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Membership recruitment and training in health care ethics committees: Results from a national pilot survey

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Abstract

This pilot study reports on a survey regarding recruitment, appointment, and training of members for health care ethics committees (HCECs).

Background—Past studies have examined HCECs, but have focused on the roles of the committees and the broad makeup of membership. Thus, our study fills an important knowledge gap in trends of membership recruitment and appointment processes employed by HCECs to comprise their membership.

Methods—We posted our survey on several bioethics listservs between June and August 2015. Of the 103 respondents that started the survey, 59 were eligible for inclusion based on our criteria. We analyzed survey results descriptively and qualitatively.

Results—Overall we found no unifying standards of recruitment or appointment across the 59 respondents. Additionally, while responding committees varied in the professional backgrounds and attributes they valued in potential members, we found that most respondents valued traits of the applicants over specific knowledge or skills.

Conclusions—This study provides a first look into how HCECs recruit members. Future research is needed to better understand the complexities of the issues discovered during this study, given that the HCEC members appointed are the individuals who fulfill committee obligations.

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Author contributions

All authors assisted with aspects of this project, from conception through publication. Anya Prince developed and tested the survey design with support from Arlene Davis. Jean Cadigan and Warren Whipple assisted with testing the survey and refining the questions. After data collection, all authors met regularly to discuss findings and trends. After an initial draft written by Anya Prince, all authors contributed to drafts of the article, revisions, and publication.

Conflicts of interest

None.

Ethical approval

This study was reviewed by the UNC Institutional Research Board and deemed to not constitute human subjects research under federal regulations.

Keywords

health care ethics committees; recruitment; core competency; membership; quality; professionalization

Health care ethics committees (HCECs) are interdisciplinary groups that aim to address the myriad ethical issues that arise in patient care. Indeed, for most hospitals, they not only serve a practical need, but are a mandated requirement. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) requires hospitals to have a mechanism with which to address ethical issues in order to receive accreditation, and most hospitals have chosen HCECs to fulfill this requirement (JCAHO 1992). As HCECs have become more common across the nation, increasing scrutiny has been given to the committees and to the qualifications of the members.

Within the larger history of bioethics generally, scholars often trace the origins of clinical ethics, and thus the work of HCECs, to the late 1960s and the 1969 formation of the first professional association aimed at moral issues in health care (Moskop 2016, 20–21). The earliest literature and studies related to HCECs explored broad questions regarding the design and purpose of the committees (d’Oronzio, Dunn, and Gregory 1991; Hoffman 1993; Teel 1975; Youngner et al. 1983) and patient perceptions of them (Youngner et al. 1984). As the number of HCECs expanded and their importance within health care systems increased, focus began to shift away from the committees as a whole to examine how committees handled clinical ethics consultations specifically (DuVal et al. 2004; Fox, Myers, and Pearlman 2007; McGee et al. 2002) and the professional education and competency of those committee members engaged in ethics consultations (American Society of Bioethics and Humanities [ASBH] 1998; Hoffmann, Tarzian, and O’Neil 2000).

Ethics consultations are one of the three traditional roles of HCECs, in addition to education and policy advisement (Hester and Schonfield 2012; McGee et al. 2001; Youngner et al. 1983). During consultations, HCEC members work directly with health care teams, patients, and families to address ethical concerns related to patient care. There has been a growing movement to assess the quality of the committees (Leslie et al. 2016; Spike 2014; Tapper 2013) and to standardize the consultation process. Two professional organizations have been key to the movement. The older and larger organization, the American Society of Bioethics and Humanities (ASBH), was formed in 1998 as an amalgam of three prior bioethics groups, including the original 1969 organization (Moskop 2016, 21). ASBH created a Code of Ethics for consultants (Tarzian, Wocial, and ASBJ Clinical Ethics Consultation Affairs Committee 2015) and a task force that published voluntary “competencies” for the ethics consultant (ASBH 1998), an education guide to improve the competencies (ASBH 2009), and an updated set of “core competencies” in 2011 (ASBH 2011). A newer, sister organization formed in 2007, the Association of Bioethics Program Directors (ABPD), has concentrated on accreditation of training programs for interested individuals (Spike 2014).

Notably, discussions about competency and professionalization have focused on the credentials and skills of individual consultants, not on committees overall (Magnus and Fishbein 2015). However, many consultants are drawn from a subcommittee within the

HCEC or from members at large of the HCEC. HCEC general membership is thus often the gateway to the role of consultant. A spotlight on consultation services could inadvertently shift attention away from understanding what committees value in their general membership composition, which is also important because HCECs must also muster skills and experience for their other important services: education and policy development. While some prominent studies have explored the characteristics of committees and background of members (Fox et al. 2007; McGee et al. 2001; Youngner et al. 1983), they have not explored in depth committee recruitment processes. What professional backgrounds, traits, skills, and knowledge are valued during the selection process? What requirements satisfy consideration of a prospective member? How, if at all, are educational and training programs developed to complement the backgrounds of committee members? This pilot survey sought to fill this gap in the literature and collect initial data on how members of HCECs are chosen and trained.

Methods

We designed the survey by examining relevant literature and with assistance from UNC (University of North Carolina) Health Care's ethics committee members. Additionally, we conducted cognitive interviews with three current or former members of HCECs for feedback and refinement of the questions and response options. Several questions regarding desirable attributes of HCEC members were developed using concepts and language from the 2011 ASBH *Core Competencies*. These core competencies include traits, skills, and knowledge that are viewed as essential for individuals to be proficient in clinical ethics consultation and competently address its goals. While we did not indicate the published source of these attributes in our survey instrument, some respondents may have recognized them. The survey consisted of primarily closed-ended questions with some open-ended questions designed to get more in-depth, qualitative detail from respondents.

Given the exploratory objectives of the survey, we sought to distribute the instrument as widely as possible through listservs and networks. Between June and August 2015, we invited participation by posting a link to the "Membership Recruitment in Healthcare Ethics Committees Survey" on several national listservs that are typically read by HCEC chairs or their colleagues. The survey was posted to listservs within the ASBH Clinical Ethics Consultation Affinity Group (CECAG), Medical College of Wisconsin Bioethics Listserv, the Clinical Ethics Network of North Carolina, and the Association of Bioethics Program Directors. Additionally, we encouraged those who received the invitation to forward it to others who might have been interested. We received feedback that the survey had been forwarded to regional groups in Texas and New York. We solicited responses from persons who would describe themselves as the most knowledgeable about the recruitment and training practices of their HCEC. The survey was administered through Qualtrics and quantitative data were analyzed using Stata 14.0. In this article we provide a descriptive report of the quantitative data through simple response frequencies. The open-ended, qualitative text responses were collated by survey question. All authors met several times to systematically review these qualitative data to identify themes both within and across questions. Quotes used in this article were selected by all authors to be reflective of the

findings. The UNC Institutional Review Board deemed this study to be non-human subjects research.

Results

Respondents

One hundred and three respondents began the survey. We excluded 34 respondents who did not complete the survey. Additionally, we excluded two respondents from other countries and eight respondents from duplicative ZIP codes where there was only one hospital with that bed size in the ZIP code. For duplicative ZIP codes, we kept the response set from the chair or most senior position in the HCEC out of the set of responses. Eighty percent of our respondents held chair or co-chair positions; the rest were members or held leadership, advisory, or coordination roles within the committee. Our final number of included respondents is 59.

Our survey collected data about five domains of questions: (1) What are the demographics of the hospitals and committees participating? (2) What is the composition of the committees? (3) What recruitment and appointment procedures do committees use? (4) What are considered valuable attributes of members? (5) What further education do HCECs provide their members? Additionally, analysis of our open-ended text data provided insight into models of recruitment that emerged and challenges for committee management.

Domains of questions

What are the demographics of the hospitals and committees participating?—

Of the 59 respondents, the majority were from large hospitals that were academic medical centers (37%) or hospitals affiliated with academic medical centers (44%). While 54% of our respondents were from hospitals with 500 or more beds, we have representation from smaller hospitals of 400–499 (10%), 300–399 (15%), 200–299 (9%), and fewer than 200 (9%) beds. Similarly, the majority of our respondents were from not-for-profit hospitals with no religious order affiliation (61%) or from public hospitals, such as state or federally run facilities (24%) (see Figure 1).

The respondents represent ethics committees that were generally long established. Forty-four percent were established pre-1990 and 27% between 1990 and 1999. The remainder were established after 2000 or the respondent was unsure when the committee was formed (see Figure 1). Overwhelmingly, the committees were standing committees of either the hospital (48%) or the medical staff (41%), with a small minority housed within an existing center or department (10%).

Seventy-one percent of respondents reported their HCEC had at least one subcommittee. Of these, 63% had a consultation subcommittee, 37% an education subcommittee, and 34% a policy subcommittee. A quarter of the committees had other subcommittees, including 8% of respondents who indicated that they had a subcommittee for membership.

What is the composition of the committees?—Although our respondents tended to represent larger hospitals, the size of committees varied, with relatively even distribution

between committees of 10–19, 20–29, and 30 or more (32%, 37%, and 25% respectively). Only 2% had fewer than 10 members and 3% of respondents were unsure of their membership size. However, the size of the committee was usually related to the overall number of beds in the hospital. For example, of the 15 committees with 30 or more members, 14 were in hospitals with 500 or more beds and 1 was in a hospital with 400–499 beds.

The majority of the responding committees included at least one community representative in their membership (86%). Approximately half (48%) the committees had different categories of membership. Of these, 86% offered full/active membership, 61% had ex officio membership positions, 36% allowed members to participate in a subcommittee only (not the general ethics committee), and 11% had other various types of membership. Additionally, 22% had delineated staff positions that were ineligible for full or active membership, such as risk managers and institutional attorneys.

Regarding membership lengths, nearly half of our respondents served on ethics committees with unlimited membership terms (49%). Other committees had 1-year appointments (5%), 2-year appointments (14%), and appointments for longer than 2 years (29%), although for all these committees, the time-limited appointments could be renewed or extended. Overall, these appointment practices led committees to have average lengths of service of 5–6 years (34%), 3–4 years (22%), or more than 6 years (20%), with a short term of 1–2 years far less common (2%). However, 22% of respondents were unsure about the average length of service for their membership.

What recruitment and appointment procedures do committees use?—

Respondents were asked to identify, through both preset survey options and an open-ended response option, the various methods the committee uses to recruit new members.

Respondents were permitted to indicate multiple recruitment strategies. Eighty percent allowed self-nomination or applications, 76% found members through nomination by others, 34% followed set rules for membership composition, and 15% used other methods in addition to those just listed. Other methods included identification by the hospital chief of staff, preset guidelines of membership composition, and membership through faculty recruitment.

Twenty percent of committees had formal, written criteria in place for candidate evaluation, and 27% required interviews as part of the recruitment process. Although 90% of committees did not require potential members to provide references, 20% of these committees encouraged them or would read them if they were received. A minority of committees required a list of references (7%) or required letters of reference (2%) (see Table 1).

What are considered valuable attributes of members?—In response to the question “Do you require all members to have a background or training in bioethics as a prerequisite to membership?” most respondents indicated that their committee did not require members to have a background or training in bioethics (54%), while 41% gave weight to a bioethics background in the selection process but had no requirement, and 5% required a bioethics

background (see Table 1). Of the 5% that did require a bioethics background, there was a wide variety of types of bioethics training that met these requirements, including graduate training, 1- to 5-day educational programs, online trainings, and clinical fellowships. Unfortunately we did not ask this question of the 41% who gave weight to the background.

Two questions, “What types of staff positions do you strive to represent in the composition of the membership?” and “What types of practice areas do you strive to represent among your clinician members?,” gathered information about different types of diversity valuable to committees (see Figure 2). Committees consistently sought a variety of disciplinary backgrounds, including some that seemed nearly universally desirable: physicians (100%), chaplains or pastoral care (98%), nurses (98%), and social workers or case managers (97%). Bioethicists or philosophers (85%) were also common. Top practice areas sought for representation included intensive care (68%), internal medicine (53%), and surgery (51%). In open-ended responses, respondents also indicated that they valued other types of diversity, such as racial, ethnic, gender, and religious diversity, and valued representation from students, individuals at various levels of training and career stages, and nonclinical hospital staff. Several also commented that while these types of diversity are sought, they are not always possible to achieve or maintain.

The survey asked respondents to indicate the importance of certain attributes, categorized as traits, skills, and knowledge, in their evaluation of candidates, from not important at all to absolutely essential (see Figure 3). As mentioned, we drew these from the *Core Competencies* published by ASBH. Process skills and interpersonal skills were the two most valued skills, as measured by the most respondents indicating that the skills were either absolutely essential or very important. Knowledge of the beliefs and perspectives of patient and staff populations and knowledge of the clinical context were the two most valued knowledge competencies. Honesty, forthrightness, and self-knowledge and integrity were the two most valued traits. Recoding the rankings as the numbers 0 through 4, the means for all three categories fall between the values that correspond to “average importance” and “very important.” Specifically, the means for traits, skills, and knowledge are 3.0, 2.5, and 2.4, respectively. We provide the means of these three categories in the aggregate, given that this is how they are divided in the *Core Competencies*. Figure 3 provides greater detail regarding responses to the individual components within these broad categories.

We compared all categories using the Wilcoxon signed rank test, assessing the p values against a Bonferroni-corrected alpha of 0.017. Ratings for traits are significantly higher than for both skills and knowledge ($p < 0.001$ for both). However, skills and knowledge did not significantly differ from each other ($p = 0.09$). Figure 3 reports responses for each individual skill, knowledge, and trait. The three competencies with the greatest percentage of respondents indicating that the competency was “absolutely important” were integrity (66%), honesty (48%), and tolerance (46%) (all of which are traits). In contrast, only 4% and 6% of respondents indicated that meeting facilitation skills and relevant health knowledge, respectively, were absolutely important. The increased importance of traits is reinforced by qualitative comments that we received. For example, one respondent, in response to whether any other skills, traits, or knowledge are important to candidate evaluation, noted, “We have

a large committee that tries to include just about every point of view. As such, all of the above qualities would be nice, but the character traits are the only ones very important.”

What further education do HCECs provide their members?—Only 35% of committees required new members to undergo a training or orientation, and of these, 75% did not vary the training requirements based on the background of the new members. The orientations ranged from assigned readings to hour- or half-day-long workshops. However, 75% of committees had an ongoing education program for committee members, including online-based programs, monthly journal clubs or ethics discussion at meetings, and annual retreats (Table 1). Forty-six percent of committees represented provided funding for committee members to attend outside continuing education conferences.

Additional findings: Models and challenges

What models of recruitment emerge?—In order to compare recruitment and training trends across respondents, we created two variables that combined several previously reported variables. In the first we sought to condense measures of the recruitment and selection process to examine entry into the committee. Four questions (“Are potential members required to provide references?”; “Does your committee require interviews as part of the recruitment process for candidate members?”; “Are there formal, written criteria for candidate evaluation?”; and “Do you require all members to have a background or training in bioethics as a prerequisite to membership?”) were combined into a variable ranging from 0 to 4. The higher the value, the more stringent were the membership requirements. No respondent answered yes to all four of our recruitment processes questions.

For the second variable, we sought to quantify the extent of membership training and education after appointment. For this measure we combined three questions (“Does your committee require new members to undergo a training or orientation?”; “Do you have an ongoing education program for your committee members?”; and “Do you provide funding for your committee members to attend outside continuing education conferences?”). The combined variable ranged in value from 0 to 3. The higher the value, the more resources were expended on further education for HCEC members.

Figure 4 illustrates the combined frequencies of the recruitment and training measures. Eight committees (14%) scored a 0 on both the membership requirements and training scores, indicating an absence of membership requirements and of training. Only three committees (5%) scored a 3 for both the recruitment requirements and training scores, offering the most rigor in selection and education. While we hypothesized that larger hospitals or those with academic affiliations might have more candidate criteria given a larger candidate pool or more resources to train members after appointment, our results did not indicate any clear trends. However, given the small number of participants and a sample skewed toward larger academic medical centers, this hypothesis remains untested.

During analysis of both the recruitment and education scores and the qualitative data, two broad models of recruitment emerged, which we label as “anyone welcome” and “formalized.” Responses demonstrate motivations that potentially explain why committees

operate in one model over the other. The selected quotes represent themes identified during our analysis of the open-ended text responses.

Anyone welcome—In open-ended response to the question “Who selects potential candidates to recommend for appointment?,” several respondents indicated a low threshold for membership selection through comments such as “almost all interested people are welcome” and “whoever volunteers is accepted.” Qualitative data indicate two underlying motivations for this openness to most volunteers at the outset: (1) the ability to train individuals once appointed to the committee, or (2) the challenge in maintaining adequate membership without an open door policy.

“Learning on the job.” Qualitative data suggest that decision makers on the committee were most interested in recruiting passionate people and that skills and knowledge building could follow after appointment. As one respondent noted,

We find there’s a lot of interest in ethics—indeed, passion for ethics in health care. But that interest and passion often exceed knowledge and understanding. Thus we devote a portion of every meeting to education.

Other respondents noted that the need for some new members to be highly trained was balanced with the ability for the broader committee to learn during the membership tenure. For example:

Our evaluation of candidates is stricter for clinical consultant, obviously. We strive to have good representation from community and staff, but we do not require training of bioethics knowledge, rather an interest in the issues so they will learn from our process and discussions. We have very high level of skill in some of our committee members, and those serve to teach other new members.

Another respondent with a similar two-tiered system explained his or her system as such:

We have learned that the single most important quality in a member of our larger ethics committee is a genuine interest in ethics. This group, which can be more than 35–40, serves to “seed” ethics throughout the hospital. The smaller group, the Ethics Committee, has additional training. This group meets monthly, or is called, as needed, as an ethics consult team. These folks have shown willingness to have more training, willingness to meet at 0700, and a commitment to ethics in the hospital.

Difficulty maintaining membership: In contrast, other committees “welcome anyone” because “it’s not like people are waiting at the door to be on another committee.” One respondent explained,

Our committee is far below any standards. Anyone willing to be on the Committee is appointed. Consultations are performed by individuals with no training, education, or experience in clinical ethics consultation.

In response to the question “Are there any other skills, traits, or knowledge that are important to your evaluation?,” several respondents noted the importance of a baseline

interest in the committee. Listed in the qualitative responses were “willingness to show up to the meetings”; “interest in participation”; and “desire to participate in the work of the committee.”

Formalized—The qualitative data also indicate that some committees are formalized in their recruitment and education process, or are in the process of formalization. As one respondent noted:

We have a deeply engaged set of 3 HEC groups with varying experience resulting in 3 different skill sets and trajectories. We are beginning to align them compatibly so that future training can be standardized and aimed at an identifiable and measurable skill sets including values identification, clinical moral reasoning, individual and community focused beneficial outcomes, respectful engagement of ethnically and religiously diverse patient and staff populations.

Another commented about broad system changes to create a more formalized process:

We now do ongoing assessment of membership and over the past 5 years have maintained an integrated ethics approach to committee membership. We have successfully generated system changes because we now have members representing Compliance, Nurse Leaders, Quality, accreditation and licensing, ambulatory practice leader, as well as staff nurses who serve as Nurse Council Chairs.

“Problem members”—Several respondents who had scores of 3 for the formalized recruitment measure highlighted the need to effectively screen potential members at the front end in order to ensure a proper committee environment. As one described,

Identifying (and keeping) good members of the consultation staff is also very challenging due to the fact that they are volunteers and their motivations for doing the work must be carefully vetted (we made a couple of big mistakes over the past 15 years).

Another explained how they utilized the interview to measure how collaborative a candidate is because they had “problem members” who were “judgmental and defensive” in the past.

What challenges for management are highlighted?—Although we did not ask specific questions about challenges for committee chairs, two specific challenges, funding and pressure from hospital administration, emerged from the qualitative data. In terms of funding, 46% of committees reported that they were able to fund outside continuing education for committee members. Yet in qualitative reports, several respondents noted that they were unable to provide as much training as they wanted due to limited funding support. As one respondent noted,

The biggest lesson is ethics committees need adequate funding to perform well the functions with which they are tasked ... We are given independence of judgment but no funding for education or training. The handful of well-trained individuals are heavily tasked with critical analysis and leadership. While we have had no crises, I know we are not as prepared as we could be for any major challenges that could come our way.

Difficulties were also discussed in terms of increased pressure from the hospital to provide services, but without dedicated time for members to provide these services.

As pressure has increased to provide more traditional service, some members have had to drop off the committee due to their inability to juggle responsibilities. This phenomenon argues for specific allocation of time to engage in ethics consultation and having this activity be a specific component in one's performance plan.

Since we did not ask all respondents questions about these challenges, further research is needed to understand the impact on recruitment and membership composition.

Discussion

The goal of this pilot survey was to fill a void in the literature regarding recruitment of new HCEC members and their training after appointment. Indeed, the literature often focuses on the competencies of ethics consultants on HCECs, perhaps at the expense of looking at HCECs and their work more generally. Given that survey recruitment was performed through listservs and by word of mouth, and given the small sample size, the results cannot provide generalizable information for all ethics committees across the United States. The results, therefore, are limited to descriptive statistics from our specific population of 59 committees. This small sample size provides a glimpse into potential recruitment and training complexities in hospitals across the country at a time when competent consultation is scrutinized, but not the means by which we identify and educate those who may become consultants. This narrow focus also neglects attention to important attributes of members whose key contributions are in education and policy work. Despite these limitations, we hope that these survey results will provide a starting point for dialogue and more formalized study of the importance of recruitment and training processes.

Overall, our survey results suggest that HCEC membership recruitment, appointment, and training are fairly ad hoc processes across responding committees. We found no unifying guiding principles for recruitment or appointment of new members, nor any common educational pathways thereafter. When creating the survey we hypothesized that committees without stringent or formalized recruitment procedures would be more likely to have increased training to ensure member competency. We were surprised to find a relatively high number of committees with low scores for both recruitment and education (Figure 4). Our survey indicated that most committees have a fairly informal recruitment process—only 29% of the committees scored 2 or more on our recruitment questions. Instead, chairs often identify potential members informally without utilizing interviews, letters of recommendation, or formal written criteria. Further study is needed to test whether and how these types of informal recruitment procedures, such as recommendations from colleagues or self-identification, measure the qualifications of the individuals being recruited. Perhaps these methods are sufficient and best practices can be identified by closer examination of their merits and of any deficits. Compared to recruitment, the committees had overall higher scores on our education questions—56% of respondents scored 2 or more—although there was great variety in the types of education programs offered by committees, from a monthly journal discussion to annual retreats. Further examination of these various methods and their effectiveness may be useful to HCECs across the country, particularly those committees with

limited resources looking for ways to enliven interest in HCEC membership and education thereafter. Future research can more systematically query whether larger hospitals or academic medical centers have recruitment or training processes that are distinct from other hospitals, a finding that our study did not address, given the number and demographics of our responding committees.

Our study results also problematize the current credentialing movement for clinical ethics consultants. Given that the HCEC recruitment processes presumably lead to the appointment of members who subsequently offer clinical consultation and related ethics work, the ad hoc nature of becoming a member of an ethics committee stands in sharp contrast to the increasing attention and support for the competencies and professionalization of the ethics consultant, if not the committee membership overall. Our survey sought to gather information about recruitment of members to the general committee, but it quickly became clear that the differences between recruitment of consultants and recruitment of general committee members are simultaneously very important and difficult to distinguish and clarify. Many respondents noted that they provide additional training for individuals who will be providing consultations, sometimes qualifying their comments with the “obviousness” of such assertions. However, the process by which chairs or committees choose who will undergo this additional training remains unclear, suggesting that the process is potentially as ad hoc as the overall recruitment for general members. Few committees had formal written criteria available that would assist both individual members and committees to assess qualifications that are needed for participation. Several responding committees had a dedicated membership committee, but we did not see any clear differences in recruitment between those committees with or without a membership committee. The small number of committees with this group, however, made detailed analysis impossible.

We asked survey respondents to judge the importance of the traits, skills, and knowledge laid out in the ASBH *Core Competencies* when evaluating candidates for HCEC membership. While their authors set forth these traits, skills, and knowledge as essential, efforts to create assessment systems tend to focus only on skills and knowledge (Kodish et al. 2013). This is reinforced by efforts of the ABPD to accredit training programs for clinical ethics consultants that teach the requisite knowledge and/or skills base, but say nothing about traits (Spike 2014). This tension in assessing skills and knowledge despite an overall interest in, and the importance of, personal traits is not limited to HCEC professionalization. For example, mediation offers many parallels to HCEC, given similar efforts at credentialing and professionalization (Prince and Davis 2016). Similar to trends in HCEC assessment, assessment in mediation also focuses on skills and knowledge without adequately addressing traits (Bowling and Hoffman 2000).

In contrast to the current HCEC focus on training and identifying potential consultants who demonstrate key competencies in specific knowledge and skill sets, our respondents also offered a strong endorsement for the value of individual traits in selecting members. These valued personal qualities, less discussed in the literature and perhaps more subjectively assessed, warrant closer examination. Overall, respondents rated traits as more important than knowledge and skills when evaluating candidates. This is perhaps not surprising because, as some respondents note in open-ended questions, traits are intrinsic while skills

and knowledge can be taught. The further question is, of course, whether that assessment framework, in its general scheme or in its individual descriptors of traits, skills, and knowledge, is valuable to choosing candidates at all or whether our responses indicate that committees value different attributes.

There is tension between the increasing desire to have competent members of HCECs, especially those who will undertake consultations, and limited funding, institutional support, and interest of members. Additionally, overall there is a desire to have good people who are easy to work and get along with. These factors likely contribute to the trend for committee chairs to utilize an ad hoc recruitment process and focus more on training members once they are on the committee. For the HCEC leadership charged with selecting desirable candidates, balancing the attributes of one candidate against the needs of the membership generally is a daunting task. As our respondents indicate, leadership strives for an ideal committee composition and then proceeds practically—with the people and resources available to the group. “Desirable” and “ideal” are themselves problematic descriptors; our respondents offer some cautionary examples where an individual’s good intentions, stated expertise, or passionate interests derailed the workings of the larger assembly. Even if the language and requirements can be refined in a way that proves satisfactory, necessary people and resources may not be available, given that the formalized recruitment processes that may yield stronger candidates require thoughtful time and attention by the leadership. Thus, recruiting a candidate with some attributes, ones that fill in recognized gaps, may be the best achievable outcome. However, as committees face growing pressure to formalize their consultation process, committees must reevaluate their recruitment and appointment processes to clarify expectations between subcommittees and identify essential and desirable member skills or traits.

Overall, our study provides a glimpse into the recruitment and training practices of HCECs. In an era of increased focus on professionalization and credentialing, further study of how potential members’ qualifications and fit are assessed is necessary. Without this component, any future proposals regarding professionalization and credentialing may overlook the realities of membership recruitment processes.

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Figure 1.
Demographics ($n = 59$).

Figure 2.
Representation goals for committee.

Figure 3.
Likert scores for core competencies.

Figure 4.
Recruitment and education scores.

Table 1**Membership recruitment and training frequencies.**

Membership recruitment		
Are potential members required to provide a reference?		
Yes, a list of references is required	4	7%
Yes, letters of reference are required	1	2%
No, but we encourage them or read them if we get them	12	20%
No	41	69%
Unsure/unknown	1	2%
Does your committee require interviews as part of the recruitment process?		
Yes	16	27%
No	39	66%
Unsure/unknown	4	7%
Are there formal, written criteria for candidate evaluation?		
Yes	12	20%
No	41	69%
Unsure/unknown	6	10%
Do you require all members to have a background or training in bioethics as a prerequisite to membership?		
Yes	3	5%
No	32	54%
No, but such background is given weight	24	41%
Member training and education		
Does your committee require new members to undergo an HEC training or orientation?		
Yes	20	34%
No	37	64%
Unsure/unknown	1	2%
Do you have an ongoing education program for your committee members?		
Yes	44	75%
No	15	25%
Do you provide funding for your committee members to attend outside continuing education conferences?		
Yes	27	46%
No	29	49%
Unsure/unknown	3	5%