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Networking Ethics: A Survey of Bioethics Networks Across the U.S.

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Abstract Ethics networks have emerged over the last few decades as a mechanism for individuals and institutions over various regions, cities and states to converge on healthcare-related ethical issues. However, little is known about the development and nature of such networks. In an effort to fill the gap in the knowledge about such networks, a survey was conducted that evaluated the organizational structure, missions and functions, as well as the outcomes/products of ethics networks across the country. Eighteen established bioethics networks were identified via consensus of three search processes and were approached for participation. The participants completed a survey developed for the purposes of this study and distributed via SurveyMonkey. Responses were obtained from 10 of the 18 identified and approached networks regarding topic areas of: Network Composition and Catchment Areas; Network Funding and Expenses; Personnel; Services; and Missions and Accomplishments. Bioethics networks are designed primarily to bring ethics education and support to professionals and hospitals. They do so over specifically defined areas—states, regions, or communities—and each is concerned about how to stay financially healthy. At the same time, the networks work off different organizational models, either as stand-alone organizations or as entities within existing organizational structures.

Keywords Bioethics · Ethics networks · Ethics consortiums

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Introduction

The existence of institutional ethics bodies within healthcare facilities—e.g., clinical ethics committees, organizational ethics committee, or clinical ethics consultation services—is still relatively new. The 1960s saw the advent of an allocation committee for Seattle's dialysis treatments and committee evaluations of the moral implications regarding life sustaining treatment by the Catholic Hospital Association of Canada (Heitman 1995). However, the development of ethics committees was slow to take hold. Karen Teel's 1975 article, *The physician's dilemma: A doctor's view—what the law should be.* (Teel 1975), recommended an institutionally-based multidisciplinary committee for addressing legal, ethical, and medical issues in the care of severely deformed infants, while the court opinion *In re Quinlan* endorsed ethical review of challenging cases like that of Karen Ann Quinlan. By the 1980s, the President's Commission for the Study of Ethical Issues in Medicine and Biomedicine and Behavioral Research was arguing that institutions should have procedures to ensure thoughtful decision-making regarding the ethical challenges posed by end-of-life care, and it highlighted review by ethics committees as a possible mechanism (1983). It was not until 1992 that the Joint Commission on Hospital Accreditation (then, JCOHA; now, The Joint Commission) required all accredited hospitals to have a formalized ethics mechanism. However, that mandate, both then and now, does not include explicit guidelines regarding the structure, composition, or responsibilities for these ethics bodies, leaving it up to individual institutions to create their own approach to ethics review.

As a consequence of the above (and other) forces, most hospitals have determined to address ethical issues by utilizing an in-house ethics committee. Ethics committees typically are comprised of hospital personnel, including physicians, nurses, social workers, chaplains, and sometimes lawyers and lay persons (McGee et al. 2001). The charge to ethics committees has been to provide education for hospital personnel and the greater community, consultation and mediation, and policy recommendation. However, with approximately 4000 Joint Commission accredited hospitals in the US[1] (The Joint Commission 2015) and less than 2000 professionals who self-identify as experts/scholars in medical ethics and humanities,[2] many ethics committees are left to their own devices and limited resources for educating themselves and supporting their institutional efforts. This can lead to stagnation in the work of ethics committees and failure-to-thrive

[1] The Joint Commission accredits more than 20,000 healthcare institutions, and as of the most recent completed survey for 2012, there are 4091 accredited hospitals.

[2] Since there is no centralized database of self-identified bioethicists, we must approximate "self-identify." We start from the knowledge that there are approximately 1700 members of American Society for Bioethics and Humanities (ASBH). We realize that some of these members would not self-identify as "experts", but it is not unreasonable to assume that a large majority of persons willing to pay annual dues to a professional organization that focuses on bioethics and medical humanities take a substantive aspect of their professional identities to be tied closely with these topics. From this base, we simply rounded up to the nearest thousand, since it is safe to assume that not all those who self-identify will be part of the organization.

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syndrome (Fletcher and Hoffmann 1994; Kuczewski 1999; Mills et al. 2006; Conrad 2006).

In response to a desire to "strengthen…institutional ethics programs" (Spencer 1994) by offering education and pooling resources, several areas around the country have created syndicates focused on bioethics that bring together the expertise of institutions and individuals (Brody et al. 1992; Pinkus et al. 1995; Loeben 1999; Moldow 2002). Beginning in the mid-1980s, "bioethics networks" or "consortiums", appeared in Midwestern states where "such networks serve as umbrella organizations that provide ethics resources to healthcare institutions [and individuals] in their geographic area" (Tarzian et al. 2006, p. 86).

Located in a largely rural state with only one academic medical center, the authors and other local healthcare professionals believed that a bioethics network could prove useful within hospitals, long-term care facilities, and individual providers by reducing isolation and increasing education for healthcare institutions and individuals across the state. To do so, we began by turning to the scholarly literature for information on existing networks. While there are a number of, now older, articles on development of specific ethics networks (Brody et al. 1992; Dunn 1992; Pinkus et al. 1995; Baruch 2005), on the strengths and weaknesses of ethics networks (Loeben 1999), and (more recently) on ethics networks as a resource for rural communities (Anderson-Shaw and Glover 2009), there is little regarding the general nature, scope, and function of ethics networks. In order to learn more about nature, scope, and function of networks for the purpose of helping develop our own network, we designed a simple survey to help fill the gap in the knowledge, looking specifically at the organizational structures, professed missions and functions, as well as the outcomes/products self-reported by network leaders.

Methods

A survey was designed to gather information on, among other things, the mission, membership, and administrative structure of existing bioethics networks, and was determined by our institution to be exempt from IRB review. With no central organization keeping lists of bioethics networks, it has been noted that networks "appeared to increase from 1985 to the mid-nineties, but some networks have disbanded since then" (Tarzian et al. 2006, p. 85). In order to begin the process, three members of the Division of Medical Humanities conducted independent internet searches in order to identify currently active bioethics networks or consortiums to formulate a list of all potentially eligible organizations. Searches utilizing several search engines included combinations of the words "bioethics", "ethics", "healthcare", "committee", "network", and "consortium". From these searches, a total of 18 consortiums were identified, and of these 18 networks, we found contact information for 16 of them (88.9 %). Subsequently, two more networks were identified through discussions with colleagues around the country—making an initial list of 18 networks with contact information (see Table 1 for list of identified networks).

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Table 1 Identified Bioethics Networks

Arizona Bioethics Network
Bioethics Network of Ohio
Consortium Ethics Program (W. PA)
Florida Bioethics Network
Health Care Ethics Consortium of Georgia
Illinois Healthcare Ethics Committee Forum
Kansas City Area Ethics Committee Consortium
Maryland Healthcare Ethics Committee Network
Medical Ethics Resource of Michigan
Metropolitan Ethics Network
Mid-South Biomedical Ethics Center
Midwest Ethics Committee Network
North Texas Biomedical Ethics Network
Ocean State Ethics Network
South Carolina Healthcare Ethics Network
Southern California Bioethics Committee Consortium
Vermont Ethics Network
West Virginia Network of Ethics Committees

The driving stimulus for the survey was to help in the development of our own state-wide network. As such, both qualitative and quantitative data were targeted, and the team determined to gather information regarding the development of, services provided by, and commonly faced problems of bioethics networks (see Table 2). A survey was created using the online tool, SurveyMonkey, and individual members of local ethics committees piloted the survey and offered feedback to help clarify questions on the survey. Once the authors were comfortable with the final wording and scope of the survey, a link to the survey was sent to the 18 networks for which a contact email address was available. Reminders about the survey were sent on two occasions after the initial solicitation, and of those solicited for participation, responses were provided by 10 networks (55.5 % response rate).

Data were collected online and downloaded in both Adobe pdf and Microsoft Excel formats for further analysis. Given the relative simplicity of (see Table 2) and small sampling (10 respondents) for survey, no statistical software was needed for calculations and no coding methodology was applied to the typically brief comments provided. The authors discussed any possible ambiguities in the results (noted below) and formed a consensus around how best to report the data.

Results

We report results below using the following categories: composition and catchment areas, funding and expenses, personnel, services, and mission.

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Table 2 Survey tool

Question	Data type
Who are the members of your network? [Select all that apply.]	Quantitative
Individuals	
Institutions	
Other	
If individuals are members of your network, what is (are) the primary profession(s) represented? [There can be more than one "primary" type.]	Quantitative
Physicians	
Nurses	
Allied health professionals	
Researchers	
Academic professionals	
If institutions/facilities were selected, what is the primary kind of institution represented?	Quantitative
Hospitals	
VA	
Hospice	
Research organization	
Other	
What kind of area does your network primarily serve?	Quantitative
City	
Region	
State	
Nation-wide	
How did you come to choose this "service area"?	Qualitative
What resources provided funding to initiate your consortium? [Please rank order all that apply.]	Quantitative
Grant funding	
Corporate support	
Healthcare institutional support	
Foundation funding	
Individual support	
Which of the following monetary sources (ranked in relation to approximate percentage of budget) comprises the on-going funding for your network expenses? [Please rank all that apply.]	Quantitative
Institutional fees	
Individual fees	
Grant funding	
Corporate sponsors	
Foundation/Individual philanthropy	
Support from the network's sponsoring entity/institution	
Other	

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Table 2 continued

Question	Data type
If any, approximately how many individual memberships do you currently have?	Quantitative
No individual memberships	
< 25	
26–50	
50–75	
75–100	
> 100	
If any, approximately how many institutional memberships do you currently have?	Quantitative
No institutional memberships	
1–5 Memberships	
6–10 Memberships	
11–15 Memberships	
16–20 Memberships	
More than 20 memberships	
What are the benefits/services you provide to individual members? [Please select all that apply.]	Quantitative
Discounted fee to annual conference	
Access to all educational materials available on the website	
Ability to request ethics consultation (clinical and/or research)	
Quarterly or other circulation	
Other (please specify)	
What are the benefits/resources provided to your institutional members? [Please select all that apply.]	Quantitative
Discounted fee to annual conference	
Ability to request ethics consultation	
Assistance in developing ethics committees or consult services	
Scheduled educational in-services to institution	
Access to online and other educational resources	
Quarterly or other circulation	
Other (please specify)	
What are your expenses?	Quantitative
Administration/support staff	
Printing expenses	
Material expenses	
Capital equipment	
Website development and maintenance	
Conference development and expenses	
Distribution expenses	
Other (please specify)	

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Table 2 continued

Question	Data type
What kind of organization is your network?	Quantitative
A stand-alone charitable organization	
A non-profit (non-charitable) organization	
An entity within another organization	
Other (please specify)	
If your network is an entity within another organization or you selected "other" for the previous question, please describe:	Qualitative
Who performs the day-to-day operations? [Examples: "Executive Director paid by the network" or "Administrative Assistant within the Department of…at…University"]	Qualitative
Do you have a board of directors?	Quantitative
Yes	
No	
If you have a board of directors or executive/advisory committee, how are members selected? [Please, select all that apply.]	Quantitative
Elected	
Appointed	
Volunteer	
Ex officio	
N/A	
If you have a board of directors or executive/advisory committee, are there term limits?	Quantitative
Yes	
No	
N/A	
Please describe the mission of your network.	Qualitative
If your mission is multifaceted, which one mission would you say has the greatest impact or focus?	Qualitative
Which of the following does your network include as functions of the network? [Please select all that apply.]	Quantitative
Education	
Consultation	
Service	
Other (please specify)	
If education is a function of your network, which of the following educational activities/functions are provided by your network? [Please select all that apply.]	Quantitative
Provide case studies	
Provide continuing education credit activities	
Manage library or other resource materials	
Distribute a regular circulation (newsletter, e-mail updates)	
Offer a conference	
Provide lecture/educational series	
Other (please specify)	

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Table 2 continued

Question	Data type
Of all educational activities, which one is the most utilized by your constituents?	Quantitative
Provide case studies	
Provide continuing education credit activities	
Manage library or other resource materials	
Distribute a regular circulation (newsletter, e-mail updates)	
Offer a conference	
Provide lecture/educational series	
Other (please specify)	
Does your network itself provide a mechanism for ethics consultation for its members (or other constituents)?	Quantitative
Yes	
No	
If your network provides a mechanism for ethics consultation, what process is used to trigger and provide the consultation, and who provides it?	Qualitative
Is your network involved in local, regional, or state-wide policy, legal, regulatory, or statute development (such as POLST or medical futility issues)? If so, please describe.	Qualitative
Who (not names but roles) was involved in the development of your consortium?	Qualitative
To date, what do you think has been the greatest accomplishment of your consortium?	Qualitative
What, if any, problems, concerns, or obstacles has your consortium/network faced?	Qualitative

Network Composition and Catchment Areas

All (100 %) of the responding networks indicate that they have individual members,[3] and a majority include institutional memberships (80 %).[4] Of those networks with individual members (nine reporting—one skipped answering this question), a strong majority have physicians, nurses and academic professionals (88.9 % for each category), while fewer networks also have allied health professionals (55.6 %) and researchers (22.2 %). In many networks with individual memberships, there were fewer than 25 individual members (40 %); however, 10 % had between 75 and 100 individual members, and 30 % had greater than 100 members.

Institutional members, on the other hand, showed no variety among the types of institutions that participated, with all networks having hospitals as members, and none claiming any VA, nursing home, hospice, or research organization members. The majority of networks with institutional members reported 20 or greater institutional members (57.1 %), with one network having five or fewer institutional members.

[3] Two respondents later indicated that they do not have individual memberships. This would indicate that there may be an ambiguity between individuals who are members because of institutional affiliation and individuals who are members *qua* individuals.

[4] Elsewhere only 70 % reported members. This may be an ambiguity between *having* such members and *allowing* for such members.

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Since networks bring together members across a defined location or region, we wanted to identify what locale or region was served and why. Our survey shows that the majority of the networks serve to cover a particular state (60 %), while the remaining 40 % serve an identifiable region and one network serves a local city/community. Driving factors in determining the "catchment" area of a network included state-based incentives for ethics committee formation, "shared burdens under state law", and identifiable geographic boundaries.

Turning to the organizational framework, many of the responding networks are incorporated as a non-profit or non-charitable organization (40 %), while 50 % of the networks are founded as an entity within another organization—typically funded, housed, and operated by an academic institution. One network is the project of a university faculty member.

Network Funding and Expenses

We asked respondents to tell us how they seeded their initial funding for the network. Seven respondents answered, and three identified grant and foundation funding as the largest source for initial funding. Another two received large support from healthcare institutional funds. At the same time, few relied on individual funding, and none of the networks were initially funded by corporate sponsorship.

After this initial start-up, all responding networks identified that "funding is always a challenge", creating a hardship in the development and maintenance of their network. Of the seven who responded to the question about funding sources, six networks rely heavily on fees paid by both institutional and individual members, while four also rely on the support of a sponsoring entity (like a university). Also, four networks get about half of their support from foundation/individual philanthropic funds.

The purpose of the funding is, of course, to cover network expenses. Administration and support staff were identified as being the largest proportional expense of the responding networks. The second largest expense tended to be conference development and implementation, followed by newsletters/other distributions, website development and maintenance, printing, material acquisition, and capital equipment, in descending order of endorsement.

Network Personnel

Since someone has to be responsible for the administrative activities of the network, we asked who was so invested. Networks reported that a combination of administrative staff (80 %), often paid for by the hosting institution, and individual directors (50 %) perform "day-to-day" operations. Also, half of the networks have a board of directors (50 %) with members of the board being selected by election (60 % of networks with boards), appointment (60 %), volunteering (80 %), and/or ex officio status (20 %). Further, of those networks with a board of directors, 80 % had term limits for the members of the board.

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Services of the Networks

Given that bioethics networks have been developed in response to some considered need for support and education, networks should offer some purpose or service to members. In fact, all networks in our survey noted that education was a specific function they performed, and all offer a conference, which was noted as the most utilized network service as well, in response to the need for education throughout the network. Other educational services include continuing education credit (90 %), lectures/educational series (80 %), case studies and a regular circulation (50 % each), and access to a library or other resource materials (40 %). Several of the responding networks endorsed involvement in local, regional or state-wide policy or regulatory development at least in some capacity. In contrast, the vast majority (80 %) of the responding networks noted that the network itself does not provide mechanisms for ethics consultation to its members.

Responding networks identified the following benefits of having a membership at the individual level: access to all educational materials available on the internet (80 %), discounted conference fees (70 %), quarterly or other circulation (40 %), and ability to request an ethics consultation (10 %). An option for "other" was frequently (80 %) chosen, with explanations such as online discussion forums and listserv membership, webinars, and service discounts. Of those networks with institutional members (8), institutional benefits included: discounted conference fees (62.5 %), access to online and other educational resources (75 %), assistance in developing ethics committees or consultation services (62.5 %), quarterly or other circulations (25 %), and ability to request ethics consultation (12.5 %). As happened under individual memberships, respondents frequently (75 %) chose "other" regarding services to institutional members, including such resources as having employees receive mailings, ethics committee guideline books, and access to discussion forums.

Network Missions and Accomplishments

Responding networks offered a variety of mission statements; however, several themes emerged within these network mission statements. Four of the ten responding networks identified advancing ethics in health care as central to their mission, while three of the responding networks made specific reference to education in their mission statement. Further, four of the ten responding networks suggested that discussion forums focused on community-building and the sharing of information were central to their network mission. A smaller minority of responding networks identified the development of practices and the understanding and resolution of ethics-related problems as part of the mission for their networks.

Six of the networks identified core components of their mission statements and, from these responses, the two primary themes of networking/community-building and education/training emerged. Four of the six networks identified education/training as the core component of their mission, while the other two identified networking and community-building as being central to their mission. The centrality

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of education, followed by community building, parallels the importance ranking of the services that are offered by the responding networks.

Networks were asked to identify their most significant accomplishments. Respondents, in turn, identified community development, passage of specific laws and standards of practice, and raising awareness of ethical issues in medical practice.

Discussion

Bioethics networks have emerged as mechanisms to support ethical aspects of healthcare for both institutions and individuals serving varying catchment areas across the country. Though the number of bioethics networks remains relatively small, the present survey was created in order to help understand common themes among these networks in their development, service, and missions so that this information could be used in the formation of a network in the authors' home state. We began analyzing our results by noting areas of convergence and divergence among the results in order to determine which considerations best fit our situation.

Convergence

Every respondent indicated that education was a fundamental service provided by the network. This result is not surprising given what we already know are some of the stated reasons for starting a network—namely, educational and peer support (Loeben, 1999; Tarzian et al. 2006). Further, though educational offerings take many forms, conferences look to be a universally provided source for educating network members. While conferences take coordination, funding, and time to develop, we speculate that there are several good reasons networks rely on conferences for education. First, conferences bring network members together in face-to-face environments. This builds acquaintance and community among the membership. Second, conferences disseminate education in an intensive program that is time-limited. This allows for busy professionals to get a good deal of insight in a brief period of time devoted to bioethics. Third, conferences offer the opportunity to obtain continuing education credits which might otherwise be unavailable, particularly to individual members. Fourth, given that funding is a persistent concern of networks (see below) conferences often earn money for the network.

Another point of convergence among networks is that all responding bioethics networks have individual members[5] but only 80 % have institutional members. This finding was a bit surprising to us, since we had speculated that networks were primarily about institutions (and their ethics committees), not individuals per se. But what this suggests is that both types of members have needs that are uniquely fulfilled by network membership. Further, most of the professions represented by individual members were diverse, including physicians, nurses, academic

[5] See note iii.

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professionals, and (to a lesser extent) allied health and research professionals. This interprofessional make-up of the membership importantly mirrors actual practice. In contrast, however, respondents noted that only hospitals made up institutional membership. While some networks' mission statements and websites suggest that they accept, even encourage, VA, nursing homes, hospices, or research organizations, none of the networks indicated actually having such institutional members. To our minds, this demonstrates a striking gap of service, as nursing homes and hospice organizations confront ethical dilemmas and would benefit from ongoing ethics education and service as well. And, even though the VA system has a robust national network and ethics core, affiliation with local and regional ethics networks might help identify shared concerns and overlapping interests between the VA and other hospitals nearby. Further examination into why networks have not succeeded in bringing such institutions into their membership is needed as it would be beneficial to determine the nature of this disparity. The authors' own initial inclination is to push for inclusion of nursing home and hospice facilities, and it would be beneficial to understand if there are important barriers for these organizations to become members of bioethics networks.

Furthermore, another area of agreement among the respondents is that funding the networks is a continual challenge. While grant funding and institutional support seeded the initiation of many networks, membership fees from both intuitions and individuals, along with continuing institutional support where applicable, become the primary source of continued funding. But networks also cite a variety of mechanisms to which they have turned for financial support, and it may be that different mechanisms are more appropriate for different stages of development. This suggests that networks should have a staged development planned out in order to transition from one funding source to another over time, and that continued consideration of the appropriateness of relying on any particular funding source is necessary. Overall, the high level of variance for funding networks means that there is no identifiable "gold standard" funding mechanism available for bioethics networks.

Finally, nine of the ten respondents indicated that administration and support staff were often the largest (or a large source) of budgetary expenditures. Given that personnel take up significant funding resources of a network, networks must find ways to reduce these expenses through in-kind "donations" from host institutions or, as noted by several respondents, the use of volunteers to aid in administrative efforts.

Divergence

Along with the areas of convergence noted above, substantial divergence is also present, suggesting that networks are not a one-size-fits-all phenomenon. For instance, while education and conferences are ubiquitous services, only a small number of responding networks offer ethics consultation. Indeed, since the authors, living in a mostly rural state with only one academic medical center, had initially discussed the possibility of a state-wide network offering ethics consultations for members, we were surprised at the limited number of networks that offer ethics

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consultation as a service. Networks may not provide this function for a number of reasons, including the ready availability of consultation services within most member facilities, logistical concerns surrounding arranging consultations among members, or concerns over liability for providing consultations across institutions and individuals. More thought and investigation is necessary to determine which direction to take any new network with regard to consultation.

Next, with membership fees accounting for a large portion of the annual income of networks, the size (and cost[6]) of membership matters, and yet respondents reported a wide variance of membership sizes. However, it looks like where individual membership numbers are low (e.g., less than 25) institutional members are high (e.g., greater than 20), and vice versa. This likely reflects differences in the emphasis the network has placed on recruitment of members, as well as the catchment area served by each network. Respondents suggest that decisions around what area to serve has grown out of serving a specific need or common interest. Our initial goal in the development of a bioethics network was to expand communication among individuals and institutions which serve in relative isolation given the distinctly rural nature of our state; in addition to the literature (Anderson-Shaw and Glover 2009), the survey results indicate that ours is not a unique goal among existing networks.

Bioethics networks are founded on primarily two different organizational frameworks, a non-profit entity or an entity subsumed by a larger institution (such as a unit in a university). Further, those with non-profit status have boards of directors, while those subsumed under another institution do not. It is unclear why individual networks have taken the organizational routes they have. At first we speculated that there might be a correlation between who (or what type of professionals) founded the network and the structure that was chosen. For example, it could be that a network founded by faculty at an academic medical center would be subsumed under the faculty's institution, but no such correlation exists. Instead, organization may be driven by budgetary constrictions, as it is clear that budgetary issues are the top concern among the networks. Having a network subsumed by a larger entity likely allows for resource sharing including administration and support staff, which were cited as the largest proportional expense. On the other hand, we have speculated that in our state some potential members might want a non-profit status that stands outside any particular institution in order to identify the network as independent of any particular institution's interests and mission. This may be a fundamental reason some networks are independent non-profits.

General Conclusions

The purpose of our survey was to gather information about existing bioethics networks in order to help in the development of our own state-wide network. Rather than simply reinventing the wheel, we began from the belief that information about what others developed and experienced would either help support our own initial

[6] Many networks have a membership fee structure on their websites. While not part of survey itself, it is worth noting the wide divergence in fees across networks as well.

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reasons for creating such a network or might give us insight into areas we had not otherwise considered. In this light, the data confirmed our own approach, revealing that bioethics networks are designed primarily to bring ethics education and support to professionals and hospitals. They do so over specifically defined areas—states, regions, or communities—and each is concerned about how to stay financially healthy. At the same time, however, we discovered that networks work off different organizational models, either as stand-alone organizations or as entities within existing organizational structures, and that almost all networks struggle to find sustainable funding sources.

Over the last two decades, investigation of the journal literature and the internet reveals that some bioethics networks have ceased to function. With no "state of the art" approach to network organization, what is clear is that individual networks must gain buy-in throughout the region they serve, and the process of developing that buy-in may prove the best method for determining an organizational model with staying power. But, according to our data, a well-functioning network can accomplish important things—from promotion of ethics across healthcare institutions to education of healthcare personnel, from policy promotion to legislative action.

We believe that our survey data can prove useful not only for groups like us who want to stimulate discussion among potential stakeholders in order to develop a bioethics network but also for existing networks as they continue to evolve.

Limitations

The survey was designed to gather information that would help the authors develop a state-wide bioethics network, not in light of a research project, per se. As such, the questions asked attempted primarily to gather facts about the networks and only rarely drilled down to reasons behind some of those facts. For the purpose of generalizable knowledge, the meaning of some of the responses remains ambiguous. More information is needed in order to understand why certain networks have developed in the exact ways they have. Further, with no single source that captures contact information regarding bioethics networks, the authors relied on internet searches. No doubt several networks went undiscovered using this process. Further, even once identified, not all networks have clear contact information for someone in a position of responsibility or authority in the organizations. As such, we were left to assume that the individual who filled out the survey was well-positioned to answer our survey accurately with regards to the details of the network. Finally, as is inherent in all surveys, the information gathered from this research is reflective only of what was endorsed in the surveys; as such, the conclusions we have drawn are based upon the information provided to us and may not fully generalize to all ethics networks.

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