Report and Recommendations of the ASBH Advisory Committee on Ethics Standards (ACES)

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Section One: Introduction

Following the last ASBH meeting in the fall of 2005, President Matt Wynia convened an Advisory Committee on Ethics Standards (ACES) to "use appropriate methods of research to provide insight into the question of what ASBH members would like a code of ethics to accomplish" and to report to the ASBH leadership on its findings and recommendations. A Past Presidents Task Force had been convened a year earlier and had done some preliminary work. There was an expectation that the Task Force was to retain some oversight of the process. The new Advisory Committee soon took its charge to be one of "needs assessment." The three original members were Ken Kipnis (Chair), Bob Baker and Caleb Alexander. Caleb Alexander later left the Committee and was replaced by Robert Pearlman. Holly Taylor joined the Committee after data collection was completed. This ***Report and Recommendations of the ASBH Advisory Committee on Ethics Standards*** is a summary of our research and deliberations.

The task of developing a code of ethics for bioethics and related fields has appeared on the agendas of ASBH's parent bodies and has been undertaken by other comparable organizations. Many of the tasks routinely undertaken by ASBH members are novel and carried out amidst an array of varying clients and stakeholders: a complexity giving rise to quandaries and dilemmas. Many of those who routinely take on these tasks have joined and supported organizations that promote shared understandings and professionalization. **Appendix One** -- ***The Professionalization of Bioethics: A Chronology*** – briefly recounts some of the history that has brought ASBH to the occasion of this report.

Opinions on the question of whether ASBH should draft ethical standards for the work of its membership had been varied and audible for some years. One salient event involved a prominent ASBH member who had lost her position after she testified in court in a case involving her home

institution. While Section 4.1 of the ASBH Bylaws prohibited the Society from issuing ". . . positions on substantive moral and policy issues," many felt that ASBH needed to come forward with some public statement on that case. There had been prominent and deep divisions within ASBH around whether it should or should not take stands. Some held there was a moral duty to do so, but others saw the option as dangerously divisive. A referendum in 2002 cooled the debate by permitting ASBH to:

> adopt positions on matters related to academic freedom and professionalism in the fields of bioethics and humanities in health care upon an affirmative vote of two-thirds (2/3) of the full Board of Directors.

This enquiry regarding a possible ASBH Code of Ethics appears within the framework of this new organizational policy.

By definition, professional codes of ethics exist to set standards for the behavior of individuals engaged in certain types of activities. Characteristically they include a general statement of a profession's role within the larger society -- often these are set out in a preamble. And, with varying levels of specificity, they articulate norms that should govern practitioners' interactions with, for example, clients, employing organizations, colleagues, affected third parties, the larger society and so on. It should be emphasized at the outset that there are good codes and bad ones. Codes may be inaccessible, unclear and/or inconsistent. They may pass over troubling issues commonly encountered in professional practice, failing to provide guidance when it is needed. Worse yet, they may lack professional "ownership." Those to whom a code applies may see its provisions as an alien set of imperatives.

Accordingly the Advisory Committee was mindful that its work had to be as transparent as possible. We shared our thinking in a series of three letters to the membership. The first ACES letter set out five ethical problems exemplifying those an ASBH code might address. The second listed six organizational purposes that might be furthered by a code. The last heralded the ASBH Survey that would shortly appear. All three of these letters remain accessible on the ASBH website and are attached to this report as **Appendix Two -- *ACES's Letters to the ASBH Membership*** .

Using a designated website and coded passwords, the survey was administered during May of 2006. A copy of the questionnaire is attached as **Appendix Three – *The ACES Survey Instrument***. To ensure compliance with professional standards and to hold open the option of publishing results, our protocol was assessed in accordance with the standards and procedures of the University of Hawaii institutional review board, which officially confirmed exemption from committee review. The survey was announced and publicized to the membership using email and, for the few without e-addresses, using the United States Postal Service. Several waves of reminders were posted electronically. Of the roughly 1500 ASBH members who were contacted, approximately one third completed the questionnaire. This effort resulted in a substantial amount of qualitative and quantitative data.

The report consists of five additional sections. **Section Two: What the Quantitative Data Tell us About the Survey Respondents** summarizes demographic and other respondent characteristics. **Section Three: What the Quantitative Data Tell us about Respondents Beliefs about Codes** presents respondent attitudes about codes in general, about a possible ASBH code in particular, and about the ethical problems a code might address in the event that ASBH undertakes to promulgate one. **Section Four: A Synthesis of Respondent's Reasons for Opposing/Favoring an ASBH Code** presents qualitative data regarding respondent attitudes. **Section Five: A Synthesis of the Reported Ethics Issues** also reports on some of the qualitative data: specifically those ethical issues the respondents have encountered in the course of their professional work. Finally, in **Section Six: Findings and Recommendations**, we summarize our research and deliberations and record our recommendations to ASBH.

Section Two: What the Quantitative Data Tell Us about the Survey Respondents

A. Demographic Characteristics of ACES Survey Respondents

The majority (56%) of ACES survey respondents are between 40 and 59.

Table 2.1: Age of ACES Survey Respondents

Age	**Number**	**Percentage**
<30	20	4%
30-39	98	18%
40-49	122	23%
50-59	179	33%
≥60	122	23%
Total	541	100%

ACES survey respondents were evenly split among those who have spent 10 years or less in the fields of bioethics and medical humanities. The mean value was 13 years, range was from 0 to 40 years.

Table 2.2: Years ACES Survey Respondents have Worked in Bioethics and/or Medical Humanities?

Years	**Number**	**Percentage**
>10	271	51%
≤10	265	49%
Total	536	100%

B. Professional Background of ACES Survey Respondents

Survey respondents were asked to identify the field that best describes their professional field. Respondents were allowed to select more than one field. Almost three-quarters of respondents selected bioethics. Only 15% of respondents identified humanities as their field. Of note, if we assume that the term humanities is an umbrella term for a combination of disciplines including philosophy, religion, literature, and history, a total of 50% of respondents indicated their primary field as one of the humanities. Table 2.3 includes two different summary percentages. The first

indicates the percentage of the total number of respondents (n=533) that chose the field in the first column and the second indicates the percentage of the total responses to this item (n=1323). The latter is relevant as respondents were able to choose more than one field. On average respondents chose 2.3 fields. This outcome could be related to either the fact that bioethics is a inter-disciplinary field and/or the fact that terms like bioethics and humanities are more general than many of the other choices, leading respondents to select bioethics or humanities along with the discipline in which they were trained (e.g. medicine).

Table 2.3: Professional Field

Professional Field, in rank order	**Number**	**Percentage of Responders n = 533**	**Percentage of Responses n = 1323***
1. Bioethics	381	71%	29%
2. Medicine	195	37%	15%
3. Philosophy	152	29%	11%
4. Humanities	81	15%	6%
5. Religion	78	15%	6%
6. Public Health	72	14%	5%
7. Law	66	12%	5%
8. Nursing	65	12%	5%
9. Literature	36	7%	3%
10. Psychology	29	5%	2%
11. Biology	18	3%	1%
12. Social Work	17	3%	1%
13. Anthropology	15	3%	1%
14. History	14	3%	1%
15. Business Administration	14	3%	1%
16. Dentistry	5	1%	.5%
17. Statistics	4	1%	.5%
18. Economics	3	1%	.5%
18. Natural Science	3	1%	.5%
19. Other	75	14%	6%

* Respondents were asked to check all that apply

ACES Survey respondents were also asked to indicate how much time they spend in the fields of bioethics and humanities (Table 2.4). Given the number of respondents that identified bioethics as their professional field it is not surprising that almost all subjects indicated that some of their professional time was spent in bioethics. 41% of respondents indicated that they spend more than 50% of their professional time on bioethics. Approximately half of the respondents indicated they spent some of their time in the field of medical humanities with the vast majority indicating they spend 50% or less of their time in the field. More respondents indicated they spent time in a field other than bioethics or medical humanities as compared to those who indicated they spent time in the medical humanities.

Table 2.4: Time ACES Respondents Spend in Fields of Bioethics or Medical Humanities

Field		Number	Percentage
Bioethics	>50	217	41%
	≤50	314	59%
	Total	531	
Medical Humanities	>50	18	7%
	≤50	238	93%
	Total	256	
Other	>50	210	53%
	≤50	189	47%
	Total	399	

ACES survey respondents were asked what they do in the fields of bioethics or medical humanities. As noted in Table 2.5 the respondents indicated, in order, that they spend most of their time in four areas: teach or work in a health care related field; engage in research or other scholarly work; staff or serve on an institutional ethics committee or provide bioethics consultations in clinical settings. Respondents were able to identify more than one activity and their responses indicate that they are engaged in multiple activities. Table 2.5 provides information both on the percentage of respondents who indicated they participated in a particular activity and the percentage of responses under that activity. For example, 83% of respondents indicated that they spent time teaching or working in a health care related field and 21% of the responses fell in that category.

Table 2.5: What ACES Respondents do in the Fields of Bioethics or Medical Humanities

Activities in Field, in rank order	**Number of Respondents**	**Percentage of Responders n = 542**	**Percentage of Responses n = 2150***	**Rank**
Teach or work in health care related field	449	83%	21%	1
Engage in research or other scholarly work	399	74%	19%	2
Staff or serve on institutional ethics committee.	338	62%	16%	3
Provide bioethics consultations in clinical setting	319	59%	15%	4
Staff or serve on IRB or other research oversight committee	215	40%	10%	5
Teach or work in non-health care related program	187	36%	9%	6

Work or serve as bioethicist in non-clinical, non-academic setting	99	18%	5%	7
Serve as an expert witness in healthcare related court cases	52	10%	2%	8
Other	92	17%	4%	9

* Respondents were asked to check all that apply

ACES survey respondents were also asked if and how their work in bioethics and medical humanities is compensated. Two-thirds of respondents indicated that their work in bioethics or medical humanities is a component of their written job description. 41% indicated that their ethics and/or humanities work is not part of their job description and that they are not compensated for it. Respondents were allowed to mark more than one response so it is also possible that some who are compensated for the work they do on the job are also externally compensated for bioethics or medical humanities work they do outside of their job.

Table 2.6: How the Respondents' Work in Bioethics or Medical Humanities Work is Compensated

	Number	**Percentage of Responders n = 526**	**Percentage of Responses n = 871***	**Rank**
Component of written job description for which I am compensated	351	67%	40%	1
A volunteered activity or service outside of my job for which I am not compensated.	216	41%	25%	2
Job related activity that is not part of my written job description	195	37%	22%	3
An externally compensated activity or service that I provide outside of my job	109	21%	13%	4

* Respondents were asked to check all that apply

C. Affiliation with Professional Organization with a Code of Ethics

70% of ACES survey respondents indicated they were currently affiliated with a professional organization that had a code of ethics. Of those, 71% indicated they had referred to that code of ethics for guidance.

Table 2.7: ACES Respondents with an Affiliation with Professional Organization Having a Code of Ethics

	Number	Percentage
Yes	381	70%
No	161	30%
Total	542	100%

Table 2.8: ACES Respondents Affiliated with a Professional Organization Having a Code of Ethics and Having Referred to that Code for Guidance

	Number	Percentage
Yes	273	71%
No	109	29%
Total	382	100%

Section Three: What the Quantitative Data Tell Us about Respondents' Beliefs About Codes

Support for ASBH Code

ACES Survey respondents were asked to indicate their level of support for an ASBH code. Notably, 61% of the respondents support the adoption of an ethics code compared to 17% opposed: the former outnumbering the latter 3.6 to 1. The reasons in favor and in opposition to the code will be discussed at length in Section Four below.

Table 3.1: ACES Respondents Opinion About ASBH Adoption of Code of Ethics

Opinion	Number	Percentage
Favor	305	61%
Oppose	84	17%
Neutral	110	22%
Total	499	100%

Bi-variate analysis related to Demographic and Professional Characteristics and Support or Opposition for an ASBH Code of Ethics

Bi-variate analysis was conducted to determine if any demographic or professional characteristics were associated with being more or less likely to favor or oppose the adoption of an ASBH code of ethics. For the purpose of this analysis, those who indicated they were neutral about the adoption of a code were excluded. Two analyses were statistically significant.

1. Support for adoption of ASBH code of ethics

- ACES survey respondents who support the adoption of an ASBH code of ethics are much more likely currently to belong to an organization with a code of ethics ($p=.005$) and to have referred to that code ($p = .000$).

2. Opposition to adoption of ASBH code of ethics

- ACES survey respondents who oppose ASBH adopting a code are more likely to have been in bioethics or medical humanities for more than ten years. ($p = .045$)

Beliefs about Codes in General

Table 3.2 presents data that strongly suggest positive beliefs and attitudes about codes of ethics in general. Over 90% of respondents reported that codes of ethics inform students, employers and the public of the profession's responsibilities, and also set a standard for regulating the conduct of professionals. Over 80% of respondents reported that professional codes prompt valuable discussion among colleagues about standards and expectations, and promote professionalization of occupations. In addition, over 80% reported that professions should discipline members who violate their codes. Interestingly however, almost 50% of the respondents reported that codes of ethics would be unlikely to settle disagreements between professionals.

3.2 General Beliefs about codes of ethics

General Beliefs	**Agree**	**Neutral**	**Disagree**	**Rank***
Codes of ethics inform students, employers and the public of the professions responsibilities	94%	4%	3%	1
Ethics codes set a standard for regulating the conduct of professionals	90%	5%	4%	2
Codes of ethics promote the professionalization of the occupations	84%	10%	6%	3
Professional codes prompt valuable discussion among colleagues about standards and expectations	83%	9%	9%	4
Professions should discipline members who violate their codes	83%	11%	6%	4
Members of a professions should report other members who do not follow the code	70%	20%	10%	6
Ethics codes can provide protection for professionals	68%	20%	13%	7
Ethics codes are unlikely to settle disagreements between professionals	47%	14%	39%	8
Professional codes do not improve behavior	37%	17%	46%	9

*Rank based on level of agreement

Beliefs and Attitudes about a Code for ASBH

Some Reasons for Favoring/Opposing an ASBH Code

In Table 3.3a, respondents indicated a favorable attitude about a code of ethics for ASBH. Nearly three-fourths of the respondents reported that an ASBH code of ethics would be useful to those entering bioethics and a little over half of the respondents thought that an ASBH code of ethics would be useful to those entering medical humanities. In Table 3.3b nearly three-fourths of the respondents also reported a preference for a code with a broad focus that would be applicable to all members. 30% agree that a code should focus narrowly on fields with frequent and serious ethical concerns. In this set of questions a larger percentage of respondents expressed neutrality about the issues, which may demonstrate uncertainty about an ASBH code that currently does not exist. In Table 3.3c, only 15-18% of respondents indicate that they believe that the professionalization of medical humanities/bioethics would be a bad thing.

3.3a Beliefs about a Code of Ethics for ASBH

Beliefs about ASBH Code	Agree	Neutral	Disagree	Rank
An ASBH code of ethics would be useful to those entering bioethics.	74%	14%	12%	1
An ASBH code of ethics would be useful to those entering medical humanities.	54%	27%	19%	2
ASBH members in my field would benefit from an ASBH code.	52%	26%	22%	3
ASBH members in fields other than mine would benefit from an ASBH code.	48%	37%	15%	4
ASBH members already have adequate codes of ethics from other professional societies.	31%	26%	42%	5

*Rank based on level of agreement

3.3b Attitudes about the Level of Focus for Code of Ethics for ASBH

Level of Focus	Agree	Neutral	Disagree
Any ASBH code should focus broadly on standards applicable to all ASBH members.	73%	15%	11%
Any ASBH code should focus narrowly on fields associated with frequent and serious ethical concerns.	30%	21%	48%

3.3c Attitudes about Professionalization of Medical Humanities and Bioethics

Attitudes about professionalization	Agree	Neutral	Disagree
The professionalization of medical humanities would be a bad thing.	18%	37%	44%
The professionalization of bioethics would be a bad thing.	15%	21%	63%

Bi-variate analysis related to support/opposition to code for ASBH and beliefs about the adoption of an ASBH code

In general, those who support the adoption of an ASBH code of ethics are more likely to agree with positive statements and disagree with negative statements. Of note, there is no trend regarding whether the code ought to be general or narrow.

- Those who favor a code are much more likely to agree that code would be useful for new bioethicists. ($p = .000$)
- Those who favor a code are much more likely to agree that code would be useful for new medical humanists. ($p = .000$)
- Those who favor a code are much more likely to agree that members of their field would benefit. ($p = .000$)
- Those who favor a code are much more likely to agree that members in other fields would benefit. ($p = .000$)
- Those who favor a code are much more likely to disagree that ASBH members already have adequate codes. ($p = .000$)
- Those who favor a code are much more likely to disagree that professionalization would be bad for bioethics. ($p = .000$)
- Those who favor a code are much more likely to disagree that professionalization would be bad for medical humanities. ($p = .000$)
- No trend by support as to whether code should be general or narrow.

Beliefs about Issues a Possible ASBH Code Should Cover

In Table 3.4, respondents reported perceived importance of issues if ASBH were to develop a code of ethics. Nearly all respondents felt that three topics were moderately or very important. These included identifying and managing conflicts or interest, honoring confidentiality and obligations to disclose, and reporting serious misconduct. Over 80% reported two other issues (ascribing authorship and crediting contributions to reports and published work, and identifying and managing improper pressures and boundary violations by employers and supervisors) as being very or moderately important. The majority of respondents did not feel that an ASBH code of ethics should address the issue of including negative remarks in letters of reference.

3.4 If ASBH were to develop a professional code, how important would it be to cover the following issues?

Important Issues	Very Important	Moderately Important	Total Important	Rank
Identifying and managing **conflicts of interest**.	73%	25%	98%	1
Honoring **confidentiality** and **obligations to disclose**	74%	23%	97%	2
Reporting serious **misconduct**.	67%	27%	94%	3
Ascribing (co) **authorship** and crediting contributors to reports and published work.	50%	38%	88%	4
Identifying and managing **improper pressures** and **boundary violations** by employers, supervisors.	44%	44%	88%	4
Presenting **incomplete characterizations** of complex issues in public venues.	31%	42%	73%	6
Reporting problems to employers, supervisors when these are likely to be unwelcome.	28%	48%	70%	7
Including negative remarks in letters of reference.	7%	33%	40%	8

*Rank based on total importance

Section Four: A Synthesis of Respondents' Reasons for Opposing/Favoring An ASBH Code

Question 2.5.2 asked ASBH members to set out their reasons for opposing or favoring an ASBH code of ethics. The membership submitted 290 narratives totaling 39 single-spaced pages. What follows is a synthesis of the content of these narratives.

In Section Two, above, we reported on the quantitative data on support and opposition to a code, noting that support exceeded opposition 3.6 to 1. No effort was made to determine the prevalence or sources of their judgments reported. Rather the aim was to draw out and assemble a range of plausible considerations that, taken together, would assist in assessing any final ASBH decision to develop or not to develop a code. Whatever ASBH's decision turns out to be, how might one respond to the views of the other side? The comments below are best understood as reminders, liberally drawn from members' recorded reflections. They are a checklist of issues to be considered in the course of deciding ASBH's future. Some of these will be addressed in Section Six, reporting on our recommendations.

Reasons for Opposing an ASBH Code

A Code Would Serve No Useful Function

1. **Redundancy:** ASBH members are already subject to other professional codes; a new code would be redundant. There are too many codes. ASBH could simply endorse those other codes. And it would be better if other institutions drafted them instead of ASBH. Moreover, because bioethicists are specifically trained in ethics, a codification of ethics is unnecessary.

2. **Fluff:** Codes are window dressing, vacuous bureaucratic fluff. They do not influence behavior. (It may be useful, however, to commission some thoughtful position papers -- on conflict of interest for example.)

3. **Nonenforcement:** Without enforcement, codes are useless.

4. **Not a profession:** Professions require codes. ASBH does not represent any profession nor is it a professional organization.

5. **Licensure:** Licensed occupations need codes. The ASBH membership is not representative of any licensed occupation.

An ASBH Code Would be Misconceived

6. **Contrast with morality:** Professional codes presuppose an unacceptable "cookbook" approach to ethics. Our lives are more complicated than that. Codes suggest that, unlike ordinary people, professionals are not subject to universal ethical requirements. The common morality is already taken for granted, at least as ideals. It has all been said already, and probably better. It is not the place of ASBH to impose a unified moral framework upon all of its members

7. **Youthfulness:** Codes are appropriate for mature fields. Bioethics is too young to have a code.

8. **Diversity and generality:** The diversity of ASBH's membership entails that any resulting code would be too general to be useful. Warm and fuzzy generalizations are of little practical value. (But, likewise, specific rules can hamper decision-making in difficult cases.) Moreover, diversity is one of ASBH's strengths: codifying bioethics as a single identifiable profession diminishes the value of diversity. Except for paying ASBH dues, there are no activities all our members have in common.

9. **Bias:** Codes are commonly hijacked by small groups. Accordingly they reflect political biases, personal ideals, special interests and minority views. It is unwise to exalt the preferences and opinions of the few into ethical commandments for everyone.

A Code would be Difficult/Impossible to Draft

10. **Divisiveness:** The process of developing a code would be divisive, thereby damaging the reputation of ASBH. Those with minority views would be marginalized by a code.

11. **Impossibility of consensus:** The membership and activities of ASBH are too diverse to achieve consensus.

12. **Professional goals?:** Drafting a code requires agreement on professional goals. This has not been done.

13. **Ethicists?:** Drafting a code requires prior agreement on what an ethicist is. This has not been done.

14. **Incompetence:** ASBH does not have members who are competent to draft a code. Indeed it is not clear that anyone could do this job.

15. **Ethical conflicts**: The provisions of any ASBH code could conflict with other institutional or professional obligations.

Reasons for Favoring an ASBH Code

The Value of a Code

1. **Standards:** A code, consisting of guiding principles or standards for behavior, would be useful, especially to those members who engage in ethically challenging activities: e.g., clinical consultation, expert witnessing, industry work. Too many of our members have moved from academic roles into clinical roles posing difficult and characteristically unfamiliar ethical challenges. It is not clear that we know what a good bioethicist won't do; what situations we must avoid. Too many of our internal ethical problems are insufficiently studied. Because there is no basis for assuming that ethicists are inherently ethical, it would be useful to have a code governing certain of our activities.

2. **Transparency:** In its transparency, a code can augment the credibility, acceptance and reputation of the field: with respect to other health-related professions, the public, our clients and our employers.

3. **Education:** A code can serve as an educational tool: a reference for students and newcomers to the field. It sets a tone and communicates to potential initiates what is expected of them. It is a codified institutional memory of lessons learned.

4. **Accountability:** A code can enable both principled disapprovals and conscientious refusals on professional grounds. In allowing members to appeal to authoritative standards that are conceived in the public interest, it can reduce the costs of ethical behavior, supporting those who "speak truth to power." It counters the misconception that decent people instinctively know how to manage ethical complexity.

5. **Organizational integrity and legitimacy:** A code can promote the integrity of ASBH, defining its identity and the social value of its organizational commitments, clarifying expectations and aspirational goals, and furthering cohesiveness. Lacking a code, we are a ship without a rudder. Too many of us work without ongoing contact with peers. We need a code precisely because we are so diverse. If ASBH fails to meet the needs of clinical ethics consultants, they may create a separate professional organization.

6. **Nonmembership in code-governed occupations:** Many ASBH members are engaged in activities that are not covered by existing codes.

The Value of Code Development

7. **Locus of dialogue:** A code can serve as an organizational locus for healthy debate, dialogue and discussion on a range of professional issues. We need to deliberate together about what we "are about" as professionals. This discussion alone would be positive.

8. **Tracking emerging challenges:** A code, together with its ongoing review processes, allows identification, reflective assessment and disposition of ethically vexatious emerging issues.

9. **Membership needs:** In meeting the felt needs of members engaging in ethically challenging activities, a code can strengthen ASBH.

10. **Professionalization:** A code promotes professionalism among ASBH members and, organizationally, it is essential to an occupation's development into a profession. We would be better professionals if we all knew what it meant to be a bioethics professional. We could avoid pitfalls if we all knew what it was to violate our code.

On Not Having a Code

11. **Embarrassment:** It is an embarrassment for ASBH not to have a code. Even as we have become arbiters of ethical judgment, we are not subject to professionally articulated ethical standards. Even an imperfect code would be a step forward and could be improved over time. Even a low ethical floor is better than no floor. Without our own standards, misconduct will be handled by the law. With no standards to point to, a high-profile scandal could be devastating to our field. If, as practitioners, we perform valuable services requiring specialized knowledge and skills, we should be held to standards that are higher than those applicable to others who do not serve in our distinctive roles. It is arrogant to claim expertise in ethics while lacking any authoritative standards against which we measure ourselves: this is power without accountability. Other health-related professions have codes. Why are we exempt?

12. **Timeliness:** It is high time for professional bioethicists to develop a code, to come clean about our professional norms and aspirations. We have been under fire and have learned that we too can betray trust. Many of us worry that anyone can self-designate as a "bioethicist" regardless of their skills and commitments. There are

> tasks we commonly undertake that are not routinely handled by other health-related professionals. While other health-related professions have developed codes that are useful to practitioners, we have been "winging it" as individual practitioners for 25 years. We have become too large to be monitored on an ad hoc basis. We have the expertise to do the job well; and, provided the process is aimed at service rather than self-promotion, we would collectively learn a great deal in the attempt.

Other Comments

In addition to the reasons for and against developing a code, members submitted cautionary admonitions not readily assignable to either side. Here is a selection of these.

> A code is more important to consulting bedside and benchside bioethicists than it is to academic bioethicists. A medical humanities code is less of a concern.
>
> A professional code must distinguish between the goods its members should be striving for in their work and the principles they must take care not to violate.
>
> A generic professional code would be less useful than one focused on specific issues/activities.
>
> A code should focus on conduct rather than attitudes or beliefs.
>
> There should be broad discussion of drafts.
>
> The difficulty is in crafting a meaningful code that provides both explanatory power and action-guiding advice, without slipping into the all-too-common morass of vaguish principles or overstated ideals.

Section Five: A Synthesis of the Reported Ethical Issues

Question 2.4 of the survey asked for examples of ethical problems respondents had noted in their professional work. In part, the question read:

> In order to draft a code that would be of practical use to ASBH members (and to assess the usefulness of such a project), we would like you to think of an actual situation in which a bioethicist or medical humanist has either faced a comparable ethical problem directly (i.e., not addressing the ethical problems of others as a consultant) or has been concerned that a colleague may have acted unprofessionally. Please describe the situation, indicating why it was troubling . . . .

In all, 88 narratives were submitted by 69 respondents: approximately 26 single-spaced pages of source material. In this section the intention is to sketch what we take to be much of the substance of the concerns registered by the membership. Many of the cases duplicated issues and some were unresponsive in certain respects. A selection of 34 of the submitted narratives have been rewritten and substantially abbreviated. The parenthetical numbers at the end of each case refer to the specific source narrative in our database. The focus is on the ethical concerns registered by the membership in their replies to 2.4. The goal is to highlight the range and intensity of issues faced by ASBH members.

While we have used seven headings to organize this material, we do not commend these as a taxonomy of the issues in our field. There are too few cases to make confident judgments about the variety that might be disclosed by further data collection and analysis. It will be obvious as well that some of the cases could fit under headings other than the one chosen. (A second categorization is set out in the Discussion at the end of this section.) Notwithstanding these and other shortcomings, we believe that the narratives exhibit a broad range of serious ethical concerns faced by ASBH members.

Conflicts of Obligations

Some of the narratives describe situations in which individuals find themselves subject to conflicting obligations. Here are two of the most dramatic:

> **1. The Post-doc Fellow:** Expecting full confidentiality, a post-doc fellow discloses to a staff bioethicist that a supervisor may have plagiarized his work. The fellow does not want to report possible misconduct. One of the bioethicist's duties is to ensure compliance with federal regulations and report possible violations. How does one

resolve the conflict between the duties to maintain confidentiality in consultation and to promote compliance with federal regulations? (03)

2. The Retired Colleague: You work as a bioethicist at a university hospital. A friend, a retired colleague, has sought your assistance in anticipating medical decisions at the end of his life. You help him prepare an advance directive and agree to accept appointment as his health care proxy. He is now unresponsive with respiratory failure secondary to fungal pneumonia and leukemia: there is no chance of recovery. When the family learns that you have decided to abate life-support, they go to court arguing that, as an employee of the University, you have a conflict of interest: your salary is paid by the University which is underwriting the costs of his care. You appreciate that, while you have obligations toward your friend and toward a client for whom you are an advocate, you also have obligations toward the University – your employer: The attorney for the University has told you not to go against the wishes of the family. (10)

Righting Wrongs

Here there is observed misconduct of some sort and the typically distressed narrator worries about whether and how he/she should respond.

3. In the Dark: A bioethicist EC member is aware of physician behavior suggesting an effort to conceal possible malpractice. Facts had been obfuscated to deflect attention. A patient had died and the family had suffered. The EC had provided a complainant with ethics education and advice, but the matter was not pursued. I had to leave the family in the dark about the circumstances of the patient's death. We handled the consultation by the book but were uncomfortable seeing a wrong and not acting to right it. We left the family unempowered. (07)

4. Credentials: I had a colleague who claimed academic credentials he did not have. (15.1)

5. Murder: Our "ethicist" believes that ventilators should never be turned off. It is murder. It is not the role of the ethics consult to find reasons to continue unwanted medical therapy at all cost, regardless of physician opinion, advance directives or surrogate requests. Makes life very challenging. (21)

6. Other Employers: An ethicist discovers that another ethicist in her employ is sexually harassing students. She fires the employee but wonders whether she should inform other potential employers. (24.4)

7. Signing for Others: At a medical school students report that classmates taking a bioethics course were signing for those not present. Those involved needed the credits for graduation. The course is an elective. (42)

8. The Outpatient: An outpatient tells a hospital ethicist that she had been lied to by a senior hospital administrator. She asks the ethicist to go with her to a hospital board meeting to confront the individual. The patient rejects other suggested options. (59)

9. No Benefit: I have been involved in consultations where, following family requests, physicians provided treatments they felt to be of no benefit to patients. Both the treating physician and members of the ethics consult team focused on the family's requests, rather than the patient's interests. A code of ethics would help to codify appropriate ethical priorities. (09.3)

Authorship

These cases evidence concerns about plagiarism, credit for authorship and some related issues. It may be that variations in our interdisciplinary collaborations and in the practices of our several fields make joint undertakings somewhat vulnerable to unexplored differences in expectations.

10. Pulling Out: A senior scholar pulls out of a research project complaining that he disagrees with the methods of analysis. The paper is completed by the remaining researchers and is about to be submitted for publication. The scholar now demands to be listed as an author. (51)

11. The Same Standards: An employee-management team has created a document setting out ethical standards governing certain practices within its organization. While attending a national conference some years later, a member of the team hears a presentation describing the same document but attributing it to a second organization. (57)

12. The Junior Colleague: A senior scholar assists a junior colleague who is writing an article. Nearly all of the article is the work of the junior colleague. The senior scholar has listed himself as first author. (15.2)

13. Unattributed Passages: An author discovers that some passages in a journal article he has published were verbatim quotations he had inadvertently failed to attribute. Is it sufficient merely to notify and apologize to the author, or must the journal editor be notified and required to publish a correction? (02)

The Role of the Consultant

The cases in this section highlight a need to clarify the role of the bioethicist; a need, perhaps, to assemble reminders for the benefit of those who take on comparable responsibilities. Several of the cases emerge from occupying multiple roles.

14. Talking Points: For several years your hospital has had poor labor relations with nursing staff. A labor union is working to organize the nurses. The hospital's president asks you to construct ethical arguments against unions in health care. You are aware of the arguments on both sides of the issue and, coming from a union family, you tend to support labor. A failure to develop the correct "talking points" could cost you your job. What should you do? (20.1)

15. Perioperative Behavior: A patient exhibited a preoperative behavioral pattern that substantially increased the risk of indicated surgery. An ethics consultant was asked to comment on the ethics of proceeding with the surgery. The written consult contained recommendations for specific behavioral measures that could impact negatively upon the patient and that were outside the scope of his training (the PhD was in an unrelated field). There was no discussion of the ethical issues. (22)

16. Palliative Care: The chair of our ethics committee is a doctor specializing in palliative care. The case involved a patient who was rapidly deteriorating and a family requesting aggressive treatment that the nursing staff felt was futile. The physician took matters into his own hands, convinced the family that he would assure that the patient received appropriate palliative care, changed the plan of care to comfort measures and wrote a DNR order. The medical team did not have the opportunity to contribute to the plan. I felt that our physician had a conflict of interest. He had been serving in the role of ethics consultant, but crossed that boundary by usurping the medical team's role. Many who do clinical ethics are also medical professionals. (39)

17. You Are All Nuts: I am at a meeting on an ethics case on which I have been consulted. The medical plan strikes me as way beyond anything sane, totally inhumane and burdensome on the patient. But everyone, including the patient, thinks it's a good plan. Should I say, "You are all nuts here!" I said nothing but I should have had the wits to think of something to say. (09.4)

18. Costly Drugs: I sit on the pharmacy and therapeutics committee. Very costly drugs are accepted for the hospital's unreasonably large formulary. How strongly should I press the cost issue? I have tried with increasing persistence and force as time goes by. (09.5)

19. Omitting Problems: Preparing the annual report to a granting agency, the supervisor of a bioethics program asks a bioethicist to omit references to problems with the funded project. (24.1)

20. Not Asked: I am routinely asked to attend ethics consultation meetings. No one asks my advice or asks an ethics question. Should I render an opinion if not asked for one? Sometimes I ask for a question and get one. But, if I am not asked, I don't give an opinion. In these consultations, I try not to answer questions not asked. Committee work is different. (09-3)

21. Community Representative: Seeking clinical experience, a humanities professor volunteers to serve on the ethics committee of a local hospital and is invited as a nonvoting community representative. She attends meetings and contributes, but can not look at medical records or go on ethics rounds or otherwise interact with patients. She rarely has enough information to contribute to consults. Her proposals are typically rebuffed because of her lack of clinical experience. She begins to see her presence as window-dressing. (58)

Information Management

The issues here pertain to the disclosure and withholding of information obtained in the course of one's work.

22. Teaching Cases: An ethics professor used content from a hospital case consultation in teaching at his educational institution. The committee members felt violated and the professor was dismissed from the committee. (26)

23. Collecting Summaries: At a large tertiary care center, the ethics committee chair hands out detailed case summaries that include patient names and contact information. These are not collected at the end of the meeting. (38)

24. Stealth: The chair of the ethics committee and animal research IRB refuses to release the names of the committee members and the times and places where the committee meets. This doesn't support transparency and trust. It suggests stealth and secrecy. (41)

25. Permission to Discuss: I am unclear whether we should inform doctors and patients, etc., that materials they have disclosed to us will, in redacted form, be discussed in print; or whether we are required to seek and obtain their permission? Or should they be consulted and, if so, what powers would they then have? People say various things about this issue but I have yet to see it discussed in a comprehensive and authoritative way. (61)

Public Statements

The cases here focus on statements made in various settings and on the posture of the speaker: on ethics committees, in the courts, to the press, in grand rounds and to the public generally. What obligations accompany these utterances?

26. Suicidal Intent: Jim is a hospital ethics consultant who also serves on an ethics committee for a home health care agency. The committee was reviewing the agency's policy covering patient disclosures of suicidal intent. Jim argues persuasively that a choice for suicide, especially at the end of life, should almost invariably be honored. A second committee member is concerned that Jim is not representing the spectrum of opinion on this issue. Are there standards about presenting all the major positions on an issue? (18)

27. Experts for Hire: An ethicist at a medical school often thrusts himself into the public eye. He has served as a "bioethics expert" in high-profile court cases and wonders whether he should he accept payment for offering testimony. The attorneys who hire him often do not allow him to explain the finer points of his reasoning, so that his advice has, at times, become simplified to the point of being misleading. Is this his fault? Should bioethicists not serve as experts for hire? (29)

28. Reply to Reporter: Journalists call you about an event that may have ethical implications. You do not have any expertise in the area, nor have you written on or seriously researched it. Can you give a public statement or must you refer the journalist to a genuine expert in the field? (31.2)

29. Public Attack: A journalist calls you for a comment on a prominent bioethicist's work. You see his views as repugnant, even evil. You can truthfully tell the reporter that you find no intellectual merit in his writings. But the bioethicist is widely cited and has been published in major academic presses and peer-reviewed journals. Is it ethical to attack a fellow bioethicist in public? (31.3)

30. The Ethics Certificate: Having a certificate from a course on medical ethics, a nurse presents at nursing grand rounds. She lays out the 4 principles as if they were a checklist and explains each in a way that demonstrates confusion. I was horrified at the thought of this person making recommendations at the bedside. We need to recognize that the advice of an "Ethicist" can be given weight in the clinical setting and that the power attached to the title can be dangerous. We need to be cautious and rigorous in creating standards for the profession. (48)

31. Speaking to Audiences: One troubling circumstance pertains to the ambiguous role of bioethicists who speak to audiences. Is this a balanced bioethicist? A critical bioethicist? A citizen who has a professional connection to bioethics? And so on. (45)

32. Softening the Expertise: Should I take a public stand on moral issues which do not require bioethical review, but on which clear moral judgments seem to be at hand? Should I present these opinions as a result of the objective professional study of ethics? I make the judgments, but soften the expertise claim. (09.8)

Conflicts of Interest

While there is a general appreciation that the judgment of professionals should not be tainted by interests that reasonably call into question fiduciary loyalty and disinterested judgment, it is far less clear how that standard should govern professional practices. Here are a few of the concerns registered in this arena.

33. Nanomedicine: You are offered $5000 to consult for a nanomedicine company on ethical issues associated with a new product. At the same time you are the PI on a grant to study the ethics of nanomedicine and you are writing a book on the topic. Can you take the money? (01)

34. Who Pays?: A family asks a bioethics consultant -- a philosopher – “Who is paying for your services?” The consultant answers that it is the hospital. The family complains that his role is not credible because of a conflict of interest. How should bioethics consultants be paid? (16.1)

35. The Researcher/Physician: A senior researcher/physician plays a major role in a hospital’s ethics deliberations. He is also involved in industry-sponsored trials, some of which are conducted on hospital patients under his clinical control and he is a well-paid consultant and speaker for several drug companies. It is often difficult to discern the reasons for his recommendations and decisions. In institutions where ethicists play other roles, there are many possibilities for conflicts. Shouldn’t a full-time ethicist do the job? (27)

Discussion

When President Wynia established ACES it was assumed that the various fields from which ASBH members emerged would be significantly correlated with support and opposition toward various issues. In particular, there was a conjecture that those identifying as specialists in medical humanities would have significantly different beliefs and attitudes than those identifying as Bioethicists. There was a sense that the multiplicity of the fields represented by ASBH would make it difficult to develop a single code. One question we were asking the survey to resolve had to do with whether a code should address all fields or only those that were generating

frequent and difficult ethical problems. Several findings have forced us to revisit these initial conjectures.

The percentage of respondents who report spending more than 50% of their time in bioethics was 41%, compared with only 7% spending more than 50% of their time in medical humanities: a ratio of nearly six to one. Those self-identifying as medical humanists were a small minority. Notwithstanding, it is notable that 29 % of the respondents listed their field as philosophy, 15% as humanities, 15% as religion, 7% as literature and 3% as history. Certainly all of these are humanities disciplines. Even allowing for overlap, it is likely that the percentage of ASBH membership from feeder disciplines in the humanities is far greater than the very small percentage or respondents who report working primarily as medical humanists.

It began to appear that our foundational academic disciplines were not as important as we had taken them to be.

A clue to what was going on emerged in analyzing the ethics cases reported by the membership. Surprisingly, these cases could be understood as arising, not out of fields, but out of certain activities that are commonly and characteristically undertaken by a very broad range of ASBH members. Though it may be that data collection will be required to confirm this, it appears that the activities generating problems in professional ethics are generally these:

1. Clinical and other forms of consultation.

2. Service on an ethics committee or IRB.

3. Research and publication, including pertinent collaborations.

4. Communication to the public and other audiences (courts, mass media, reporters etc.).

5. The use and handling of confidential material.

6. Ensuring compliance with regulatory and other standards.

Some of the issues emerge from engaging in several of these activities at once, or from undertaking one or more of these while occupying another potentially conflicting role: doctor, administrative assistant, friend, employee, medical researcher, and so on.

While it is not possible here to make a well-founded recommendation, it may be that, were ASBH to choose to develop ethical standards, those involved in the drafting should remain mindful of these specific activities that are routinely undertaken by its members.

Regardless of the taxonomy, the 35 cases assembled above represent a window into the ethical

concerns of the ASBH membership. Any ***comprehensive*** code of ethics would have to provide useful guidance for members who might face such problems in the course of their work, and for other ethical problems that might be reported to the organization over time.

Section Six: Findings and Recommendations

Of the 1522 members of ASBH, 488 -- roughly one third -- responded to the survey. We conjecture that those who replied are more likely to attach importance to the subject matter of the survey, one way or the other. After reviewing the data and materials set out in Sections One through Five, the Advisory Committee concurs on two major findings.

First Finding: That the membership supports developing an ASBH code of ethics.

Second Finding: That there is an unmet need among many ASBH members for the guidance a code of ethics might provide.

The committee notes that 61% of the survey respondents favor the development of an ASBH code of ethics. Only 17% oppose developing a code of ethics: a ratio of 3.6 to 1.

Asked about eight specific issues that might be addressed by an ASBH code of ethics, more than 75% of the respondents rated six issues as either very important or moderately important. Four issues were rated by 85% as either very important or moderately important. Two of the issues (confidentiality and conflict of interest) were rated by more than 95% of respondents as either very important or moderately important.

Especially revealing were the ethics problems submitted by the membership and synthesized in Section Five above. These should be reviewed with care, as they offer insight into the types of issues that can be faced by ASBH members, issues that should be addressed in any code that aims at being comprehensive.

A careful review of Section Four suggests that objections to developing an ASBH code of ethics are largely unwarranted. For example, some hold that a code is unnecessary because ASBH members are already covered by other codes. Yet 30% of the respondents report that they do not belong to a professional organization that has a code. Moreover, the provisions of many professional codes do not anticipate certain distinctive and ethically problematic activities of ASBH members. Others object that developing a code of ethics can be arduous, that consensus can be hard to come by, that those who draft a code may be biased or just not up to the job, and that there may be problems in implementation. These warnings are well-taken and should be addressed in ASBH's planning.

We are nonetheless persuaded that ASBH either has or could obtain the resources to develop a code. We believe that that ASBH could (1) muster the skills and personnel required, (2) achieve a level of transparency and participation necessary to achieve broad ownership of the code, and (3) establish an oversight process for the initial code development process and for ongoing interpretation, revision and amendment. We are persuaded further that a strong organizational commitment to such a process will redound to the benefit of ASBH and its members.

Recommendation: Given the organizational mandate in the two findings above, the Advisory Committee on Ethics Standards recommends that the ASBH Board initiate a process of drafting and promulgating a comprehensive Code of Ethics that will be owned by its membership.

The Advisory Committee was never intended to begin work on a code. Our charge was to gather information that might help the ASBH leadership to make an informed decision that would serve both the organization and its membership. We have however briefly considered the steps ASBH might now take and the organizational resources that would be required. While we were not in agreement about what procedures would be ideal for ASBH, we were clearer about some of the issues the Board should bear in mind. If the Board decides to move forward with our recommendation above, there are at least four subtasks the Board should bear in mind.

1. ASBH should determine how it will marshal the organizational and financial resources needed to implement the development of an ASBH Code of Ethics.

There was some support on the committee for the idea that ASBH obtain funding for such a project, as it did with the Core Competencies task. Much turns on how important, how arduous and how complicated the Board judges the code development process to be. And that, in turn, will depend to some degree on how the Board envisions the development process and the outcome.

2. ASBH should establish new (or modify existing) organizational mechanisms to draft a code in a way that can ensure comprehensiveness and ownership, and to provide stable oversight, if needed, during the code development process.

Turnovers in Board membership can derail a lengthy code development process: a consensus that informs cooperation at the outset may not be embraced by a very different Board some years later. For this reason, the responsibility to oversee a lengthy code development process should not fall to the Board. (This advice would not be applicable if it were anticipated that code development and adoption could be carried out within a reasonably short period.)

3. ASBH should determine how, when completed, such a code should be promulgated and thereafter amended.

While we were in agreement that a draft of a code should not be implemented by Board fiat, there are several other options for structuring a ratification process. We do not, however, address the alternative approaches in this Report, except to note that there may eventually be a need to amend ASBH's Constitution and Bylaws for this subtask, and for subtask 4, which follows. These requirements should be anticipated at the beginning

4. ASBH should, eventually, decide how it will establish or charge an organizational body with the task of monitoring the use of the promulgated Code on an ongoing basis, for the purposes of interpretation, amendment, revision and – possibly – enforcement.

Should a special oversight body be established in 2 above, it could evolve into the monitoring body referenced here.

From its beginnings, ASBH has operated largely as a "learned society." We have been and still are an institutional setting for academic debate and discussion about the human dimensions of health care and the biological sciences, as these are explored across a range of disciplines: e.g., literature, philosophy, religion, law, social and biological science and the health-related professions. To sustain ongoing conversation with so many scholarly voices has been perhaps the most significant achievement of ASBH to date. But to its credit, ASBH was able to accommodate certain pressing professional concerns of its clinical ethics consultants and to develop an authoritative landmark document setting out core competencies for their distinctive work. We have survived that project. Now ASBH stands at a second crossroads, deciding whether to take on another of the defining functions of a professional association: the development of professional standards. For some, this second project is an imprudent leap into uncharted peril. There are significant pockets of opposition to the project, particularly among those who have been in bioethics/medical humanities for more than ten years. For many of them, it seems the wiser choice would be to stay put. For a much larger and perhaps younger group of members, the path stretches toward a coming of age, the fulfillment of a promise. Code development would require collective deliberation on the common purposes that inform our distinctive tasks, and debate about how these values might be harmonized in the different settings in which we practice and how they might inform our organizational structure. While such a debate would be healthy in itself, any success that ASBH achieved in realizing broadly supported professional standards would be a worthy accomplishment.

Appendix 1: *The Professionalization Of Bioethics: A Chronology*

1969 Society for Health and Human Values (SHHV) founded

I986: Society for Bioethics Consultation (SBC) founded

Canadian bioethicist Benjamin Freedman issues the first call for a code of ethics for clinical ethicists. "I see no a priori reason for thinking that clinical ethics is so complicated, confusing or delicate an enterprise that it alone among professions should be without a shared and public understanding of the moral dimensions of its practice. Nor do I think that ethicists are so clear thinking and saintly a group as to be without need of such a codes. Clinical ethics is neither above nor below the need for a code." (Freedman 1989, 137-8). The proposal is stillborn.

1988 Canadian Bioethics Society (CBS) founded.

1994 American Association of Bioethics (AAB) founded

1996 SBC & SHHV form the "Task Force on Standards for Bioethics Consultation."

AAB, SBC & SHHV merge to form American Society of Bioethics and Humanities (ASBH).

ASBH issues Task Force on Standards report as ***Core Competencies for Health Care Ethics Consultation*** -- the first field-wide consensus statement on the knowledge base and skills essential to competent clinical ethics consultation.

Section 5 of the report offers the first code of ethics for clinical ethicists, who by "virtue of their role in health care institutions," ethicists" are both granted and claim social authority to influence: the clinical care of patients; the behavior of health providers towards families of the patient and towards each other; [and] the behavior of health care institutions [which] "can be abused."

The code specifies five "special obligations" of clinical ethicists with respect to: confidentiality, disclosure and recusal, conflicts of interest, autonomy, and non-exploitation. It also states the reciprocal obligations of institutions employing clinical ethicists to "foster a climate [in which ethicists] can carry out their duties without fear of reprisals, undue political pressure" respecting the independence of ethics consultation and

ethics policy initiatives." The "Special Obligations" section of Core Competencies Report is ignored in the US, but is influential in Canada.

1997 Mary Faith Marshall, Director of the Medical University of South Carolina's (MUSC) bioethics program, testifies under subpoena, that as MUSC's "bioethicist," MUSC's "policy [on managing pregnant addicted Medicaid patients] fails to meet the institution's standards [for] informed consent [because] the risk of arrest and incarceration was not made clear to patients."

1998 MUSC delays Marshall's promotion, ACLU launches investigation, Marshall promoted.

Mary Faith Marshall delivers "Speaking Truth to Power" Presidential Address at October ASBH meeting.

Members press for a resolution urging the ASBH to assert the professional integrity of bioethicists. This is rejected by ASBH board because of a bylaw prohibiting "mak[ing] or endors[ing] positions on substantive moral policy issues."

1999 Ad Hoc Working Group on Employment Standards for Bioethicists of Canadian Bioethics Society (Working Group) formed in response to Marshall case and similar Canadian cases.

2000 MUSC defunds its bioethics program. Marshall leaves MUSC.

1998 Decision on bylaw prevents ASBH from investigating or commenting on the Marshall case.

Working Conditions for Bioethics in Canada published on the CBS website. "The role of ethicist includes the unique obligation of speaking explicitly to moral concerns. She or he will often bear direct responsibility for speaking to concerns regarding the moral character and behavior of the organization. Such being the case, the ethicist will often be required to offer critiques of organizational behavior and norms and to speak uncomfortable truths" ((MacDonald et al. 2000).

2001 Leading bioethicists publish statements critical of ethics consultation without ethics standards. "If bioethicists have gained any credibility in the public eye, it rests on the perception that they have no financial interest in the objects of their scrutiny." .The problem with ethics consultants is that they look like watchdogs but can be used like show dogs" (Carl Elliott 2001)

Increasing media coverage of financial conflicts of interest in bioethicis: "And Now Ethics for Sale: Bioethicists and Big Bucks," Boyce, *US News and World Report*; "Bioethicists Fall Under Familiar Scrutiny," Stolberg, *New York Times*.

2002 ASBH revises its bylaws to permit "adopt[ing] positions relat[ing] to academic freedom and professionalism in bioethics upon an affirmative vote of two-thirds (2/3) of the full Board of Directors."

ASBH and the American Society for Law, Medicine and Ethics (ASLME, founded 1911) joint task force publishes ***Bioethics Consultation in the Private Sector*** in the *Hastings Center Report* (Brody et al. 2002). The report offers voluntary guidelines for bioethics consultants. Asserting ideals of integrity and independence in bioethics consultation it states that "consultants [have] obligations as an advocate and as a whistleblower" in contexts in which the "harm" from "disregarding advice may be great" (p. 19). Thus if "continued advocacy within the client context is inadequate, public disclosure may be required, even though it may violate the terms of contracts." In fairness to the client and to honor the client as best as possible, "the consultant should offer the client, at the highest level, the opportunity to respond before taking any action involving public disclosure" (p. 19). The consultant-client relationship is thus construed in terms reciprocal obligations in which consultant bioethicists' obligations to prevent harm override their commitments to their clients.

Neither the ASBH nor the ASLME adopt the task forces recommendations.

ASBH national conference features a panel discussion, "The Public Face of Bioethics: Watchdog or Show Dog?" (Baylis, Eckenwiler, Sharp) and a workshop "Codes of Ethics: Understanding the History and Writing Codes of Ethics (Baker, McCullough, Wynia).

CBS issues ***Draft Model Code of Ethics for Bioethics*** (MacDonald 2002) offering a "national standard for ethical conduct in bioethics" on the grounds that the "social role" they play "implies" that they have "fiduciary responsibilities" as "those to whom the public looks for guidance." The body of the code is formulated as a pledge in which bioethicists commit themselves to eleven obligations: professional integrity, humility, confidentiality, disclosure and recusal, non-authoritarianism, non-exploitation, professional honor, advancing the field, integrity in conditions of personal employment, integrity in positions of employment for others.

2004 Steve Miles, former President AAB and founding member of ASBH resigns publicly from ASBH stating as reasons ASBH's "reluctan[ce] or [in]abil[ity] to act on behalf of the threatened academic interests of its members" and its "failure to articulate organizational positions on matters [such as] standards of conduct of bioethicists who have conflicts of interest bearing in their professional work [in] sharp contrast to how other professional societies conceive of their role in society [which is] a stain on the credibility of United States bioethics and the Society" (Miles 2004).

ASBH Task Force on Ethics Standards Formed (Loretta Kopelman, chair). This is the "Past Presidents" committee.

ASBH Spring Conference on ***The Ethics of Bioethics*** (Albany Medical College, Graduate College of Union University--R. Baker, organizer)

A Draft Model Code of Ethics for Bioethicists by R. Baker, (AJOB 5 (4) 2005), Commentaries by Beauchamp, Cohn, Kipnis, Latham, Lantos, Miller, Spike, etc.

2005 ASBH President Arthur Derse urges contemplation of Ethics Standards for Bioethicists (ASBH Exchange 2005 (3) 8:2).

ASBH Fall Meeting: Task Force on Ethics Standards presents findings. Panel presentation on The Ethics of Bioethics (Baker, Derse, Mcgee and Wynia).

ASBH appoints Advisory Committee on Ethics Standards (ACES) to conduct survey on advisability of ASBH code of ethics and advise on developing a code : Kipnis (Chair), Baker, Pearlman, Taylor.

2006 ACES (Baker, Taylor, Kipnis, and Pearlman) conducts its survey of the ASBH membership after initiating electronic discussion of a code.

ACES submits its ***Report and Recommendations of the ASBH Advisory Committee on Ethics Standards*** to the ASBH Board, for consideration at the 8th annual ASBH meeting, October 26-29, in Denver.

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Appendix 2: *ACES' Letters to the ASBH Membership*

First Letter

AN ETHICS CODE FOR ASBH?
December, 2005

Following a session at the 2005 ASBH Annual Meeting, President Matthew Wynia appointed an Advisory Committee on Ethics Standards (ACES) to survey the membership on the need for a code and to make recommendations on the basis of its findings. The three of us -- Bob Baker, Caleb Alexander and Ken Kipnis (Chair) -- currently constitute ACES.

In keeping with our charge, we plan to draft and distribute a questionnaire. In light of the diversity of ASBH's membership -- some of us from fields with codes and others not -- we will also be sending out informative letters on the issues we are considering. This is our first.

Opinions differ on whether to have a code and, if so, what purposes it should serve. One possible purpose is to provide guidance in troublesome situations. Here are five cases raising issues that some feel could be addressed by a code. Although they are heavily fictionalized, they are based on actual events.

1. Emily Able, whose field is literature, has an appointment in a medical humanities program. A troubled medical student, seeking counsel, describes a pattern of abusive conduct on the part of a senior physician. Following the discussion, the student decides he will neither report the incidents himself, nor permit Emily Able to do so. The information, he says, is confidential.

What confidentiality standards should apply to communications between bioethicists/medical humanists and medical students/interns/residents?

2. Professor Donald Bravo, a philosopher, works for Dr. Juliet Chan in a bioethics research center. The two have submitted a commissioned report. Drawing on it, Dr. Chan writes an article that does not list her junior colleague as an author. Professor Bravo says he is a co-author since her article contains little that was not in their report. Dr. Chan says she did almost all of the research and properly acknowledged him for his contribution in a footnote.

What standards should apply in listing collaborators as authors?

3. Kelly Delta is the sole ethics consultant at a private hospital. A novel problem arises that is beyond her resources. When her supervisor discovers that she plans to consult with a more experienced bioethicist at another institution, he lays down the law: She is not to alert outsiders to problems arising in the hospital.

With respect to clinical consultation, what information management standards should apply to communication between bioethicists and their colleagues at other institutions?

4. Professor Irene Oscar is completing a major study on controversial issues arising in a new area of research. The Anodyne Pharmaceutical Corporation -- which does such research -- offers her a lucrative consultancy, with stock options. Should she decline the offer? Can she accept and disclose the consultancy in her study? Accept but not disclose? Or should she delay accepting the consultancy until after her final draft is sent off?

How should bioethicists/medical humanists identify and manage conflicts of interest?

5. Mike Kumar is offered a position at a government agency. One term of the contract is troubling: His director must review all manuscripts prior to submission to an outside publisher and shall have the power to veto publication.

Are such publication restrictions acceptable for bioethicists/medical humanists?

The three of us do not know how common or how troubling such situations are, or whether it would be wise to address them in a code. Cases like these often indicate where explicit ethics standards may be helpful. If you know of other cases or quandaries that we might consider, or if you have comments or suggestions that you would like to call to our attention, we invite you to pass them along.

Stay tuned.

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Second Letter

WHAT CAN CODES DO?
January, 2006

Our first letter (at http://www.asbh.org/code-of-ethics.htm) described five situations in which an ASBH member might face ethical distress. If such problems are common, that might be a reason for developing a code. But what organizational purposes might a code serve?

Michael Davis (of IIT's Center for the study of Ethics in the Professions) addressed this issue in a recent piece in AJOB, drawing on work presented at a special ASBH conference on "The Ethics of Bioethics." Davis usefully defines a code of ethics as "an authoritative formulation of the (morally permissible) standards governing the conduct of members of a group, just because they are members of the group." He then considers six organizational purposes of codes. Here are some reflections on these.

First, in extracting authoritative guidance from a field's collective ethical experience, a code can "change practice for the better." Although Davis does not mention it, learning from experience might require ASBH to reconfigure itself: setting up channels of communication and an authoritative deliberative process. The American Medical Association, through its Council on Ethical and Judicial Affairs, receives and considers ethical questions and regularly publishes "judicial opinions." Some formal process like this could be required.

Second, by summarizing the lessons of the past, codes can be used to teach novices. Familiarity with applicable standards is a common precondition of practice. Some fields suppose that norms are reliably absorbed from the ambiance of professional education while others require a mentored study of the literature. A code for bioethicists could become a standard element of our education.

Third, codes can have a "mnemonic function," serving as an organized set of reminders for those who might forget. It can be useful to have a comprehensive and current set of standards readily accessible in a single place.

Fourth, codes can provide frameworks for settling disputes, even for those with experience. A common standard is especially important when practitioners emerge from fields with differing conventions. Sometimes a code can provide a determinate answer, defining, for example, "conflict of interest" well enough to resolve Professor Irene Oscar's issue with the Anodyne offer. But even where determinate guidance is not at hand, a code can set out factors to be considered. Perhaps Donald Bravo should be listed as an author only if he has "contributed

materially" to the published research. Even where informed opinion is divided, a code can record the presence of unresolved responsible ethical disagreement.

Fifth, codes can tell the public what can reasonably be expected from members of the group. While this can facilitate trust, codes can also support practitioners whose supervisors and employers are unfamiliar with the professional role. Provisions in codes can evolve into terms of professional employment contracts.

Sixth and last: codes can provide a basis for discipline and legal liability and, we would add, for appealing wrongful firings in court. A New Jersey Supreme Court opinion, *Pierce* v. *Ortho Pharmaceutical Corp.* 84 N.J. 58, 417 A.2d 505 (1980), contains these oft-quoted lines: "Employees who are professionals owe a special duty to abide not only by federal and state law, but also by the recognized codes of ethics of their professions. That duty may oblige them to decline to perform acts required by their employers." Provided a code's requirement is conceived in the public interest, a professional employee may have a cause of action if he or she is fired for refusing to violate it. Professional standards can provide a juridic foundation for professional autonomy, substantive legal protection for those who take them seriously.

In these six ways, codes mark a transition from personal judgment to a "standard of practice"; from asking "What do I do?" to asking "What do we do?" Though they can move occupations toward responsible professionalism, it is a separate question whether ASBH and its membership should take such a step.

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Third Letter

A SURVEY OF BIOETHICISTS AND MEDICAL HUMANISTS
April, 2006

Last fall ASBH President Matt Wynia appointed an Advisory Committee on Ethics Standards to advise the organization's leadership on whether to take up the task of code development and, if so, to recommend the type of code ASBH should have. For months, the committee has worked through more than 20 drafts of a survey instrument that we hope will up to the job. Here is our progress report.

The committee agreed that the questionnaire should be a needs-assessment tool rather than an opinion survey. We want to gather data that will tell ASBH something about the ethical problems that worry our membership (if such there be) as well as who the worriers are. We want to know about any fears and hopes our membership may have about a code. We want to assemble a database of narratives describing some of the ethical problems actually faced by our membership. (This list will likely be essential should a decision be made to draft a code.)

As ASBH has an interdisciplinary membership, the need for and interest in a code will likely vary within the organization. A code can seek to cover all of our separate endeavors, or only our common work, or it could focus on those areas where the problems are frequent and serious. Accordingly the survey does not seek merely to elicit judgments about whether to have a code. If a code is in ASBH's future, it would be good to know what problems it should consider and how broadly it should be addressed.

Here are two caveats. First, ASBH does not now plan to consider whether it would ever "enforce" the provisions of an ethics code, should it choose to develop one. And, second, it is not now considering how any such code would be updated over time, Those questions are set aside. It would be challenging enough for ASBH to develop consistent ethical standards that are comprehensive, clear, and duly endorsed by the field. Whether ASBH should undertake this task is the sole question on the table.

Working with Jerry Kaup at MemberLink (a private company under contract with ASBH's management organization), we will be fielding our survey electronically. Although we may be using postcards to notify those few members for whom ASBH does not have email addresses, we will be relying upon the internet both to announce the survey and to collect responses. You can expect to receive a personalized password giving you access to ACES' website and allowing you to fill out and submit the survey. Identifying references will be stripped so that responses cannot be linked to those who submit them. MemberLink will be able to track those who have not replied, sending reminders until the deadline for submission passes. The protocol we are using

will be submitted to the University of Hawaii IRB. While we expect to receive an exemption, this formal IRB review will allow us to retain the ability to publish our results.
Several of our questions call for narratives. While we will strip any identifying references in these narratives, and even "fictionalize" them if need be, it would be best if these were written to preserve anonymity.

Our hope is to analyze our data during the summer and to submit our report to the ASBH leadership early in the fall.

One final item. Caleb Alexander had served on ACES from the very beginning: I regret to announce that he has resigned. We wish him well and welcome his replacement, Robert Pearlman.

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Appendix 3: *The ACES Survey Instrument*

MEMBER SURVEY:

CODIFYING ETHICAL STANDARDS

INSTRUCTIONS

Unless noted otherwise, all of your answers will be kept strictly confidential. Your answers to question 2.4 and some others that call for narratives may be distributed or published. While we will strip any identifying references if necessary, or even "fictionalize" your submission, it would be best if you took care to preserve anonymity in all of your narrative responses.

There is extra space at the end of the survey: use it if you need more room for your answers or if you have comments for us. We are interested in your feedback.

If you have any questions about the survey, you may post them to Ken Kipnis, Chair, ACES, at kkipnis@hawaii.edu

If you have any questions about your rights as a participant in this survey, you may post them to the University of Hawaii IRB at UHIRB@hawaii.edu.

Please indicate your acceptance of anonymous publication of the survey results by clicking on the "I Agree" radio button just below.

O I agree

WE WELCOME THE RETURN OF EVEN PARTIALLY COMPLETED SURVEYS. THANK YOU FOR YOUR HELP

INTRODUCTION

Most ethical questions that ASBH members consider are faced by families, clinicians, researchers or policy makers. However, sometimes there are ethical problems that confront ASBH members themselves, in the conduct of their work as bioethicists and medical humanists. We are interested in your general experience with these. The survey asks about the ethical issues that arise in your work and your beliefs about and attitudes towards professional codes.

First, some questions about you.

1.1 Approximately what percentage of your time is spent in: [Your total should add up to 100%.]

Bioethics: _______
Medical Humanities: _______
Other: _______

1.2 Over the last five years, which of the following, if any, have been a significant part of your work in bioethics and/or medical humanities? Check all that apply.

1.2.1 Teach or work in a healthcare related program (e.g., nursing, medicine, public health, etc.).
1.2.2 Teach or work in an academic non-healthcare-related program (e.g., B.A. program).
1.2.3 Provide bioethics consultations in a clinical setting.
1.2.4 Staff or serve on an institutional ethics committee.
1.2.5 Staff or serve on an IRB or other research oversight committee.
1.2.6 Work or serve as bioethicist in a non-clinical, non-academic setting (e.g. business, government, private agency, etc.).
1.2.7 Serve as an expert ethics witness in healthcare related court. cases
1.2.8 Engage in research or other scholarly work.
1.2.9 OTHER ___(Please describe) _________________________________

1.3. My work in bioethics and/or medical humanities is (check all that apply):

1.3.1 A component of my written job description for which I am compensated (e.g., in-house bioethicist, medical humanities teacher).

1.3.2 A job-related activity (part of my regular job) that is not part of my written job description (e.g., IRB member, on-the-floor ethics consultant).

1.3.3 An externally compensated activity or service that I provide outside of my formal job (e.g., consultant, expert witness).

1.3.4 A volunteered activity or service outside of my formal job for which I am not compensated (i.e., community member of hospital ethics committee).

1.4 About how many years have you worked in bioethics and/or medical humanities?

____

1.5 How old are you?

1.1.1 Under 30
1.1.2 30-39
1.1.3 40-49
1.1.4 50-59
1.1.5 Over 60.

1.6 About how many years have you been a member of ASBH? ____________

1.7 Do you belong to a professional organization or work in a field that has a code of ethics?

Yes No or Don't know [SKIP TO QUESTION 1.9]

1.8 Have you ever referred to that code for guidance?

Yes No

1.9. Which of the following best describe your field(s)? Check all that apply.

1.9 1 Anthropology
1.9 2 Bioethics
1.9 3 Biology
1.9 4 Business Administration
1.9.5 Dentistry
1.9.6 Economics
1.9.7 History
1.9.8 Humanities
1.9.9 Law
1.9.10 Literature
1.9.11 Medicine
1.9.12 Natural Science (excluding biology)
1.9.13 Nursing
1.9.14 Philosophy

1.9.15 Psychology
1.9.16 Public Health
1.9.17 Religion
1.9.18 Social Work
1.9.19 Sociology
1.9.20 Statistics
1.9.21 Other (Please describe ____________)

2.1 Next, a few questions about your beliefs regarding professional codes of ethics in general – not your beliefs about an ASBH code.

Completely Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Completely Disagree

2.1.1 Ethics codes set a standard for regulating the conduct of professionals.

2.1.2. Professional codes do not improve behavior.

2.1.3 Ethics codes can provide protection for professionals.

2.1.4. Ethics codes are unlikely to settle disagreements among professionals.

2.1.5 Professions should discipline members who violate their codes.

2.1.6. Members of a profession should report other members who do not follow the code.

2.1.7. Codes of ethics promote the professionalization of occupations.

2.1.8. Professional codes prompt valuable discussion among colleagues about standards and expectations

2.1.9. Codes of ethics inform students, employers and the public of a profession's responsibilities.

2.2. Next, a few questions about your beliefs regarding a possible ASBH code of ethics.

Completely Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Completely Disagree

2.2.1 ASBH members already have adequate codes of ethics from other professional societies.

2.2.2 An ASBH code of ethics would be useful to those entering bioethics.

2.2.3 An ASBH code of ethics would be useful to those entering medical humanities.

2.2.4. The professionalization of bioethics would be a bad thing.

2.2.5 The professionalization of medical humanities would be a bad thing.

2.2.6 ASBH members in my field would benefit from an ASBH ethics code.

2.2.7 ASBH members in fields other than mine would benefit from an ASBH code.

2.2.8. Any ASBH code should focus broadly on standards applicable to all ASBH members.

2.2.9 Any ASBH ethics code should focus narrowly on fields associated with frequent and serious ethical concerns.

2.2.10 It is not clear that ASBH needs a code.

2.3 Some feel that a professional code should address common and troubling ethical problems faced by professionals. If ASBH were to develop a professional code, how important do you think it would it be to address each of the following issues in it?

Very important Moderately important Not very important Not at all important

2.3.1. Identifying and managing conflicts of interest

2.3.2. Honoring confidentiality and obligations to disclose

2.3.3. Ascribing (co-) authorship and crediting contributors in reports and published work

2.3.4. Identifying and managing improper pressures and boundary violations by employers/supervisors.

2.3.5. Including negative remarks in letters of reference.

2.3.6. Reporting problems to employers/supervisors when these are likely to be unwelcome.

2.3.7. Reporting serious misconduct (whisteblowing).

2.3.8. Presenting incomplete characterizations of complex issues in public venues (e.g., to the mass media).

2.3.9. Other (please list as many problems as applicable)

TEXT BOX – 200 WORDS.

2.4. Many professions have codes of ethics that are useful in guiding practice and in identifying substandard professional behavior. In the field of early childhood education, one of the most common problems looks like this:

> ***The Nap:*** Timmy's mother has asked you not to let her four-year old son nap in the afternoon. She says: "When he naps, he stays up until 10 p.m. I go to work in the mornings and I am not getting enough sleep." Along with the rest of the children, Timmy takes a one-hour nap almost every day. He seems to need it to stay in good spirits during the afternoon.

The problem arises from concerns good early childhood educators have for both the family and the child. While the first concern grounds a professional “Ideal” to respect the family's childrearing values and its right to make decisions for children, Principle 1.1 in the ECE code reads:

> Above all, we shall not harm children. . . This principle has precedence over all others in this Code.

Thus, whether Timmy should be kept from napping turns on whether doing so will harm him. "The Nap" calls for a judgment about Timmy's needs, a judgment squarely within the competence of knowledgeable early childhood educators. If a code's provisions are drawn from practical ethical experience, they can provide useful guidance..

In order to draft a code that would be of practical use to ASBH members (and to assess the usefulness of such a project), we would like you to think of an actual situation in which a bioethicist or medical humanist has either faced a comparable ethical problem directly (i.e., not addressing the ethical problems of others as a consultant) or has been concerned that a colleague may have acted unprofessionally. Please describe the situation, indicating why it was troubling and, if you can, how it was handled.

NOTE: ACES expects to distribute a set of these narratives to the leadership, the membership, and possibly beyond. We will strip identifying references and "fictionalize" your case if necessary, but it would be better if you anonymized your narrative with the understanding that it may be used as a learning tool

[TEXT BOX 1000 words].

2.5.1 Overall, are you generally in favor of or opposed to an ASBH ethics code?

GENERALLY IN FAVOR , GENERALLY OPPOSED, NEUTRAL OR NO OPINION

2.52. Please explain your answer to 2.4.1

[TEXT BOX 200 wds]

2.6. Please use the box below for comments on the survey.

[TEXT BOX 1000 WORDS]