organizationally integrated and not isolated, accountable according to measurable outcomes and not just the good intentions of their members and oriented by institutional values” (10).
**Which model would you rather have for your HEC?**

<table>
<thead>
<tr>
<th>Traditional Ethics Committee/Team</th>
<th>Modern Ethics Committee/Team&lt;sup&gt;7&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>◦ Exists independently of politics and business of the organization.</td>
<td>◦ Blake’s four principles/values (2000)</td>
</tr>
</tbody>
</table>
| ◦ Focuses on ethics education, policy and individual clinical ethics consultation re: issues confronting individuals and not the committee. | 1. Proactive, not just reactive.  
2. Organizationally integrated, not isolated.  
3. Accountable according to measurable outcomes, not just good intentions of members.  
4. Orientated by organizational values, not just patients’ rights. |

Seen as **expert** ‘go to’ teams re: ethics issues – although the decision should rest with the primary stakeholders (patient, family, healthcare team, etc.).

**Common Concerns:**

- Isolated, marginalized. Seen as irrelevant. Not actively sought out due to fear issue will be complicated.
- May be viewed as the “Ethics Elite”. Seen as dispensers of wisdom. Ethics is to be owned by the Committee, not by all.

<table>
<thead>
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<th>Common Concerns:</th>
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So...what does it take to be successful in getting your HEC up and running? A commitment on the part of senior leadership to support the ethics committee and its activities is essential to success. What does this commitment look like?

- There is Senior Leadership representation on the HEC or a direct reporting structure to Senior leadership or the Board of Directors.

- Senior Leadership supports the development of an Ethical Decision-making Framework in congruence with the Strategic Plan. The Framework delineates a formal process for addressing ethics related issues and concerns. Use of the Framework helps to guide decision-making, reflection and fosters commitment to patient-centered care process evaluation.

- Senior Leadership plays a role in promoting the visibility of the HEC by supporting and participating in its ongoing development and activities.

- Senior Leadership facilitates ethics education leave for committee members and staff.

- Senior Leadership supports the provision of administrative assistance to facilitate the HEC’s clerical/education/publication processes.

- Senior Leadership encourages and maintains open communication with committee members with respect to progress, evaluation and future needs.
TERMS OF REFERENCE...OR “WHAT ARE WE ALL DOING HERE?”

A commitment to an integrative ethical climate in a site, program or region can be seen – in part – in the extent to which its HEC is strong, effective and accountable. The three most common activities of ethics committees are:

- Education
- Development and review of policy, and
- Clinical consultation or facilitation of decision-making in specific areas.

Note: In some contexts, research access review may also be included.

At this step in the process it is important to consider carefully what the HEC’s mandate/purpose will be. Be clear about what the HEC can and cannot offer. Bashir Jiwani (2001) provides this cautionary observation: “In my experience, ethics committees [that] have tried to take on all three of these functions...have found this challenging, if not overwhelming. I have also found that HECs that do take on all three of these functions tend to do few of them exceptionally well.” He adds, “If a committee has limited resources and/or limited experiences, it may be worthwhile limiting the committee’s mandate to a set of responsibilities that are within the abilities of the committee, and that the institution/organization that the committee belongs to can reasonably hold the committee accountable for” (36).

Thus, the focus, direction and functions of the HEC must be carefully considered at the outset. It is often directed by the Board and/or Senior Leadership of the site, program or region it will serve. The development of the Terms of Reference is most often seen as the initial task of the committee membership with final approval by senior leadership. While the specific format will depend on site, program or regional guidelines, in all contexts the Terms of Reference should delineate how the HEC will be accountable for its services. It should clearly outline the HEC’s:

- Purpose
- Functions/duties
- Membership
- Meeting schedule
- Reporting structure

---

8 HECs should not engage in ethics consultation until membership processes are well-established and the Committee is well-informed.
Remember to review the mission, vision and values and be clear on the direction that the board and/or senior leadership have in mind for the HEC and its role in integrating ethics in your site, program or region. This information is important as it is foundational to the creation of an effective Terms of Reference and the HEC’s evolution.

Go to Appendix: Sample Forms/Templates section for Terms of Reference examples.

MEMBERSHIP CONSIDERATIONS
Members may not necessarily have extensive expertise and knowledge in health ethics. In the early recruitment stages, it is important to scan your site, program or region for potential members who have experience or interest in ethics in healthcare. Members should come from a variety of backgrounds. As the HEC is established, and the role and focus of the HEC is determined, Senior Leadership should require that members participate in initial and/or continuing ethics education relevant to the focus and purpose of the HEC. It is important that members be credible in their roles as ethics educators or consultants, and educational preparation for such roles is critical to care competency development of members.

While you may begin your HEC with membership with limited expertise in ethics, there are many ways to provide members with educational opportunities. This can be incorporated into your Work Plan. Members should commit to a minimum of a two year term of membership should be expected to allow for this learning curve. Additional terms of membership may be added, if appropriate to your HEC. Membership composition will depend to a great extent on the nature of the organization it serves.
Membership may include:

- Senior Leadership – e.g., Executive representation or as ex officio
- Physicians – e.g., CMO, Department heads, ICU or palliative care physicians
- Nurses – e.g., direct care and/or nurse managers, educators, CRN, CNS
- Ethics Specialists – e.g., those who have degrees or fellowships in bioethics
- Allied Health Care Professionals – e.g., Social Worker, Clinical Dietitian, Occupational Therapist, Physiotherapist, Pharmacy, Respiratory Therapist, Speech Language Pathologist
- Supportive Services Personnel – e.g., Food services, Health Care Aides, Diagnostic imaging personnel
- Spiritual Healthcare
- Individuals familiar with Health Law
- Community representative(s)
- Others – e.g., Quality Officer, Patient Safety representatives, etc.

What to look for in a potential HEC member:

Identify the criteria that will be used in selection. For example,

- Individuals should have an interest in the field of healthcare ethics
- Individuals should be willing to think broadly about a range of health care ethics topics and perspectives
- Diversity is a good thing! – By age/gender/ethnicity/experiences/ values
- Excellent interpersonal skills and respect for the opinions of others
- Willingness to address difficult issues in an interprofessional environment
- A desire for continuing personal education
Consider how each of the following will be addressed:

- How will members be selected and how long will their term be?
- How will new members be orientated?
- What processes will be used for the identification of future members and member renewal?
- What strategies and processes will be put in place to ensure the HEC is credible, respected, trusted and accountable?
- How will pre-existing competencies and strengths inform the initial development of the HEC?
- What competency requirements will be established/targeted? How will these be addressed and monitored?
- How will issues such as member burnout be addressed?
- What will be done to avoid monopolization by a professional group or special interest group?
- How will the committee members be thanked for their participation?

**MEETING STRUCTURE AND FORMAT**

“The meetings of an ethics committee deserve a great deal of careful attention because they are the life of the committee” (Wilson et al, 1993, p. 29).

Giving care and attention to the planning and structure of the committee is essential, as it will shape its identity. The role of the Chair can be an individual or a shared responsibility. The chair and/or co-chair will draw on the strengths and abilities of HEC members. The chair will ensure that a Terms of Reference is in place, work with the HEC to create an effective Work Plan, set clear agendas, facilitate discussion, run the meetings efficiently, and expect effective participation from each committee members.
Signs of an effective Chair and Co-Chair:

- The meeting runs “smoothly”
- The agenda is covered
- Participation is encouraged broadly from members
- Discussions are not dominated by a single individual or group
- There is recognized progress (however slight)
- The meeting has closure

**RECORD KEEPING: MEETING AGENDAS AND MINUTES**

HECs should be attentive to record keeping for ethical, legal, and operational reasons. The practice of record keeping can vary. Each HEC should ensure its documentation is congruent with applicable policies, standards and practices, recognized ethical processes, etc. These factors will influence how the HEC establishes its Agenda and Minutes templates and it determines how these will be completed, approved, disseminated, etc.

Agendas should be prepared with due consideration of the time available for each agenda item. The agendas should be circulated in advance to allow members sufficient time to read any attachments in preparation for discussion. Each HEC agenda should include an educational item to ensure that members continue to advance their learning and knowledge in health ethics. Those leading HEC subcommittees or working groups should be invited to provide regular progress reports and receive input or feedback on their initiatives.

Minute-keeping provides continuity between meetings and gives updates to members absent from meetings. Minutes should be clear, concise and complete. They should archive key themes or points made in HEC discussions and record the HEC consensus decisions for later reference. The Minutes also provide the HEC with a means of ensuring accountability and transparency in its reporting. They can be distributed to members by email (with due consideration of the need for confidential transmission and storage).
Some key points regarding meeting structure and format include:

- Discussion topics are **well articulated** or prepared in written format.
- There is an expectation of **punctuality** from all members.
- An environment where **trust** and **respect** prevail and discussion of difficult issues is facilitated. Critical elements are **positive regard** and **empathetic understanding**.
- **HEC evaluation** should involve full member participation.
- Members commit to **confidentiality**.
- Members participate enthusiastically and with vision. They actively plan for **future** endeavors.

**WORK PLANS**

A **Work Plan** is an effective way to document and direct the activities of the HEC. A Work Plan should begin by describing your HEC’s specific **goals**, **strategies** and **performance measures**. It outlines **what** the HEC plans to achieve, **how** it will measure what has been achieved, **who** will do it, and by **when** it will be completed.

The following are suggested objectives to include in the HEC Work Plan⁹:

- Learn about health ethics committees in general, their goals, composition and functions from a variety of resources.
- Learn about ethical theories, principles, frameworks and processes to utilize in decision-making.
- Concurrently, plan for committee self-education together with ethics education activities for staff in your site, program or region. Plan first year activities based on goals for the committee and functions.
- Consider how well you are beginning to develop a sense of moral community as a HEC.
- Work with your site, program or region to identify policies in need of revising or drafting.

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♦ Engage in a retrospective discussion of de-identified case scenarios from your site, program or region. Focus on the ethical themes and issues in the scenarios.

♦ Periodically review committee activities and modify plans for the future based on the committee’s assessment.

♦ Consider whether or not the HEC will expand its Terms of Reference to include ethics consultation. Consider what would need to be done in order to do this in a credible and accountable manner.

**Did you know?**

WRHA Ethics Services and MB-PHEN staff are available to help your HEC develop a work plan? Call 204-926-1312.

**Go to Appendix: Sample Forms/Templates section for Terms of Reference examples.**

**Annual Reports**

A HEC report should be prepared at least annually. Without the **Work Plan** and **Annual Report** it will be difficult to be focused and effective. The HEC needs to demonstrate that it has made progress and been successful! An **Annual Report** should outline your committee’s operations for the year and give financial information about the HEC’s funding and expenses, if applicable. It should address how well the committee achieved the goals and objectives outlined in the work plan, summarizing committee activities and highlighting accomplishments.
**Education for HEC Membership**

**Orientation**

It is unrealistic and unnecessary to expect all ethics committee members to have formal degrees or fellowships in bioethics or health ethics. However, when appointed to the HEC, members must be willing to participate in a continuous process of ethics education. New members should receive orientation to the HEC’s

- Terms of Reference
- Past Agendas and Minutes
- Work Plan
- Framework for Ethical Decision Making (if already developed)
- Key readings and resources relevant to health ethics

**Two excellent reading resources for new HEC members are:**


**Initial Education**

If new members do not have a background in ethics, they should be encouraged to register for upcoming ethics courses or workshops offered by the region, site or program, universities or colleges, or on-line through distance education.

**Ongoing Education**

Responsibility for ongoing HEC’s membership education can be that of the chairperson, an education subcommittee or working group, or a designated member. The committee should establish clear education goals in their **Work Plan**. HEC educational goals should be considered alongside the HEC setting, needs and resources.
Some additional thoughts regarding education of HEC members:

- Recognize that committee members have varying interests and levels of knowledge about bioethics, but expect all members to become sufficiently acquainted with the issues and take personal responsibility to achieve an adequate level of understanding.

- Continually learn about new developments and issues in bioethics. HECs in some sites/programs (i.e. primary health clinics, personal care homes, etc.) may wish to narrow the scope to topics relevant to their focus of practice.

- Set educational priorities.

- Develop time at each meeting for a planned education initiative.

- Members will increasingly bring personal and professional knowledge and experience to the committee that the committee should utilize. When members attend conferences, workshops or courses, encourage them to share their experiences and written materials with other members.

- Evaluate the committee’s education program to assess its effectiveness.

Education for committee members can take the following forms:

**Formal course work** – Offered by a university or college, site, program or region, distance education.

**Informal course work** – Regional, site or program-based or ethics committee sessions covering one topic.

**Internal study groups** – Usually site or program-based, yet independent of ethics committee meetings, these involve extended study of a single topic using books or articles.

**Education meetings or as an agenda item** – Committee meetings that focus on a single article, case, topic or skill for all or part of the meeting.

**External conferences** – Seminars, workshops and conferences on general and specific areas of bioethics, usually sponsored by organizations external to the site, program or region.

**Webcasts** – Universities and professional bodies have expanded education to the global market. Online education sessions offer simultaneous, live viewing from many parts of the world.
Literature & Film – These formats provide much room for variety and creativity. There are many effective films and books created with the goal of ethics education; however, you can often find relevant ethical situations embedded in more mainstream literature and films. Individuals typically easily and deeply relate to these formats, and they often become the impetus for further discussion.

Role Playing – Although some may feel self-conscious about role-playing, most find it a valuable education tool when done frequently in an informal and supportive environment. It is important to de-brief the role-playing exercise, in order to give people an opportunity to reflect on how they felt and what they learned.

EDUCATION AND INTEGRATIVE ETHICS: GETTING THE WORD OUT!

PUBLICITY
One of the challenges faced by many HECs is ensuring that their site, program or region is aware of who they are and what purpose they serve.

Publicizing your HEC in a variety of ways can open the lines of communication between the committee and other staff, patients/residents, clients and family members. It can also serve to gain support for the committee and the mandate it holds. A brochure can raise awareness of the committee’s existence, activities, and how it can be accessed. It should be eye-catching and easy to read. When thinking about what might be helpful information to include in your brochure think about the “5Ws & 1H” – the “who, what, where, when, why, and how” of your HEC! Some questions you might want to address in your brochure are:

- Who are your current members?
- What is health ethics?
- What are the goals and purpose of your HEC?
- What is the HEC contact information?
- Where do your HEC members come from?
- When should someone contact the HEC?
- Why is a HEC important and why should others know about it?
- How can your HEC help?
Staff Education

An important HEC role is to facilitate ethics education throughout a site, program or region. Education improves the health ethics knowledge base of the staff, promotes ethics capacity building and awareness, and can enhance ethical sensitivity. Sensitive ethical practice is central to the advancement of patients’ rights and the provision of quality care.

HECs should take time to consider the reality that each professional or vocational group tends to have its own particular tradition of values. This means that healthcare “culture” is comprised of many ethical “subcultures” which can be a potential source of conflict. This may create challenges for HECs as they work to enhance ethics awareness via educational initiatives throughout their organization (Jiwani, 19). Educating staff and providers may therefore require a creative approach to meet the needs of the site, program or region. For example,

- **At New Staff Orientation Session** – provide information about “Ethics at Work” (What is Ethics? What does ethics have to do with me/my work? Include common language and definitions.) Include the site, program or region’s HEC purpose and goals as an effective way to tell new staff about the HEC.

- **Regular Education Sessions** – these do not have to be complicated to organize, in fact, the more accessible the better! Brown bag lunches with pre-advertised topic, noontime lectures, or use of rounds time are examples of education sessions you might want to consider.

- **“The Ethics Committee Is In”** – have a regular, well-advertised time and place where the committee is available to anyone wishing to discuss ethical issues within the site, program or region.

- **Ward/Unit/Clinic Based Discussions** – provide regular opportunity for staff to raise and discuss the ethical concerns or considerations in their work.

- **Health Ethics Week** – traditionally held in the second week of March, this is an excellent opportunity to engage your site, program or region in ethical discussion through a special ethics event. Use this week as an opportunity to promote awareness and activities of the committee (See a list of Ethics Week Activities on the MB-PHEN website for ideas!).
Brochures – produce and distribute pamphlets on health ethics topics or regional policies relevant to health ethics.

Newsletter – develop a monthly or quarterly newsletter that includes educational opportunities, or discusses a timely bioethics issue with reference to relevant reading materials.

“Let’s Talk Ethics” – 1) Monthly or once per quarter, plan educational opportunities for staff to hear case studies and apply decision-making algorithms/frameworks to address the ethical issues. Topics such as ethical questions around issues of feeding and hydration or restraint use are examples you might want to consider. 2) Table top placards providing thought-provoking communiqués to induce thought about matters of an ethical nature. These don’t necessarily have to be “health” ethics issues. They can be media topics of an ethical nature, ethics issues raised in current films, TV shows or documentaries, or day-to-day ethics questions that everyone can relate to or talk about. 3) Posters encouraging contemplation of ethical issues.

Modern Health Ethics Committees:

✓ DO contribute to the development of effective ethics frameworks.

✓ DO lead and foster integrative ethics initiatives throughout the site, program or region.

✓ DO model commitment to learning and growth about ethical concepts and processes – both for members and the site, program or region as a whole.

✓ DO connect with internal and external ethics resources.

✓ DO provide a lens on ethics in policy or process development.

✓ DO NOT engage in ethics consultation until membership processes are well established and well-informed.

For more information on ethics consultation, see Health Ethics Committee Toolkit – Part Two: Ethics Consultation.
REFERENCES


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SECTION FOUR

ESSENTIAL RESOURCES FOR YOUR HEALTH ETHICS COMMITTEE (HEC)

RELEVANT LEGISLATION FOR HECS
To function effectively, your HEC members need to be familiar with applicable federal and provincial legislation, including

PRIVACY AND CONFIDENTIALITY
The Freedom of Information and Protection of Privacy Act (FIPPA)
The Personal Health Information Act (PHIA)

PROXY DECISION MAKING
The Health Care Directives Act
The Mental Health Act
The Vulnerable Persons Living with a Mental Disability Act

PROFESSIONAL GOVERNANCE
The Regulated Health Professions Act

PROFESSIONAL CODES OF ETHICS
HEC members need to be familiar with their Canadian and/or Manitoba professional codes of ethics and also encourage their colleagues to recognize them as a valuable resource in terms of professional ethics learning and decision-making. For example,
NURSING

College of Registered Nurses of Manitoba – who provide a link to the CAN Code of Ethics: http://www.crnmb.ca/publications-standardscodedocs.php

College of Registered Psychiatric Nurses of Manitoba: www.crpnm.mb.ca

College of Licensed Practical Nurses of Manitoba: www.clpnm.ca

ALLIED HEALTH
Canadian Association of Medical Radiation Technologists: www.camrt.ca

Canadian Association of Occupational Therapists: www.caot.ca

Canadian Physiotherapy Association Code of Ethics: www.physiotherapy.ca

Canadian Association of Social Workers: www.casw-acts.ca

College of Occupational Therapists of Manitoba: www.cotm.ca

Dietitians of Canada Code of Ethics: www.dietitians.ca

Manitoba Association of Registered Respiratory Therapists: www.marrt.org

Manitoba Speech and Hearing Association: www.msha.ca

HEALTH LEADERS
Canadian College of Health Leaders: http://www.cchl-ccls.ca/site/about_codeof_ethics

ORAL HEALTH
Canadian Dental Association: www.cda-adc.ca

Canadian Dental Hygienists Association: www.cdha.ca

PHYSICIANS
Canadian Medical Association Code of Ethics: https://www.cma.ca/En/Pages/code-of-ethics.aspx

PHARMACY
Manitoba Pharmaceutical Association: http://napra.ca

SPIRITUAL HEALTH
Canadian Association for Pastoral Practice and Education: [http://www.spiritualcare.ca](http://www.spiritualcare.ca)


**STANDARDS**

*Qmentum Standards.* Accreditation Canada – Agrément Canada. [www.accreditation.ca](http://www.accreditation.ca).
Alternatively, contact your Quality Manager for information.

**POLICIES**

To function effectively, HEC members need to be familiar with applicable regional, site or program policies. These are generally available on staff intranets and/or site, program or regional internet sites, or by contacting applicable Policy Committees.

**HEALTH CARE ETHICS WEBSITES**


*Note:* “For the Public” section especially helpful.

Chris MacDonald. *EthicsWeb.ca.* [www.ethicsweb.ca](http://www.ethicsweb.ca)

Manitoba Provincial Health Ethics Network. [www.mb-phen.ca](http://www.mb-phen.ca).


ASSOCIATIONS/CONFERENCES
A range of health ethics associations exists both in Canada and internationally and some interesting conferences are offered annually. For example,

- The Canadian Bioethics Society (CBS). [www.bioethics.ca](http://www.bioethics.ca)
- The American Society for Bioethics and Humanities (ASBH). [www.asbh.org](http://www.asbh.org)
- International Global Ethics Association. [www.igea.ugent.be](http://www.igea.ugent.be)
- Bioethics Associations. [http://bioethics.net](http://bioethics.net)

TRAINING/EDUCATION
Many regions, sites and programs plan ethics events. Watch for upcoming rounds, workshops and courses related to ethics.

The following are some ethics education opportunities created and offered by WRHA Ethics Services in Winnipeg since 2002. They have now been adapted for delivery in other Manitoba health regions:

1. Level I Health Ethics Workshop
2. Level II: Ethics Resource Workshop
3. Ethics in the Healthcare Organization Workshop
4. Strategies & Work Plan Development for Ethics Committees
5. Ethics in Pandemic Planning Workshop
6. Ethics in Accreditation Presentations
7. Annual Health Ethics Forum

Check university and college catalogues for credit courses in ethics.

To receive news of upcoming ethics events subscribe to “Ethics News” at ethics@wrha.mb.ca or visit [www.mb-phen.ca](http://www.mb-phen.ca).
**BOOKS AND DOCUMENTS**


McDonald, M. A Framework for Ethical Decision-Making: Version 6.0. Ethics Shareware (accessible through author email mcdonald@ethics.ubc.ca).

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**ARTICLES**


**ETHICS FRAMEWORKS**

Clinical Ethics focuses on ethics in the direct delivery of health care. The following are the ethical theories, bioethics principles and moral rules most commonly considered in clinical ethics:
Essential Resources for your Health Ethics Committee (HEC)

- **Ethics Theories**: Virtue Ethics; Relational Ethics; Consequentialism (outcomes based); Utilitarianism (greatest good or benefit of the greatest number); Deontology (duty or right action).

- **Bioethics Principles**: Autonomy; Beneficence (doing good); Nonmaleficence (avoiding harm); Justice.

- **Moral Rules**: Veracity (truth); Fidelity (faithfulness/loyalty); Privacy; Confidentiality.

Clinical issues or cases are ethically charged when they involve value conflicts and/or the decisions made have the potential for significant ethical implications. Ethical frameworks are often used to guide clinical decision-making. A well-respected North American framework that is effective in the ethical discussion of individual cases is the **Four-Topics Method** developed by Jonsen, Siegler and Winslade (first published in 1998)\(^ {10} \). Their framework focuses on four topics: medical indications, patient preferences, quality of life and contextual features and their alignment with the bioethical principles of autonomy, beneficence, nonmaleficence and justice. In the actual framework, each quadrant contains a series of questions to guide ethical reflection and decision-making. This framework has also been adapted for the personal care home setting by Bethel Anne Powers (see Books and Documents). There are a number of decision-making frameworks available for clinical and organizational contexts in healthcare. It is important the HECs select a framework that aligns with their context. Please check the Books and Documents and Website listing for other resources for ethical frameworks.

<table>
<thead>
<tr>
<th>Medical Indications</th>
<th>Patient Preferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Beneficence &amp; Nonmaleficence)</td>
<td>(Respect for Autonomy)</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>Contextual Features</td>
</tr>
<tr>
<td>(Beneficence, Nonmaleficence &amp; Respect for Autonomy)</td>
<td>(Loyalty &amp; Fairness)</td>
</tr>
</tbody>
</table>

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LIBRARIES
Libraries are great resources for health ethics print, e-journal and AV resources. For example,

UNIVERSITY OF MANITOBA LIBRARIES
Search or link via www.umanitoba.ca.

Speak with a hospital or university librarian.

SALVATION ARMY ETHICS CENTRE
Booth College
447 Webb Place
Winnipeg, MB R3B 2P2
Phone: 204-957-2412

HOW TO OBTAIN LISTED RESOURCES
If you are having difficulty locating any of the above resources, or if you have other good resources to suggest, phone 204-926-1312, email ethics@wrha.mb.ca or visit www.mb-phen.ca.
SECTION FIVE

APPENDIX

TERMS OF REFERENCE

In this section you will find sample Terms of Reference for

1. Acute Care site or program (in the early stages of development, non-consultative role)
2. Personal Care Home
3. Community

Please feel free to use as a template for your HEC.

In this section you will also find a short review of the key points to consider when developing your HEC Work Plan as well as a sample format for your consideration.
ETHICS COMMITTEE

TERMS OF REFERENCE

(Sample of an Acute Care HEC in early stages of development with non-consultative role\(^1\))

1. PURPOSE

1.1. To provide a multi representative forum to assist staff, physicians, patients and families to recognize and resolve ethical dilemmas in the areas of clinical and non-clinical practice and the organization.

1.2. To encourage reflection and increase the level of consciousness about ethical issues among staff and physicians.

1.3. To discuss and facilitate the application of an ethics lens to the development, revision and implementation of hospital policies and practices.

2. FUNCTIONS

2.1. To facilitate application of an ethical lens in the review of and provide recommendations about clinical and administrative policies and clinical procedures and practices.

2.2. To discuss clinical, professional and administrative ethical issues and ways in which these issues may affect patient care, staff, and other hospital operations.

2.3. To recommend and arrange for educational activities and reference materials to support an ethical organization.

2.4. To ensure that a case-by-case ethical consultation process is developed and known to staff, physicians, patients, families and alternate decision-makers.

2.5. To ensure the work of the site or program Ethics Committee is in alignment with the work of e.g., a Regional Ethics Council, Committee or Strategy.

\(^1\) Adapted from the Grace Hospital Terms of Reference which in turn was adapted from the Royal Alexandra Ethics Committee Terms of Reference in Ethics Committee Member Manual (2005) PHEN Alberta.
3. **MEMBERSHIP**

Membership representative of a broad range of health care disciplines and facility staff such as:

- Senior Management representative or ex officio
- Spiritual Healthcare
- Allied Health Professional Lead
- Educator, Education Resources
- Ethics Specialist
- Clinical Manager
- Program Director
- Medical Staff (2)
- General Duty Nurse (2)
- Front-line Allied Health representative
- Patient Relations Officer
- Clinical Nurse Specialist
- Health Care Aides
- Support Services representative(s) (non-clinical)

Each member is required to have completed an introductory ethics course at minimum and commit to attending the *Level Two Ethics Resource Workshop* within a year of joining the committee.

4. **MEETINGS**

4.1. Monthly from September to June or at call from the Chair.

4.2. Minutes are considered confidential and will be circulated to Committee members and members of the Senior Management Team. Reference to particular patients/residents will be anonymous.

4.3. A quorum shall consist of at least 30% of the membership of the Committee.

5. **REPORTING STRUCTURE**

The Ethics Committee will report to the (site or program name) Senior Management Committee.
ETHICS COMMITTEE

TERMS OF REFERENCE

(Sample for Personal Care Home/Long Term Care)

1. PURPOSE

1.1. To provide a multi representative forum to encourage reflection, mutually reflective dialogue, critical analysis and promotion of standards of conduct reflecting the values of the PCH.

1.2. The Committee works to promote the achievement of quality resident care which is ethical and promotes Resident Rights.

1.3. To facilitate application of an ethics lens to the development, revision and implementation of PCH/LTC policies and practices.

2. FUNCTIONS

2.1. To promote ethics in everyday thinking, decision-making and policy development within the PCH.

2.2. To identify educational needs for promoting ethically sound practice for committee members, staff and community. Provide advice on or develop educational programs to address these needs.

2.3. To provide facilitation regarding site, program and/or regional policy requirements and development related to ethical issues as requested.

2.4. To ensure that a case-by-case ethical consultation process is developed and known to staff, physicians, patients, families and alternate decision-makers.

2.5. To develop a process to facilitate ethical discussion to provide resource support to health care personnel and residents.
3. **MEMBERSHIP**

Membership representative of a broad range of health care disciplines and PCH staff such as:

- Director of Care
- Medical Director
- Spiritual Healthcare
- Ethics Specialist
- Board of Directors Representative
- Community Representative
- Social Worker
- Clinical Resource Nurse or Nurse Supervisor
- Team Leader or Unit Nurse
- Health Care Aide
- Others as deemed appropriate

Each member is required at minimum, to have completed an introductory ethics course and commit to attending the *Level Two Ethics Resource Workshop* within a year of joining the committee.

4. **MEETINGS**

4.1. The Ethics Committee shall meet monthly from September to June.

4.2. Minutes of the Ethics Committee are considered confidential and will be circulated to Committee members and members of the Senior Management Team. Reference to particular patients/residents will be anonymous.

4.3. A quorum shall consist of at least 30% of the membership of the Committee.

5. **REPORTING STRUCTURE**

Committee reports to the Chief Executive Officer.
ETHICS COMMITTEE

TERMS OF REFERENCE

(Sample for Community Sites)

1. PURPOSE

1.1. To provide a multi representative forum to encourage ethical reflection and learning on the ethical dimensions in direct care contexts in the community.

1.2. To promote quality client-centered care.

1.3. To facilitate application of an ethics lens to the development, revision and implementation of community care policies and practices.

2. FUNCTIONS

2.1. To promote ethics in everyday thinking and to advance consideration of the ethical dimensions inherent in decision-making and community care policy development.

2.2. To focus on the ethical dimensions in direct care contexts such as risk behaviors, service/behavior intersection, resource allocation, contextual reality and ethics of competency, and safety/judgment boundaries.

2.3. To provide a forum for issues of an ethical nature or concern to be discussed.

2.4. To identify educational needs to advance ethically sound practice for committee members and community team staff. To provide advice or develop educational programs to address these needs.
3. **MEMBERSHIP**

The Committee shall be no larger than 15 members. Ad hoc members with specialist’s expertise/knowledge will be invited to participate on an as-needed basis.

Membership representative from a broad range of Community services staff as well as:
- 1-2 Community Care Management Team (or equivalent) representation or ex officio Ethics Specialist
- Administrative support shall be provided by office of the Chair

Each member is required to at minimum have completed an introductory ethics course and commit to attending the *Level Two Ethics Resource Workshop* within a year of joining the committee.

Two year terms staggered to ensure continuity of membership.

4. **REPORTING**

The Community Ethics Committee reports to the Community Care Management Team (or equivalent) and liaises with e.g., the Regional Ethics Service, Council or Committee.
WORK PLANS

Begin by focusing on your HEC’s stated purpose as outlined in your Terms of Reference. The Work Plan should be designed to meet this purpose.

How to develop your Work Plan

As a committee begin by identifying the strategies necessary to achieve stated purpose(s).

For example, if your stated purpose is:

- To provide an inter-professional forum to assist staff, physicians, patients and families to recognize and resolve ethical dilemmas in the areas of clinical and non-clinical practice and the organization.
- To encourage reflection and increase the level of consciousness about ethical issues among staff and physicians.
- To discuss and facilitate the application of an ethics lens to the development, revision and implementation of hospital policies and practices.

Examples of possible initial HEC strategies to meet these objectives might be:

1. Ethics Education of committee members and site or program personnel.
2. HEC Publicity and Marketing throughout the site or program.

Once you have identified your strategies, set intended outcomes and/or specific performance measures to evaluate your progress. Remember to attach timelines where possible and specific working groups or individuals assigned to take the lead responsibility. See the following example:
### HEC WORKPLAN SEPTEMBER 2010-2012

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Intended Outcomes</th>
<th>Performance Measures</th>
<th>Timeline</th>
<th>Working groups (leads) and related responsibilities</th>
</tr>
</thead>
</table>
| **1. Provide Ethics Education for HEC members and site or program personnel** | - To ensure the Ethics Committee continually expands its ethics knowledge to be a purposeful and effective resource  
- To encourage all staff to apply ethics knowledge and concepts in their work in healthcare  
- To increase ethics capacity in the site or program | **The Ethics Committee:**  
1. Committee members will complete the Level II Ethics Resource Workshop  
2. Committee members will review and practice using the site, program and/or region’s Framework for ethical decision-making with case examples  
**Site or Program Personnel Education:**  
1. Promote staff engagement in Health Ethics Week annually  
2. Offers four Ethics for Lunch sessions annually  
3. Members of the committee will encourage appropriate site or program staff to participate in the following workshops:  
   - Ethics in Healthcare Management Workshop  
   - Level I Health Ethics Workshop  
   - Level II Ethics Resource Workshop | 2010-2012 | HEC members to take responsibility for leading one or more initiatives.  
This may involve finding additional staff interested in joining short-term working groups to facilitate activities such as Site or Program Personnel Education. |
| **2. HEC Role Publicity and Marketing** | To ensure that everyone in the site or program is aware of the existence of the HEC and its functions.  
To solicit membership across a variety of disciplines  
To ensure that everyone know where to seek help with ethics concerns | **Communication:**  
Implementation of an “Ethics Awareness Day”  
Share minutes of meetings in a central location Lunch and Learn Ethics Rounds  
Provide information at General Orientation of new staff sessions once a month  
Develop a brochure to advertise HEC. | | HEC members to take responsibility for leading one or more initiatives.  
This may involve finding additional staff interested in joining short-term working groups to facilitate activities. |