

How idiocultures and warrants operate independently in New Zealand health ethics review boards

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Abstract

Laura Stark's ethnography of IRB decision-making unearthed two concerns: first, even though the committees were governed by ethical principles, the committees generated their own precedents for future decision-making; second, Stark witnessed unequal power relations within committee decision-making as a member's expertise was accepted as a 'warrant'. This article examines how these warrants are practiced within the decision-making process of New Zealand's four Health and Disability Ethics Committees (HDECs or IRBs). More specifically, this article concerns these warrants during a committee's decision to consult with indigenous communities, a decision for which there exist no guidelines. The article ends by discussing ethical issues when observing in public places.

Keywords

ethics committees, ethnography, idioculture, Maori, research ethics, warrants

Introduction

Laura Stark's (2012) *Behind Closed Doors* is the only book-length study from inside an ethics committee (see also articles by de Jong et al., 2012; Fitzgerald, 2005; Hedgecoe, 2008; Jaspers et al., 2013). *Behind Closed Doors* is a remarkable sociological analysis of the culture and insidious workings of IRBs in action.

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Stark's insightful ethnography was based on her meticulous observations of the monthly deliberations of three IRBs and her interviews with more than 30 IRB chairpersons. Her analysis leads to a greater understanding of how IRBs create precedents and how a member's expertise is used as a warrant.

One of Stark's (2012) attributes as an author is that she never plays her sociologist's hand, but sociological analysis is certainly present backstage, buried in the book's footnotes. Here, sociology is framed as the study of group processes among brokers with different claims to power and expertise. Gary Alan Fine's (1987) iconic study of little league baseball players underpins Stark's theoretical work.

Fine found that, although all the baseball teams were governed by rigid rules (for example, nine players and three strikes), each team's *idioculture* created its own rules:

Idioculture consists of a system of knowledge, beliefs, behavior, and customs *shared by members of an interacting group to which members can refer* and that serve as the basis of further interaction. (Fine, 1979: 734)

For example, a baseball player missing from a team's inaugural practice would, at the second practice, need to be inducted into rules established in his absence (e.g. one's arrival at practice determined the batting order). Similarly, in Stark's research, whereas central bodies accredited local IRBs, the latter determined their own rules and used these rules as a precedent to make future decisions. That is, IRBs 'adopt review procedures rather than ethics principles' (Stark, 2012: 2). In Stark's ethnography, committee members were rarely seen consulting or referring to official ethical guidelines.

Professional expertise within ethics committees is malleable. Stark (2012: 36) suggests that these expert committee members are 'so specialized that they are effectively lay people (or non-experts) with regard to issues beyond their immediate area of expertise'. For example, a neurosurgeon may hold an expert warrant for neurosurgery but when contributing personal experiences to deliberations (her experiences as a parent or as a parent grieving about a child), these opinions are not necessarily based on her professional expertise as a neurosurgeon. Although in an Orwellian sense a neurosurgeon's personal experience is that of a lay person, in this space Stark found that the warrant holder exerts more influence than does the personal experience of a non-professional. Stark's research alerts us to the internal dynamics within ethics committees:

Whereas board members used individual-level warrants to justify their views to each other, local precedents can be thought of as shared warrants that compel the board as a whole. The important feature of IRBs local precedents is that they tend to be idiosyncratic to each board but reasonably stable within them, which explains how two well supported, fully functioning IRBs can arrive at different decisions about the selfsame protocol. Stark (2012: 47)

Elsewhere, I (Tolich, 2014) recorded how the four IRBs documented in this study were equally idiosyncratic. They created idiocultural procedures relevant to singular committees' policies around pregnancy, genomic data banking, and participant information sheets. Once created, these idiosyncratic policies were used as a shorthand for future decision-making.

Inconsistency may be endemic to ethics committees as they are to any social group. Davies' (2008) pilot study involved nine ethics committees reviewing a single application form and a participant information sheet relating to a clinical trial; six decisions were favorable and three were provisional. The major problem Davies found was the applications' lack of information rather than major ethical concerns.

Dixon-Woods et al. (2007) analyzed ethics committees' approval letters to demonstrate that inconsistency was a feature of ethics committee deliberations. Dixon-Woods et al.'s findings challenge the position that inconsistency results from incompetence, and they question how far consistency is achievable or desirable. Variability has a lot to do with the expertise brought to committees by members (Dixon-Woods et al., 2007: 98).

There are some major differences between the three ethics committees Stark studied and the four committees studied below. Most of these differences are addressed in brief ethical and methodological statements. Stark studied IRBs 'behind closed doors', whereas this study observed ethics committees open to the public. Additionally, the four New Zealand ethics committees were all part of the same system created by the Minister of Health following a major restructuring in 2012.

This article: (i) contextualizes the 2012 restructuring of the Health and Disability Ethics Committees and implications for Māori consultation; (ii) discusses the unwritten guidelines governing Māori consultation in New Zealand that compel ethics committees to invent varied ethical approval procedures or idiocultural responses; and (iii) describes how the four committees addressed responsiveness to Māori unevenly – three committees dealt with responsiveness to Māori sporadically, whereas one committee addressed it in nearly every application. When a warrant holder with expertise for responsiveness to Māori was seconded to another committee, her warrant transferred with her; however, at subsequent meetings of the second committee there is no evidence the warrant holder affected their idioculture.

Ethical considerations

Idiocultures are by their nature unique, and so too is the culture of ethics review in New Zealand. In 2012 the University of Otago Human Ethics Committee granted the author ethical approval #12/248 to observe all ethics committee meetings in

New Zealand. When the eight university ethics committees proved impenetrable, written permission was sought from the newly created Health and Disability Ethics Committee (HDECs) to observe them. An information sheet and letter outlining the study was sent to the home address of the Chair of one of the HDECs, the Northern A HDEC. When the response came back it was from the Manager of Health and Disability Ethics Committees rather than the Chair of Northern A. The email stated:

I understand you have recently been in touch with some or all HDEC chairs requesting permission to attend and observe meetings in the new year as part of a research project you are conducting. In fact, all HDEC meetings are open to the public, and their venues, dates and times are available on the web through the link below. Please be aware that venues for some meetings may change over the year, and that meetings are occasionally canceled due to low application numbers. My team and I can confirm details of any meeting on 0800ETC. Good luck with your research project, and don't hesitate to be in touch if I can be of any further assistance.

No further informed consent was required. However, an additional ethics approval was sought from the University Ethics Committee to interview HDEC committee members. This was granted as an amendment to the previous approval.

Methodology

Observations of the four Health and Disability Ethics Committees took place over a ten-month period between February and November 2013. All four HDECs (Northern A, Northern B, Central, and Southern) were observed at least twice, and one committee that conveniently meets in this author's home city was observed three times. At each meeting, field notes were collected and later spoken onto a tape recorder and transcribed professionally. These expanded field notes were coded thematically.

Unlike Stark's ethics committees, not only did these committees meet in public, but the committees' monthly minutes were also posted online. The minutes included both general business and the letters sent to the applicants. As these too were openly available online, no ethics approval was sought to analyze them thematically. Additionally, six one-on-one interviews with committee members were also conducted, transcribed, and coded thematically.

The HDECs treated the author like a researcher, but also as a member of the public and an insider. At half of the meetings he was the only observer, but at some meetings other observers were also present. There were opportunities to go native. Three of the four committees recognized the author as an expert in his own right – as having been a past HDEC chair between 2004 and 2008. On numerous occasions within HDEC deliberations, such as when discussions within the committee stalled or needed a precedent, both HDEC members and

chairpersons would turn to the author in the public gallery and ask for guidance on a ruling. On each occasion he declined to offer an opinion. On six occasions, because he was the only observer at the meeting, he was invited to sit at the committee's table. At one meeting, as the committee waited for the fifth committee member to arrive via teleconference to make the meeting quorate, the Southern HDEC chairperson asked if he could join the committee so as to make quorum. Before he could decline, the Ministry of Health's administrator present overrode the invitation. Committee members were indemnified by their appointment by the Minister of Health.

The article includes a brief autoethnographic note describing the author's personal experiences when chairing an HDEC between 2004 and 2008 and how this committee dealt with Māori consultation. In the absence of clear guidelines, the committee creating its own rules of engagement generated an idiocultural response. The vignette is only noteworthy because when this author observed the Central HDEC in 2013, a similar set of events took place.

Restructuring of health and disability ethics committees

In 2012 the health and disability ethics committee (HDEC) system of ethics review in New Zealand underwent a significant restructure, and the Ministry of Health (which oversees the HDECs) worked to create yet another iteration of health ethics review. Previous iterations were 1988–2003, 2004–2012 and July 2012–present. Rather than making remedial changes to the existing health ethics review system, both in 2004 and 2012 the system was abolished, and replaced with fewer committees and a new standard operation system, and was staffed by new members and governed by a new philosophy. In 2012 this restructuring of the HDECs was not undertaken to improve ethics review, which was acknowledged as being robust; rather, it was to enhance New Zealand's attractiveness to foreign clinical trial companies. This philosophical turn resulted from the politicization of ethics (De Luca, 2013).

New Zealand is one of a number of countries who have relatively recently attempted to simplify their ethics review system. The UK made similar changes in 2012 with a UK-wide system of 'governance arrangements for research ethics committees' (GafREC) (Department of Health, 2011; Rawlins, 2011) covering all health and social care research.

On 10 February 2010, the New Zealand (NZ) Health Committee initiated an 'Inquiry into improving NZ's environment to support innovation through clinical trials'. The NZ Health Committee released a report in June 2011 in response to the inquiry restating that 'there is a consensus among submitters that the ethics review and approval is robust but slow' (Report of the Health Committee, 2011).

The tenor of the Government's response to this 2011 report led to a number of specific changes that were largely predicated on the view that the system of ethics review in New Zealand was too slow and, by implication, impeded innovation in health research – particularly research that generated from the activity of the pharmaceutical industry (Office of the Clerk, 2011). The consequential changes to the way HDECs operate include a decrease in the number of total committees from seven to four, a reduction in the number of committee members from 12 to eight, the introduction of a 35-day turnaround expectation for applications, the requirement for researchers to organize their own peer review, and a mandated abstention of committees in assessing the quality of the science (Smith, 2013).

Specific changes to the ways Māori consultation were to be practiced were also introduced. Rather than being a prerequisite to ethical review, Māori consultation was identified as a delaying factor and rationalized to run concurrently with the ethics review process. Much of this perspective on Māori consultation was driven by two recommendations in the Health Committee's report. In Recommendation 14 it states that the revamping of the ethics review system must:

... remove duplication in the processes carried out by the HDECs, the Standing Committee on Therapeutic Trials, and district health boards *in consulting with Māori* [author's emphasis]. (Office of the Clerk, 2011: 6)

In Recommendation 15, the report proposes that the National Ethics Advisory Committee or the Ministry of Health be instructed to:

... *make clear guidelines for ethics and Māori consultation* within nine months of this report being presented. The guidelines should be clearly aimed at maximizing protection, expertise, and efficiency, and *should clarify the purpose of Māori consultation* [author's emphasis]. (Office of the Clerk, 2011: 6)

The government's response to this recommendation was not supportive (personal communication) and thus the guidelines written by the National Ethics Advisory Committee have not been forthcoming. At the August 2013 meeting of the National Ethics Advisory Committee, minutes¹ record that the committee 'agreed not to publish *Māori Research Ethics: An overview*, but it may be used as a resource document for reference'.

In the past two decades the absence of clear guidelines on indigenous consultation has effectively paralyzed researchers and ethics committees (Tolich, 2002). As of 2014, guidelines clarifying the purpose of Māori consultation are not forthcoming and, in lieu of this, the four HDECs operate in a vacuum, effectively generating their own unique idiocultural interpretations of what constitutes Māori consultation.

The post-2012 restructuring of HDEC also brought other changes to ethics committees' relationship with Māori communities. In past HDEC iterations, the government was supportive of Māori research ethics: previously two Māori were

appointed to each committee. However, in this post-2012 HDEC regime the government has stepped back from giving importance to Māori representation and consideration. For example, in terms of committee membership, Māori were not mentioned in the 2012 Standard Operating Procedures (SOP). Although Māori are appointed to three of the four committees, a non-Māori Pacifica person is appointed to the Northern B HDEC. Moreover, the SOP's (New Zealand Ministry of Health, 2012) governing committee appointments are limited to defining committee membership as a mix of lay persons (non-health professionals) and non-lay persons; Māori are not mentioned.

Guidelines for Māori consultation

New Zealand ethics review has traditionally deemed all research to be of interest to Māori (Hudson, 2009), and any ethics application, past or present, includes a section that is termed 'Māori consultation', which is underpinned by the Treaty of Waitangi's three principles: protection, partnership, and participation. These principles are enshrined into all ethical considerations. In some respects, the Treaty is New Zealand's original ethics statement. Therefore, since the incorporation of health and disability ethics committees in 1988, both health and tertiary ethics committees have absorbed these principles into their ethics review processes when considering all research involving human subjects. This has highlighted some problems, as the actual nature of the consultation is unclear. Māori, by right, have an interest in all research to the point that it is sometimes difficult to understand when consultation is mandatory, when it is not, and what the nature of that consultation is (Smith, 2013).

In an earlier iteration of HDECs, during the period from 2004 to 2012, various HDEC chairs' annual reports complained about how researchers addressed Māori consultation. In his 2008 Annual Report, the Northern Y HDEC Chair wrote, 'Some researchers pay no more than lip service to the cultural requirements'. In 2011, the Northern X HDEC Chair claimed researchers were not taking Māori consultation seriously:

We are concerned about Māori consultation on two fronts. That the researchers don't regard consultation as a chore, that 'has to be done' rather than 'want to be done'. Hence we like to see the researchers engage properly beforehand where it is appropriate.

There is no evidence to suggest that these concerns regarding Māori consultation within these annual reports were ever responded to by those who administered the HDECs.

By 2014, the Health and Disability Ethics Committees (HDECs) had been in operation for 26 years, yet the Ministry of Health had produced two ambiguous sets of guidelines regarding what constituted Māori consultation. As the annual

reports suggest, the HDECs found them unworkable. For example, the Health Research Council's guidelines on Māori research assume all research was of interest to Māori and all applicants needed to consult with Māori. An additional set of guidelines, *Te Ara Tika* (Hudson et al., 2010), was written by five Māori members of HDECs, but when they were presented to the HDEC secretariat these were not adopted as official guidelines.

History repeats

As Chairperson of the Multi-Region Health and Disability Ethics Committee between 2004 and 2008, this author often found that research applicants who failed to address the requirements for Māori consultation often frustrated committee members. Many applicants provided inconclusive statements about their responsiveness to Māori, and invariably late in the 8-hour meeting the ethics committee would reach a level of frustration that would trigger the commencement of a snap debate about what effective Māori consultation could or should look like. They asked whether Māori consultation was more about access etiquette or whether it was required to solve health disparity. The debate's outcome would restate the committee's idiocultural expectations that Māori consultation had less emphasis on culture and more on health disparity. A record of this idiocultural response is found in the 2007 Annual report of the Multi-region Ethics Committee published in October 2007:

More often than not where consultation has occurred, it is framed around the need for cultural sensitivity and understanding with much less energy given to exploring the possible paradigmatic and research issues relating to Māori that may be implicated in the project. While matters of culture are important in the research process, there is a need for greater thought to be given to conceptual issues and questions, along with the shape of research outputs, if the results from health research are to contribute more positively to the health status of Māori. (New Zealand Ministry of Health, 2007)

At an observation of the Central HDEC six years later (February 2013), conditions similar to this multi-region health and disability ethics committee's idiocultural response of mounting frustration was repeated.

Distinguishing idiocultural responses to Māori consultation from warrants

The observation of the Central HDEC in February 2013 was the third observation of a study exploring the ethics committee's decision-making processes, their use of warrants and the generation of idiocultural items. The study was not specifically focused on issues around Māori consultation. However, during this meeting the

Central HDEC was particularly focused on responsiveness to Māori more than any other committee.

In many respects the Central HDEC was organized much like the other three HDEC meetings. The chairs of each HDEC began the formal part of the meeting by inviting the assigned lead and second reviewers to share their thoughts on the applications. At this Central HDEC meeting in February, seven of the eight researchers did not attend the meeting in person or speak to the committee on the telephone. This distanced the committee from the applicants. A common tactic used by most lead reviewers was to ask the researcher, if present, to provide a short overview of the application. This summary allowed all the committee members to familiarize themselves with the project if they had not done prior to the meeting. The researcher's opening summary allowed observers to know something about the scope of the application under review.

Typically the second reviewer's comments were brief compared to those of the first reviewer. The lead and second reviewers did not comment on Māori issues pertaining to the eight reviewed applications, but instead deferred to another member, a woman, as if to leave 'Māori issues' to her. She held the 'warrant' in that her expertise was in Māori culture, and on each occasion, when it was her turn to speak, her comments went unchallenged. She commented on seven of the eight applications.

As these eight applications were reviewed, comments about Māori consultation were typed by the secretary and projected onto the wall of the room. These comments were recorded in the committee minutes and eventually included in the responding letter written to the applicants.² The HDECs instructions to the applicant were thus not written from this Māori representative specifically, but the letter was a declarative statement written as if from the whole committee, even though other committee members did not contribute to the instruction on Māori consultation.

As the 3-hour Central HDEC meeting progressed, the mood of the committee with regard to Māori consultation was both cumulative and familiar to earlier personal experiences of idiocultural responses. Field notes record that the committee's frustrations grew, especially when reading how researchers discussed what to consult and whom to consult. Sighs were heard in response to some applicants. One applicant had written that some health inequality was due to Māori not seeking health care early enough. A committee member's response to this was, 'this is so insulting'. Applicants who failed to provide answers to Māori consultation questions infuriated the committee members the most. Comments were made such as, 'how can they have no cultural issues when they are holding tissue samples?'

An idiocultural response

Sensing the members' growing frustration with how the applicants were paying 'lip service' or 'avoiding Māori consultation', the chairperson asked if the

committee would be willing to take part in a collective writing exercise. This would have been a classic idiocultural response if the group had generated a set of expectations that would direct future procedures.

The chairperson suggested to the committee that before the next meeting they individually write down what would constitute model answers to the four questions on Māori consultation in the application. This ‘innovative action’ (Merton, 1938) was a notable adaptation to the absence of practicable guidelines for Māori consultation. The four questions were:

p.4.1 Please describe whether and how your study may benefit Māori.

p.4.2 Please identify the main cultural issues that may arise for Māori who may participate in your study, and explain how these will be managed.

f.1.1 Might your intervention study contribute to reducing inequalities in health outcomes between different populations, particularly between Māori, Pacific peoples and others New Zealanders?

f.1.2 Please explain your answer above.

Had the committee members written down these answers they would have created an idiocultural response. However, this outcome was not achieved. It was disappointing to attend the next monthly meeting of this HDEC to find that the chair did not follow up on the promise to collectively recreate the Holy Grail in requiring committee members to share their model answers to the four questions. An idiocultural response was not created.

A prequel

Understanding the decision-making that took place at the February 2013 Central HDEC meeting had a prequel that gives insight into how idiocultures and warrants are created and operate independently. I did not attend the Southern HDEC meeting of January 2013. I only read about it online and I had to wait 3 months for the committee’s minutes to be made publically available. These minutes proved to be serendipitous and linked to the later observation of the Central HDEC meeting in February. The minutes recorded that at the Southern HDEC meeting, 10 out of 12 applications had comments on responsiveness to Māori recorded. Examples of the comments were either in praise of the application or to rebuke it. Here are the 12 abridged comments that relate to Māori consultation:

1. No comment on Māori.
2. The Committee commends the research team for acknowledging and recognizing tikanga Māori, especially regarding obtaining tissue samples.

3. The Committee commends the research team for acknowledging and recognizing tikanga Māori, especially regarding obtaining tissue samples.
4. The Committee is very concerned that, although bone will be removed and replaced, tikanga Māori has neither been acknowledged nor considered (p.4.2). Please acknowledge and demonstrate an understanding of tikanga Māori.
5. No comment on Māori.
6. The Committee is very concerned that there is no acknowledgement of tikanga Māori at all (p.4.2). Please acknowledge and demonstrate an understanding of tikanga Māori especially since tissue samples will be obtained.
7. Please ensure that adequate and appropriate tikanga Māori protocols are available once the ethnic origin of the tissue sample(s) is known (via informed consent).
8. The Committee is very concerned that there is no acknowledgement of tikanga Māori at all (p.4.2). Please acknowledge and demonstrate an understanding of tikanga Māori especially since tissue samples will be collection, stored for 15 years and sent overseas. Please also take into consideration that, with the targeted participant group, it is likely that some of the participants will have died during this time.
9. The Committee is very concerned that there is no acknowledgement of tikanga Māori at all (p.4.2). Please acknowledge and demonstrate an understanding of tikanga Māori especially since family members may wish to be involved in/with the child as well.
10. The Committee is very concerned that there is no acknowledgement of tikanga Māori at all, especially since the study involves the use, and disposal, of tissue samples ... Reasons for declining 4.3–4.6 Māori and ethical considerations.
11. The Committee is very concerned that there is no acknowledgement of tikanga Māori at all in question p.4.2. Given that the study will involve interviews, whānau members of Māori participants may wish to be involved as well.
12. The Committee would like to commend the research team for acknowledging that Māori consider the head to be tapu and for having tikanga Māori protocols in place for the disposal of the tissue samples.

The fact that 10 of the 12 applications had comments on responsiveness to Māori is an anomaly. Previously, and in comparison, during the Southern HDEC's November 2012 meeting it had made no comments, either positive or negative, about responsiveness to Māori. Why an HDEC idioculture would suddenly treat Māori consultation as a special case was a mystery. The answer only revealed itself by a close reading of the minutes: there was a change of personnel. Southern

HDEC's January minutes reveal that a Central HDEC member with Māori cultural expertise was coopted for this one meeting. This change in staffing explains how a committee that previously had not commented on responsive to Māori suddenly did so.

Not being present to record the outcomes of the Southern HDECs January meeting, this author cannot say how the meeting progressed. It is noticeable, however, that the first application for the January meeting did not mention responsiveness to Māori. Was the coopted member respectfully waiting for other committee members to discuss the applicant's responsiveness to Māori? It remains unknown but, by the second application and thereafter, each application (except application 5) received either a commendation or a rebuke. The coopted member with Māori expertise did not express concern about Māori consultation because she was a Māori representative, as these roles had been disestablished in the restructuring. An alternative reading of this role is more that of her taking the role of kaitiaki³ or guardian.

Interviews with other Māori HDEC members reveal the kaitiaki role is not widespread. One Māori member of an HDEC saw their role as raising issues of Māori consultation only on applications when they were the lead or second reviewer. This person did not assume the role as warrant holder in all discussions. In fact, this person did not believe that their HDEC made Māori consultation a central issue. There is evidence for this. Smith (2013) claims that, since the 2012 restructuring and without government supporting guidelines on Māori consultation, this issue has fallen off the table. However, on the Central HDEC the apparent kaitiaki role sustains it.

Discussion

This article has focused on the relationship between expertise or warrants, idiocultural responses, and Māori consultation. It compared two committee meetings – one attended and the other read through via committee minutes. In the observed Central HDEC meeting, what at first appeared to be an idiocultural response (addressing responsiveness to Māori more than any other committee) seemed instead to be an act of deferment to a relevant warrant holder.

When the warrant holder was seconded to the Southern HDEC meeting, she entered a committee that according to its online minutes did not have a strong idioculture toward Māori consultation. At its previous meeting, November 2012, zero comments were made on Māori consultation. The presence of the warrant holder at the Southern HDEC in January changed that. More importantly, the warrant holder may have changed the committee's idioculture for this one meeting. Yet when this author observed the Southern HDEC in February 2013 there was no legacy idioculture as Māori consultation was referred to sporadically.

However, it is worth noting that 5 months after the warrant holder was coopted to the Southern HDEC, in their general business minutes this committee recorded a perennial cry for help:

Committee requested that Māori consultation was raised at the chairs meeting, as applications are often avoiding or not answering the question sufficiently.⁴

Rather than attempting to solve the unsolvable problem of responsiveness to Māori within their idioculture, the committee outsourced the problem to the HDEC Chairs' committee.

There are two sequels to these findings. A postscript to this article will occur if the warrant holder discussed previously is absent from one Central HDEC meeting. However, at this point in time, and since the restructuring, this member has been conscientious, not missing one meeting. If the warrant holder were to be absent, her committee would be left to their own resources and be required to either ignore the issue of responsiveness to Māori or to respond to it.

Her rejoinder after reading this article stated she does not believe that her absence would make a difference:

In my experience, my colleagues are well versed in Tikanga Māori and the cultural requirements for researchers. I have absolutely no doubts that should I not be at a meeting, the same expectations and attention will be given to the requirements for researchers to consult with Māori and respect cultural requirements just as I am sure that all Committee members see consultation with Māori and sensitivity to cultural issues as an important and integral part of any research project.

The author is less confident that other committee members would make researchers as accountable for Māori consultation as this warrant holder.

An ethical epilogue

Stark's ethical issues were straightforward. She sought approval from her University's IRB and then gained the consent of three committees. In each case she promised the three IRB committee members' confidentiality and gave each IRB a pseudonym. The ethical issues in this study were less black and white. I also gained my university ethics committee approval but when seeking consent I was told the meetings were open to the public. Far from this being covert research, at each meeting the chairperson recognized my presence and my research topic. At the Central HDEC meeting described in this article I was both welcomed and noted in the committee's minutes:

The [Central HDEC] Chair opened the meeting at 12pm and welcomed Committee members. The Chairperson welcomed [author] who will be observing the committee's proceedings today as part of a Marsden grant to study New Zealand ethics committees and Māori consultation.⁵

Initially my research topic gave ethical protections. The unit of analysis at first was the committee's decision-making processes producing idiocultural variations among the four committees. During this observation the focus turned to the use of warrants, which by its very nature focuses on a single member's expertise, and in particular one person's contributions at the meeting I observed and one I read about. This person is not named in the article but she is identifiable.

Not wanting to harm this person, this article was sent to her not asking for consent to publish the article but to elicit two types of feedback. The feedback would allow the warrant holder to make any correction to the text and especially to locate any part that would cause her embarrassment. A similar practice was employed by Stacey (1990) in her study of *Brave New Families*, which had two subjects. Her response is presented above.

Declaration of conflicting interest

The authors declare that there is no conflict of interest.

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Notes

1. <http://tinyurl.com/nsbk7hz>.
2. Health and Disability Ethics Committee Minutes, New Zealand (July 2012 – March 2013). Available at: www.ethics.health.govt.nz.
3. A kaitiaki is a person, group or being that acts as a carer, guardian, protector, and conservator. The gods of the natural world were considered to be the original kaitiaki – for instance, Tāne, god of the forest, was the kaitiaki of the forest. All other kaitiaki emulate those original ones; see <http://www.teara.govt.nz/en/kaitiakitanga-guardianship-and-conservation/page-4>.
4. Minutes of the Southern Health and Disability Ethics Committee, New Zealand. Available at: www.ethics.health.govt.nz.
5. Minutes of Central Health and Disability Ethics Committee, New Zealand. Available at: www.ethics.health.govt.nz.

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