Nursing Ethics
19(3) 431–442

10.1177/0969733011426817
nej.sagepub.com

Nurses serving on clinical ethics committees: A qualitative exploration of a competency profile

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Abstract
The competency profile underlying higher nursing education in the Netherlands states that bachelor-prepared nurses are expected to be able to participate in ethics committees. What knowledge, skills and attitudes are involved in this participation is unclear. In five consecutive years, groups of two to three fourth-year (bachelor) nursing students conducted 8 to 11 semi-structured interviews each with nurses in ethics committees. The question was what competencies these nurses themselves say they need to participate in such committees. This article reports the aggregate of the 52 interviews in these five studies. Regarding knowledge, the article reports on health law, ethics and professional knowledge. Regarding skills, communication is mentioned, as are professional skills and skills for 'doing ethics'. An open and respectful attitude towards patients and fellow committee members is required, as well as commitment to patient care, committee work and professional ethics. The right attitude for a nurse in an ethics committee is said to include a reflective and perceptive attitude, along with an awareness of one's own limitations and convictions. A detailed competency profile for nurses' participation in ethics committees as outlined in the recommendations may serve nursing education, institutional committees and nurses themselves to meet the demands of nurses' preparation for clinical ethics consultations.

Keywords
Competencies, education, ethics committees, ethics consultation, moral deliberation, nurses

Introduction

Almost half of all healthcare institutions in the Netherlands have a regularly functioning ethics committee.[1] These include legally mandatory ethics review boards for research as well as committees for moral deliberation and consultation on clinical cases. The Netherlands has several hundred healthcare institutions, and their committees usually have several nurse members. This means that hundreds of nurses are involved in formal meetings (as opposed to incidental meetings) for moral deliberation and consultation on clinical care each year. As members of ethics committees usually rotate after a number of years, the actual number of nurses with experience in these positions can be multiplied to a larger but unknown total.

For nurses to serve in such positions, most nursing students receive training in competencies for moral deliberation and, more specifically, in participating in organized forms of moral deliberation. The

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competency profile underlying education in the Netherlands for bachelor-prepared nurses states that '[the competent nursing student] is able to have a point of view on conduct in health care, which means: *participation in ethics committees'* (italics added).[2] In other countries, such as the United States, nurses' participation in ethics committees is a requirement for the accreditation of healthcare organizations.[3]

The authors of the Dutch competency profile presume that nurses will be able to participate in (incidental) moral deliberation on the ward if and when they are able to participate in (structural) ethics committees and consultation (private communication). This is a position halfway between the consultation model requiring mainly expertise in moral theory and the facilitation model requiring mainly process skills of clinical ethics consultation.[4] This article focuses on committees or meetings for care-related deliberation and consultation, not on research review boards. In this context, healthcare ethics may be taken to mean 'reflection on good care'.[5]

Problem, question and goal

From the perspective of nursing education, a crucial problem arises: if it is not clear what it means for a nurse to be a competent participant in an ethics committee or other organized form of moral deliberation, it is not clear how to learn or to assess the competency. Competencies may be defined as integrated units of knowledge, skills and attitudes necessary to solve clinical problems or to provide clinical 'products'.[6] Examples would be preparing an anxious patient for surgery or participating in ethics committees. The competency profile mentioned above does not stipulate what knowledge, skills or attitudes the competency contains, nor how they are acquired. To train nursing students' competence, insight is needed into its content.

From the perspective of nursing education, the pertinent question is: 'What knowledge, skills and attitudes (and perhaps other conditions) do nurses need to participate competently in ethics committees or meetings?' The language of nursing empowerment and leadership, for instance, may lead one to expect a need for negotiation skills in the power struggle between the nurse's, the patient's and the physician's perspectives.[7] One of the ways to approach the question is: 'What do nurses with experience in ethics committees themselves say about the necessary knowledge, skills, attitudes and preconditions?' This article centres on this research question.

The goal of the project was to contribute empirical data to the literature on nurses and their reflection on good care in the Dutch context. The inquiry aimed at a preliminary competency description for participation in ethics committees. Such a description may benefit not only nursing education, but also workers and policy makers in the nursing profession and in healthcare institutions with clinical ethics committees.

Literature review

Recent international literature on the intersection between nursing competencies, moral deliberation and ethics committees or meetings yields a minimal result. The electronic databases PubMed, Google Scholar and CINAHL showed many results for each of these search terms separately, even when limited to the present century, but few for all three combined. Review boards, decision-making and reflection were not included in the search as they do not address the research question directly. From 2000 onwards there is some literature on clinical ethics committees,[8] on nurses in ethics committees,[9] and on the actual competencies of professionals doing ethics consultations,[10] but very few for the categories of nurses, competencies and ethics committees combined. Hoffmann et al.[10] and McDaniel[7] confirm the same for bioethics consultants in general. Apart from articles deriving nurses' competencies from conceptual frameworks and experts' opinions,[11] no empirical studies could be found. Miedema[3] calls attention to three areas of nursing skills, namely advocacy, communication and education, but without citing evidence. On the basis of practical experience, Dierckx de Casterlé et al.[5] point to the importance of professional knowledge and

communication skills, along with leadership in the form of dealing with diversity and emotions in teams. Four topical articles focusing on nurses' participation in clinical ethics committees are already more than 15 years old.[3,7,9,12] Relevant literature is summarized in Kohlen's recent doctoral dissertation,[13] albeit not in terms of competencies; however, she points to the skills needed for nurses in ethics committees to communicate ethical issues in the right 'language'. In the absence of empirical data, a qualitative study of nurses' experiences and perceptions appeared appropriate.

Method

Between 2005 and 2009, five groups of (two to three) fourth-year bachelor degree nursing students were given an assignment for their final bachelor paper. In their third year, they followed an elementary course in research methodology (interview techniques and analysis), including a substantial first exercise. For their final paper they conducted and analysed semi-structured interviews among nurses with experience in ethics committees or other organized forms of moral deliberation in clinical practice, under the supervision of a senior lecturer and researcher. Each of these five studies, all published in Dutch professional journals, focused on a separate field of health care: acute care,[14] mental health,[15] nursing homes,[16] home care[17] and people with learning disabilities.[18] The present article reports the aggregate results of these five separate studies based on the similarities between them.

Every group of students interviewed 8 to 11 nurses from randomly selected healthcare institutions. They retrieved address lists from a national website with information on health care and approached institutions in alphabetical order by mail and telephone regarding competencies for participation in ethics committees. They asked the management if the institution had an ethics committee or organized form of moral deliberation and, if so, whether nurses participated in it. Those nurses were then asked in a written letter to participate in an interview on a voluntary basis, stating the guarantee of anonymity. Each interview was conducted and recorded on tape by a pair of students at the institution where the nurse worked and lasted no longer than 1 hour.

A similar topic list in each study was used, which included open questions regarding the relevant knowledge, skills and attitudes for participation in ethics committees or other formal meetings for moral deliberation. Additional questions concerning issues discussed in the committees, preconditions for participation (such as time) and recommendations for nursing education were included.

Following Baarda et al.,[19] the recorded interviews were transcribed verbatim and, using tables in word-processing software, the texts were divided into relevant fragments. Those fragments were labelled and the resulting labels were grouped in dimensions under the categories of knowledge, skills and attitudes or issues, conditions and education.[19] This inductive process of labelling qualitative data and grouping in dimensions by one student was checked by another and supervised by the senior researcher. Finally, each separate study selected the dimensions that appeared in at least half of the interviews and listed them following a format in Pool et al.,[2] which presents a template for a competency profile in nursing education in the Netherlands. This is also the format for the aggregate result in this article, selecting the dimensions that appeared in at least half of the separate studies.

The methodology of the five studies shows minor differences, mainly because of increasing insight in the project as a whole. For instance, in the first study (acute care) nurses were not asked about the topics of moral deliberation in their committees. As it became clear that they needed knowledge about the issues specific to their field, the question of issues was included in the following four studies. In most acute care settings or general hospitals that have working ethics committees, the nurses with experience in ethics committees were interviewed in the first study. In the following years, it became clear that institutions in other fields of nursing, especially in nursing homes and home care, do not always have an ethics committee. Nevertheless, nurses with experience in moral deliberation in other formal settings, such as ethics

Table 1. Respondents' education level

Setting	Acute care (2005) $R = 11$	Mental health (2006) $R = 11$	Nursing homes (2007) $R = 11$	Home care (2008) $R = 11$	Disabled (2009) $R = 8$
Work experience	23.1 years	27.8 years	11.2 years	16.6 years	11.3 years
In committee	2.5 years	3.1 years	Not applicable	Not applicable	Not available
Education	6B, 5D	1M, 3B, 7D	7B, 4D	11B	6B, 2D

B: bachelor's degree; D: diploma degree; M: master's degree.

consultation, multidisciplinary meetings or disciplinary committees, were found in those fields. In the remaining four studies, nurses were asked about competencies for a somewhat broader range of formal forms of moral deliberation, including ethics committees. These decisions were made by the research leader. Respondents recognized the changes as relevant and justified.

Findings

Table 1 shows personal characteristics of the respondents. A total of 52 nurses were interviewed, with male and female respondents equally represented. The average number of years of work experience at the moment when respondents participated in ethics committees is high in acute care and mental health (around 23 and 28 years) in comparison with the average in nursing homes and care for disabled people (around 11 years). The data offer no explanation for this difference other than the suggestion that there is less job mobility in acute care and mental health care than the other sectors. This does mean, however, that there is more clinical experience represented in ethics committees in these two fields of nursing than the other fields. In those fields, ethics committees are also a relatively new and unstable phenomenon compared with the first two fields.

In the first two studies (acute care and mental health), a question was included regarding the duration of nurses' involvement in an ethics committee, which showed that on average nurses serve on ethics committees for only 2–3 years. In the study on nursing homes, only two interviews provided relevant data: 1 and 6 years. As the study on home care did not find any ethics committees at all, the interview question was not repeated in the study on ethics committees in care for disabled people.

Table 1 also shows the type of education held by the respondents. The data show a number of nurses with a bachelor degree (33 of 52), which is higher than the average level of education of nurses in the Netherlands. If presented with a choice between nurses in ethics committees, the interviewers, being students of a bachelor nursing programme, were asked to interview the nurse with a bachelor degree. This accounts for the high number of bachelor nurses among the respondents.

In the five studies, the 52 respondents were asked what knowledge, skills and attitudes they need to participate competently in ethics committees or meetings. Each separate study led to sector-specific competency descriptions. Table 2 shows all the dimensions that appeared in the final sector-specific descriptions of the original five studies. Some items under 'skills' in one study, for example advocacy, appear under 'attitudes' in another. The order of importance differed for most dimensions in the sector-specific competency description. A dimension may have been mentioned more often in one study and less often in another. Although the processing for the present article involved an attempt to keep the descriptions short, no attempt was made to cluster dimensions. In some cases, the original interview analysis was consulted to see under which categories the dimensions fitted best and if data fitted well under one English term. In the overview, the emphasis is on what dimensions appear in more than half of the separate studies.

Table 2. Dimensions of nurses' competencies for CEC participation

	Acute care (2005) $R = 11$	Mental health (2006) $R = 11$	Nursing homes (2007) $R = 11$	Home care (2008) $R = 11$	Disabled (2009) $R = 8$
Knowledge	Moral concepts and arguments Models of moral deliberation	Basics of health law Mental health law Basics of ethics	Health law Ethics One's institution One's profession Clinical experience	Health law Ethics, issues and 'proper channels' Social and institutional context One's profession	Professional knowledge Ethics: models and concepts Health law
Skills	Communication skills Advocating the patients' and the nurses' interests Giving voice to one's point of view Arguing for one's point for view 'People skills'	Communication skills Forming and expressing one's point of view Identifying and articulating arguments Identifying and articulating dilemmas	Communication skills Professional skills: impartiality, perspective Argumentation skills Analytical and reflective skills Social skills	Communication skills Deliberation skills Advocating the patient's interests Professional skills: reporting, knowing one's limitations	Expressing one's point of view Listening Communication skills Reflection
Attitudes	Standing for something Commitment (to committee and issues) Open and respectful Critical and reflective	Interested in ethics Open mind Advocate of the patient Understanding the patient's situation	Open and respectful Critical and observant Self-aware	Open and respectful Committed to professional ethics Patient orientated	Interested in ethics Open and respectful Self-aware

Knowledge

Each of the five studies show that respondents mentioned the need for a basic knowledge of ethics, such as moral concepts, models and issues. Four of the five studies report a basic knowledge of health law as necessary, meaning legislation, regulations and 'the proper channels'. Only in the interviews in acute care was this not reported. Three out of five studies show that nurses in ethics committees reported clinical and professional knowledge as important for organized forms of moral deliberation in profession, institutions and society. This was not the case in the studies on acute care and mental health care.

Skills

Nurses indicated in all five studies that communication skills are needed to participate in ethics committees, such as listening, speaking and writing. Four of the five studies reported that professional skills are required. The study in the care of people with learning disabilities did not show this. This group of skills includes advocacy of the patient, overview of the situation and use of methods and techniques in the nursing process. Most of these skills are identical to the skills needed for professional conduct in daily care. A third group of skills figuring in every study was moral skills, including the ability to recognize, analyse, express, substantiate or contest moral aspects and points of view.

Attitudes

The five studies all suggest that for nurses an open and respectful attitude is important, towards both other committee members and the patients' situations. Three studies observed that the nurses' contribution to ethics committees involves a perceptive and reflective person who also has an interest in ethics and a commitment to the work of the ethics committee. This was not mentioned in the studies on acute care and nursing homes. Three studies reported that nurses need to be aware of their own limitations and convictions. This was not reported in acute care and home care interviews.

Table 3 shows the results on the additional questions concerning issues, preconditions and education.

Issues

The interview topic of moral issues arising in the committees or meetings was included only after the first study. In all four remaining fields of nursing (with nuances specific to those fields), issues concerning patient autonomy arose as subjects for discussion in ethics committees. In three of the four fields, interviews indicated issues at the end of life (not in care of people with learning disabilities). In two out of four studies, the ethics committee nurses were confronted with issues arising from constraints in the institutional context, such as budget issues and staff shortages. This type of issue also includes the need for moral deliberation itself, which is sometimes an issue discussed in ethics committees.

Conditions

To facilitate nurses' competent participation in organized forms of moral deliberation, the conditions included time according to four of the original studies. This was not mentioned in the nursing home interviews. All five studies indicated the necessity of various forms of support, including education in ethics and also moral and practical support from colleagues and the institution. In all of the studies nurses were divided on the requirement of work experience: about half preferred seasoned colleagues on ethics committees whereas the other half preferred new faces. An average recommendation of 2 years of work experience

Table 3. Dimensions of additional conditions for nurses' CEC participation

	Acute care (2005) $R = 11$	Mental health (2006) $R = 11$	Nursing homes (2007) $R = 11$	Home care (2008) $R = 11$	Disabled (2009) $R = 8$
Issues	Not available	Moral deliberation Restraints of patient's freedom Euthanasia and suicide	Death and dying (active and passive euthanasia) Nutrition (forced and artificial, dehydration)	Euthanasia Palliative care Institutional context	Patient autonomy Sexuality and intimacy Work pressure and institutional context
Preconditions	Time Education Clinical experience Support (moral and practical)	Time Education Support	Clinical experience Education	Time Interdisciplinary consultation Support Formal deliberation	Information Time Interdisciplinary consultation Support
Education	Use casuistry Train reflective skills Train analytical and argumentation kills	Use casuistry Train deliberation skills	Use casuistry Train use of self Provide practical experience Teach health law	Use casuistry Teach ethics Train use of self	Use casuistry Teach concepts and models of ethics

means little from a statistical point of view, yet generally nurses seem to appreciate a mix of experienced and inexperienced colleagues as committee members.

Education

As a project about nursing education, the last interview topic addressed recommendations for ethics education. All five studies demonstrated a plea to make moral formation in nursing education more practical: the use of casuistry, role play and application to realistic clinical situations was called for in order to prepare nurses for participation in ethics committees. The necessity of teaching ethics was marked, especially in the sense of moral skills (analytical and reflective). Hardly any formal instruction in knowledge was asked for.

Summary

In order to integrate the results of the five smaller studies, Table 4 shows a summary of the commonalities between the five studies. Certainly, a few differences show up between the studies, but the results contain many similar data. Regarding *knowledge*, health law, ethics and professional knowledge stand out, although not to the same degree in every study; law and official professional statements are missing in the acute care study. Regarding *skills*, communication skills are undisputed, and also professional skills and skills for 'doing ethics' are apparent. Negotiation skills in ethics committees were never mentioned, yet the necessity of cooperation skills was. All five studies call for an open and respectful *attitude* towards patients and fellow committee members. Also, affinity with patient care, committee work and professional ethics is said to be required. The right attitude for a nurse in an ethics committee seems to include a reflective and perceptive attitude, along with an awareness of one's own limitations and convictions.

The same aggregate may be done for the data on the questions regarding conditions. Table 5 shows the common answers to the additional questions in the five studies; dimensions mentioned in two or more studies are included. Although one might expect mainly ethical *issues* specific for each field of nursing to show

Table 4. Aggregated dimensions of nurses' competencies for CEC participation

	Competencies
Knowledge	Ethics: concepts, models and issues
	Health law: legislation, regulations and channels
	Context: profession, institution and society
Skills	Communication: listening, speaking and writing
	Professional: advocacy, 'big picture', methodical
	Ethical: analysing, articulating, reasoning
Attitude	Open and respectful
	Committed to patient and professional ethics
	Perceptive and reflective
	Self-awareness: limitations, convictions

Table 5. Aggregated dimensions of additional conditions for nurses' CEC participation

	Background
Issues	Patient autonomy
	Death and dying
	Institutional context
Preconditions	Time
	Education
	Support (practical and moral, from institution and other workers)
	Some work experience
Education	Use casuistry and practical application
	Teach ethics and train ethical skills

up, three ethical issues appear to be common topics for discussion in all fields. The question was which issues were discussed in the committees, and the results featured issues surrounding patient autonomy, death and dying, and constraints on nursing care by the institutional context. Related to the last point are the dimensions mentioned as *conditions* for participating in ethics committees, as they include time (can nurses participate during working hours?), education (does the employer provide funds?) and other support (a supportive environment, secretarial support, etc.). The recommendations regarding ethics in nursing *education* were summarized in two dimensions: the necessity to teach ethics to nursing students and the necessity to make ethics education more practical.

Discussion

The aggregate results of these five separate studies are presented here in an attempt to formulate a competency profile based on the similarities between the studies. A first assumption in the integration of the findings is that the 52 nurses interviewed in the five fields of nursing form one homogeneous group of respondents, selected randomly. Most of them had a bachelor degree in nursing and at least some experience in clinical practice. However, differences in age, job description or gender were ignored. Moral deliberation in mental health care may depend more on personal characteristics and the quality of relationships than on acute care settings. Our results do not make this explicit. A survey on a larger scale may reveal whether the respondents are a good representation of the profession as a whole, and how the whole differs from the parts.

A second assumption in this study is that moral deliberation within an ethics committee is comparable to other forms of moral deliberation, such as consultations, rounds and meetings. The competency profile used in Dutch nursing education assumes that the competency for participation in formal committees is like deliberation in informal settings on the ward. Our aggregate does not show otherwise, but whether this is really the case may be a question for further investigation. Kohlen's research on the 'language' of nurses and ethics committees suggests it is *not*.[13]

Third, a deliberate choice was made to limit the interviews to what nurses *themselves* mention as their competencies. Strictly speaking, this addresses only what they reveal to be their own perception of their competencies, successes and failures. Further inquiry may reveal how other participants in ethics committees view nurses' contributions and how the perceptions of nurses and others compare.

Regarding the analysis of the findings, the question of interviewing and labelling by nursing students has to be mentioned. Fourth-year bachelor students in nursing who have followed research methodology classes possess a certain level of theoretical knowledge and expertise in interviewing and analysis. This may have influenced their conceptualization of their findings. For reliability, students checked each other's work, supervised by a senior researcher, and followed the same topic lists and method of analysis in each study. At the same time, the 52 respondents represent a sizeable and randomized group. All the five sector-specific studies were published in different professional peer-reviewed nursing journals. Two indications of the reliability of the findings are that saturation of the data was reported in three of the five studies (not in home care and care for people with learning disabilities) and that the results of all five studies shows substantial overlap (see Tables 2 and 3).

As little empirical literature was found to support the arguments for this study, the findings from our interviews contribute to a body of knowledge on the participation of nurses in ethics committees. They confirm that in other countries nurses participate in clinical ethics consultations and that they have their own distinct contribution to make.[8,9,20] This contribution is based on their professional competence and interest in ethical issues. Nurses are supposed to have a basic moral awareness, and this awareness may be cultivated into more explicit competencies for more explicit forms of deliberation. In particular, the claim of discernment as a central competency for nurses' involvement in ethics consultation is confirmed.[11] The literature confirms that educational background is an important influence on the nurses' ability to deal with ethical dilemmas.[9] However intuitively health care institutions and nursing education include nurses in their focus on clinical ethics, this study confirms that they are right to do so. Nurses have a grasp of what is required of them and this study shows in a detailed way what is required.

This also means that the concept of competencies may be studied in more detail, at least to reveal the specific knowledge, skills and attitudes necessary for reflection on good nursing practice. The assertion that for serving on ethics committees nurses need to show skills in the areas of advocacy, communication and education proved to be too general compared with our study. Although advocacy was mentioned as an important competency, communication was portrayed in more detail, and educational competencies not at all.[3] It is possible that the nurses who were interviewed did not see the educational function of an ethics committee that other authors ascribe to it.[13] The importance of professional knowledge and communication skills is confirmed by our study, but dealing with diversity and emotions in teams was phrased in terms of respect and professional conduct rather than leadership.[5] How to teach and assess these competencies during training is a matter outside the scope of this study.

Recommendations

In this study the nurses themselves reported their own competencies, yet the final result may be used as a format for a survey on a larger scale to increase reliability. Comparisons with other countries may provide further insight into the moral competencies pertinent to the nursing profession. For instance, American

Table 6. Requirements of nurses for complete participation in an ethics committee so they may provide patient care according to nursing's professional standards.

Knowledge of ethics: concepts, models and issues
Knowledge of health law: legislation, regulations and channels
Knowledge of their context: profession, institution and society
Communication skills: listening, speaking and writing
Professional skills: advocacy, 'big picture', methodical
Ethical skills: analysing, articulate, reasoning
An open and respectful attitude
A committed attitude to patient and professional ethics
A perceptive and reflective attitude
A self-aware attitude: of their own limitations, convictions

nurse researchers Oddi and Cassidy[9] report almost only female nurses as members of ethics committees, whereas we found a 50–50 division. Are there cultural differences at work? They found an average of 18.6 years of work experience and a 2.2-year average of ethics committee membership among nurses, which is very comparable to our study.

Comparisons may also be made with studies asking not what nurses say they *need* but what they say they actually possess and lack. Assuming they are the 'right' competencies, one would need to ask how many nurses participating in ethics committees possess them and how many also show them in practice, leading to the desired practice and reflection of good care. This leads us ultimately to the more fundamental question of whether the competencies for ethics committees outlined in the Dutch competency profile are in fact the 'right' competencies.

Programmes in nursing education should now focus more specifically on the knowledge, skills and attitudes required for nurses to assume such strategic positions to influence the quality of care. Nurses do have a sense of urgency where ethical issues are concerned. Fostering their attitudes, commitment and sense of responsibility is important for nursing programmes.[20] Formal instruction will probably remain important. However, ethics education needs to be more practical. Nursing students need to see the clinical application of ethical discourse. Role play, reflection on their own internships and observation of multidisciplinary patient meetings are cases in point. One valuable suggestion in one of the interviews was to implement an ethics committee simulation as part of the nursing curriculum. At the same time, the question remains as to how effective this or any other strategy will be.

In practice, healthcare institutions are recommended to use this profile to select nurse members for their ethics committees. As Hoffmann et al.[10] show, healthcare institutions may themselves have little idea how competent the members of their ethics committees are and what competencies they need to begin with. The outcome of this study may be of help to people responsible for ethics consultations in healthcare institutions when they select and evaluate nurses for ethics committees. The support they offer to nurses may also be fine-tuned in terms of time, education and appreciation of competent work in the light of the results of this study. The same goes for nurses themselves when they evaluate their own contribution to the improvement of the moral quality of their daily practice. Do they possess the right competencies to make this moral quality explicit and a topic for deliberation? Do they have the ability to reflect on good care?

Conclusion

This article aimed to bring together five studies, and thus gain insight into the competencies for nurses' participation in ethics committees or moral deliberation in other meetings. On the basis of 52 interviews, specific dimensions are identified as the required competency across the nursing profession (Table 6). In

particular, nurses themselves now have a more detailed description of their professional development, should they accept the responsibility to participate in ethics committees. It is interesting to note that many of the competencies needed to participate in an ethics committee are, to an important degree, a continuation (and intensification) of the competencies needed to participate in a team of nurses delivering daily patient care in the first place. Practising ethics is not an added extra, but it is central to practising good nursing care.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Conflict of interest

The author declares that there is no conflict of interest.

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