



This Policy Statement was reaffirmed June 2023.

Institutional Ethics Committees

Margaret Moon, MD, MPH, FAAP, COMMITTEE ON BIOETHICS

In hospitals throughout the United States, institutional ethics committees (IECs) have become a standard vehicle for the education of health professionals about biomedical ethics, for the drafting and review of hospital policy, and for clinical ethics case consultation. In addition, there is increasing interest in a role for the IEC in organizational ethics. Recommendations are made about the membership and structure of an IEC, and guidance is provided for those serving on an IEC.

INTRODUCTION

Institutional ethics committees (IECs) have evolved considerably since the 1983 President's Commission report on foregoing life-sustaining treatment¹ suggested that hospitals establish ethics committees to assist with decisions regarding the use of life-sustaining interventions and since the American Academy of Pediatrics (AAP) published its 1984 statement concerning infant bioethics committees.² At that time, ethics committees were the exception, with only 1% of hospitals having standing ethics committees.¹ A decade later, the Joint Commission on Accreditation of Healthcare Organizations (now The Joint Commission) included standards requiring hospitals to establish a "mechanism to consider ethical issues in patient care," and in 1999, Medicare began requiring participating hospitals to inform patients about resources for ethics consultation.^{3,4} Currently, IECs are the norm, present in more than 95% of hospitals.⁵

Although IECs arose as mechanisms for implementing federal regulations about treatment of infants and children who were disabled,³ modern IECs primarily serve to promote ethical practice through activities such as (1) case consultation, (2) provision of ethics education to health care communities, (3) review and development of policies related to ethical issues in patient care, and (4) provision of a forum for discussion of pressing ethical issues or concerns within the hospital community. An additional function of IECs in some institutions includes participation, with institutional leadership, in organizational ethics. For the purposes of this statement, the IEC function is separate from the research review committees present in most academic institutions.

abstract

School of Medicine, Johns Hopkins University, Baltimore, Maryland

Dr Moon was responsible for all aspects of revising and writing this statement and approved the final manuscript as submitted.

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

Policy statements from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, policy statements from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

DOI: <https://doi.org/10.1542/peds.2019-0659>

Address correspondence to Margaret Moon, MD, MPH, FAAP. E-mail: mmoon4@jhmi.edu

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2019 by the American Academy of Pediatrics

FINANCIAL DISCLOSURE: The author has indicated she has no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The author has indicated she has no potential conflicts of interest to disclose.

To cite: Moon M, AAP COMMITTEE ON BIOETHICS. Institutional Ethics Committees. *Pediatrics*. 2019; 143(5):e20190659

The AAP supports the availability and use of an IEC as an important mechanism for the discussion and resolution of ethical issues raised in the individual and institutional provision of patient care. Additionally, the AAP recognizes the value of IEC integration in a more comprehensive ethics program, including policy development and organizational ethics. The AAP recognizes that although the structure and function of IECs will vary depending on institutions, there are elements common to all ethics committees.

In this statement, we discuss the 3 most common roles for an IEC: (1) clinical case consultation; (2) education of health care professionals, patients, and other health care employees; and (3) development and review of institutional policy concerning ethical issues in patient care. Additionally, we will review the emerging role for IECs in organizational leadership and quality improvement. Finally, we will describe the structure and membership of an IEC and current commentary on competencies and standards for IEC members providing case consultation.

ROLES OF AN IEC IN CLINICAL ETHICS CASE CONSULTATION

For the majority of physician-patient-family encounters in pediatrics, conflicts about the scope, value, and desirability of medical interventions are rare. Problems occur when there are conflicts or uncertainty about the goals of care, the value of a specific intervention as it relates to those goals, and the moral implications of medical choices and when communication about these conflicts breaks down. When conflicts or uncertainties occur and communication is difficult, an IEC may be asked for assistance in resolving the ethical issues implicit in the conflict. It is important to note that some requests for ethics committee consultation may involve

concerns that are not strictly ethical in nature. Ethics committees may appropriately serve to support staff affected by moral distress related to difficult clinical situations, to lead or coordinate family meetings, or to advise medical staff leadership on medical staff professionalism concerns. These roles may be accepted at the discretion of the committee leadership, in cooperation with the institutional leadership.

The American Society for Bioethics and Humanities (ASBH) has been developing guidance on ethics case consultation. The ASBH identifies 2 core tasks of clinical ethics case consultation: (1) identify and analyze the nature of the value uncertainty and (2) facilitate the building of a “principled ethical resolution.”^{6,7} The AAP recognizes that there are a range of approaches to providing clinical ethics consultation service. The defining characteristics of the case consultation activity are that (1) it is initiated by a request for assistance; (2) it involves a specific patient, family, or both; and (3) it is documented in an appropriate manner. An IEC that is engaged in providing ethics consultations should have a policy and procedure statement that includes the following:

- who can request a consultation;
- how the IEC is contacted;
- who responds to the request;
- how the consultation is conducted;
- who is to be included in the consultation;
- proper notification of affected persons;
- protection of patient confidentiality;
- how the consultation is documented;
- whether, in some circumstances, an ethics consultation is required; and
- the advisory nature of the consultant’s recommendations.

Access to ethics consultation should be open to patients, families, surrogates, staff, and members of the medical team. Information about the availability and process of ethics consultation should be widely distributed to patients, parents, family members, physicians, nurses, and other individuals who may have reason to call on the consultative services of the IEC. Although ethics consultation is most common within the inpatient setting, the need for consultation in the outpatient setting should be recognized and supported by institutions. Research has revealed disparities in access to ethics consultation between inpatient and outpatient settings and between large and small communities.^{8,9} Some IECs, especially those in large institutions, may be able to offer support to nonaffiliated community physicians as requested.

The consultation process may involve a team from the IEC, a solo consultant representing the IEC, or, in some cases, an outside consultant. The process of consultation will include review of the clinical situation and will generally include interactions with the patient and family as well as the clinical team.

The following guidance should apply to providing ethics consultation to promote fairness and accountability:

1. Any patient, parent or guardian, or family member should be able to initiate an ethics consultation.
2. The patient and parent or guardian should be able to refuse to participate in an ethics consultation without concern for negative repercussions.
3. The refusal of a patient or parent or guardian to participate in an ethics consultation should not obstruct the ability of an ethics committee to provide consultation services to physicians, nurses, and other concerned staff.
4. Any physician, nurse, or other health care provider who is

involved in the care of the patient should be able to request an ethics consultation without fear of reprisal.

5. The process of consultation should be open to all persons involved in the patient's care yet conducted in a manner that respects patient and family confidentiality and privacy.
6. Anonymous requests for consultation are not recommended. In situations in which fear of reprisal limits open discussion of the issues, the identity of the person(s) requesting consultation may be kept confidential.
7. The primary care pediatrician should be invited to participate in the consultation to support existing physician-family relationships.

Three models of case consultation and deliberation generally have been used: (1) an individual consultant who reports on a periodic basis to the entire committee, (2) a small team of committee members, or (3) a meeting of the entire committee. Each model has advantages and disadvantages. In some circumstances, consultation provided by a single person from the IEC may suffice. In others, a variation of these models may be the best way to accommodate institutional needs. Although an individual consultant may respond in a timely and flexible manner, such an approach risks losing the diversity and range of perspectives offered by a group. In most situations, small consultation teams made up of individuals of varying personal and professional backgrounds are recommended to balance a timely and flexible response with the value of diverse points of view.

IECs and their members should attend to the following concerns in developing a reasonable process for ethics consultation:

- IECs must concern themselves with questions of procedural fairness

and confidentiality. They must have a mechanism for involving or advising patients and others who are the subjects of consultation, and they must respect the privacy and confidentiality of all persons affected by all aspects of IEC consultation.

- IECs must have means of keeping current with relevant bioethics literature and health law, including information relevant to infants, children, and adolescents. They should also know which circumstances usually warrant further consultation or review (from authorities in ethics, medicine, or law) and when hospital counsel or judicial involvement should be sought.
- IECs should work to define appropriate competencies for those who participate in ethics consultation and develop a program to create and maintain those competencies.
- IECs should adopt a code of ethics and professionalism for ethics consultants that emphasizes competence, integrity, management of conflicts of interest, and justice.¹⁰

Failure to develop and then follow reasonable policies and procedures for ethics consultation violates standards of The Joint Commission and general standards of professionalism. Information about the institution's policies and procedures related to ethical issues in patient care should be included in routine training for staff who interact with patients. Furthermore, guidance on how to raise ethics concerns should be easily accessible for patients, parents or guardians, and hospital personnel.

The quality of an ethics consultation rests first on the IEC's ability to identify and explicate the ethical issues driving the perceived conflict or uncertainty and then provide a forum for open discussion of the

medical, moral, and legal issues surrounding the difficult situation. The authority, whether institutional, moral, or legal, of an ethics consultant and an IEC is limited.^{11,12} The AAP supports the view that the recommendations from an ethics consultation are advisory only. Although case law, statutory law, and state regulations may be discussed within an ethics consultation, the mere fact that an IEC was involved in a case is of uncertain value in providing legal protection to the participants.^{13,14} Improved communication, clarification of differences and available options, and careful documentation of the decisional process may reduce the potential for future legal action.¹⁵ All ethics consultations should be documented in the committee records, and, in most cases, a summary of the consultation should be included in the patient's medical record. The form and extent of chart documentation of ethics consultations may vary depending on local hospital regulations and requirements.^{16,17}

In critiques of the role of IECs in case consultation, lack of regulation and professional standards, inadequate focus on potential conflicts of interest,¹⁸ and inadequate reviews of quality and efficacy have been cited.¹⁹ Although The Joint Commission has established standards regarding access to discussion of ethical concerns, there has been no specific guidance about requirements for ethics consultants. Surveys of ethics consultants and hospital IECs revealed wide variation in the type and extent of training in ethics, and ethics consultation varied widely among ethics consultants and hospitals.^{5,20} The ASBH has identified core skills for ethics consultants, including assessment skills, process skills, and interpersonal skills. The skills and knowledge necessary to participate as a member or leader of such a consultation team varies with one's role in the process. This is

reflected in the ASBH's recommended set of knowledge competencies for ethics consultants, including basic and advanced skills.²¹ Beyond establishing and maintaining competencies for consultation, IECs should develop mechanisms to evaluate the quality and outcomes of their work.²²

Ethics Education

An IEC should have a major role in educating all health care professionals, employees, and administrative staff in the ethical foundations of patient care and institutional relationships. Although it is evident that ethical issues occur frequently in routine patient care,^{8,23} requests for IEC consultation are relatively rare.⁵ IECs should take the lead in educating clinicians to enhance their capacities to identify and manage ethics concerns independently while encouraging appropriate use of ethics consultation. Such education can occur as traditional didactic presentations, as ad hoc discussions about common clinical situations, or as 1 aspect of clinical case consultation. It is particularly valuable to develop interprofessional ethics education programs to enhance communication within teams about ethics concerns.²⁴ Whenever possible, students and house officers should be included in these educational opportunities. Additionally, an IEC may serve the larger community by including community education and community engagement in its mission. Most importantly, an IEC should, itself, engage in continuing education and ongoing training for all its members to ensure the highest quality clinical ethics consultations and to keep members abreast of the changing dynamic of clinical care.

Policy Review and Development and Quality Improvement

In addition to involvement in case consultation and in educating patients, families, and staff members

about ethical issues, the functions of an IEC generally include the drafting and review of institutional policy and procedures specifically related to ethical issues in clinical care. Policies for the limitation or withdrawal of various treatments (such as cardiopulmonary resuscitation, medically provided fluid and nutrition, medical or physician orders for life-sustaining-treatment rules, and organ donation) often have been drafted with IEC involvement. The IEC also may be involved in drafting other policies with ethical importance, such as the ability of hospital employees to object to participating in certain aspects of patient care, the resolution of conflict, and certain aspects of relevant business practices.

The IEC role may include both response to administrative requests for policy review and development and proactive identification of issues with ethical ramifications that warrant an institutional policy and procedure. IECs, especially through the process of ethics consultation, are well positioned to identify structural or organizational factors that may be at the root of recurrent ethical problems. IECs may consider an expanded approach to consultation that allows a focus on proactive identification and prevention of ethical problems, especially systems-level factors that are likely to create ethics problems or hinder their resolutions. Specifically, IECs should work to include critical reflection on institutional factors that contribute to ethical conflicts.²⁵

THE ROLE OF AN IEC IN ORGANIZATIONAL ETHICS

Health care institutions must identify a process for addressing organization-level ethical issues. A model to integrate the IEC more completely in organizational structure has been proposed by various authors.²⁶⁻²⁸ The integrated ethics model for an IEC includes the

traditional case consultation function with an expanded role in proactive policy development and leadership on organizational ethics. It is based in a focus on ethics as integral to quality of care.²⁹ The AAP supports integration of the IEC into an institution's process for establishing and promoting organizational ethics but notes that including organizational ethics in the purview of the IEC raises specific questions about its structure, function, and member qualifications.³⁰ An IEC whose function includes organizational ethics and policy development should establish standards of membership, process, and self-improvement specific to organizational ethics issues and to the organizational structure of its home institution.

MEMBERSHIP AND STRUCTURE OF AN IEC

The membership of an IEC should be multidisciplinary with sufficient knowledge and experience to address the range of ethical issues brought to the committee. The varied tasks of an IEC (consultation, education, and policy review and development) reveal the need for a broad variety of skills, knowledge, and experience. In light of the increasing complexity of medical and information technologies and the persistent effect of resource allocation and business practices on ethical issues, an IEC may need to seek and incorporate the advice of consultants to address specific issues of concern. In some institutions, an IEC large enough to include a sufficient diversity of personal, community, and professional views as well as the requisite knowledge base and skill sets may suffer limited efficiency. It may be appropriate for the larger IEC to delegate certain tasks to smaller subgroups (such as providing ethics consultation or drafting specific policies) while retaining the authority for

coordination, oversight, and approval of activities of the subcommittees.

Two important issues concerning IEC structure are (1) the participation of the hospital attorney, risk manager, or hospital administrator in the IEC and (2) the presence of >1 IEC in an institution. The hospital attorney or risk manager may experience a conflict of interest between a duty to protect the institution and a duty to protect the patient's interest. Such conflicts should be recognized prospectively, and, in some circumstances, the consultation team may choose to restrict the hospital attorney, risk manager, or other administrators to function as ex officio advisors on specific legal or administrative matters.²⁰ Many IECs have found that the inclusion of nonhospital attorneys familiar with ethical issues is beneficial. In addressing organizational ethics issues, nonhospital attorney membership may be essential.

A single multidisciplinary IEC should have authority over all IEC subcommittees addressing consultative, educational, nursing, pediatric, or administrative concerns. The existence of special interest ethics committees, such as an infant care review committee or a nursing ethics committee, can undermine the diverse multidisciplinary context that is the strength of an IEC and may weaken the IEC's capacity to assist with development of organizational policies that support ethical practice throughout the institution. The presence of multiple IECs may create a sense that the process and deliberations of 1 IEC are not inclusive and may lead to unwarranted inconsistency in implementation of ethically critical policies and procedures. Institutions that find a need to maintain special interest ethics committees should include specific mechanisms to monitor and mediate these risks. An IEC may fulfill its functions whether it reports to the medical staff, hospital

administration, or board of directors; however, because some ethical issues may involve conflicts between the clinical, administrative, and financial commitments of an institution, the reporting structure should be able to protect the IEC from manipulation.⁸

At institutions with academic affiliations, the IEC may coexist with an academic bioethics program engaged in teaching, research, and ethics consultation. Nevertheless, the IEC should retain oversight within an institution for ethics consultation, policy review, and education when these functions have been delegated to such programs.

SERVING ON AN IEC

IEC membership requires a commitment to acquire and then maintain the knowledge sufficient to address the complex issues faced by an IEC. Each IEC should establish a continuing education program designed to assist IEC members in fulfilling the stated mission of the IEC, especially as new issues emerge. A prospective IEC member should be comfortable with the committee's general mission statement, policies, and operation and the required responsibilities with respect to these functions. Anyone asked to be a member of an IEC should assess his or her commitment to acquiring and then maintaining a sufficient level of knowledge in bioethics appropriate to the tasks of the IEC. Expertise specific to ethical issues that arise in the care of pediatric patients is necessary for any IEC that will participate in pediatric case consultation. Core knowledge components specific to ethical issues involving minors are included in the ASBH guide on competencies in clinical ethics consultation.²²

There is ongoing discussion of the role of quality attestation or certification of IEC members, specifically those who participate in ethics case consultation.³¹ As noted

previously, the ASBH has proposed a set of knowledge and skills-based competencies for ethics consultants. Certification programs for ethics consultants have emerged, although there remains no regulatory requirement for certification, and the impact of such professionalization of the field of ethics consultation has raised significant debate.^{32,33} Institutional capacity to offer specific training for IEC members involved in consultation may vary. It is incumbent on the institution and the IEC to recognize the stakes involved in ethics consultation and to ensure that the process includes high-quality, well-informed, well-educated, and competent consultants. It is important, particularly, to note that although clinical experience is often necessary to untangle the details of an ethics case, it is generally not sufficient to engage competently in clinical ethics consultation. Even when an experienced clinician possesses considerable skill in talking with patients and families about the difficult practical and moral problems faced in complex and uncertain situations, clinical experience must be supplemented with a basic knowledge of ethical theory, health policy, law, and clinical ethics literature.⁷ Many successful ethics consultants are nonclinicians supported by access to clinical expertise.

An IEC might permit different levels of member involvement, ranging from simply attending general committee meetings, discussing and drafting institutional policy, or participating in ethics consultation to leading an ethics consultation team, depending on the skills and experience of each member.

If engaged in clinical ethics consultation, it is reasonable to ask what one's legal liability might be in offering this service. An IEC should clarify the extent to which IEC proceedings are discoverable and whether its members are covered by

liability insurance. The question of legal liability is difficult to answer except in general terms. Responsibility increases with authority, so it is generally riskier for IECs to direct than to simply advise.³² States vary in legal protections afforded IEC members.³³ However, the likelihood that IEC members will be held legally liable for the actions arising from a consultation is both historically rare and practically remote.^{33,34} Nevertheless, IECs and their members have an important opportunity to help set the standards for their own work by careful attention to continuing education, preparation, policy, procedure, and documentation.^{14,35,36} IEC policies and procedures should be part of the institutional policy structure, and institutions should protect individual IEC members from liability that might arise in the course of official duties.

RECOMMENDATIONS

1. An IEC should have responsibility within an institution for oversight of clinical ethics consultation, review of policies relevant to ethical issues in patient care, and education of professional, administrative, and support staff about ethical issues, regardless of whether these functions are delegated to other subcommittees or programs.
2. Institutional policies and procedures for review of ethics concerns should be included in staff training; information on how to raise ethics concerns should be available to patients, families, and staff.
3. An IEC may play an important role, along with institutional administration, in organizational ethics and quality improvement.
4. Membership on an IEC should be diverse and reflect different perspectives within the hospital and general community.
5. An IEC that is engaged in clinical ethics consultations should have clearly articulated policies and procedures that conform to ethical principles of fairness and confidentiality.
6. An IEC should establish continuing education and training programs that ensure that IEC members attain and maintain the competencies required to perform their specific duties within the IEC.
7. Independent ethics committees within a single institution should be dissolved or restructured to report to the larger IEC.
8. IECs within a general hospital setting should ensure an adequate degree of multidisciplinary expertise for addressing ethical issues specific to pediatrics.

LEAD AUTHOR

Margaret Moon, MD, MPH, FAAP

COMMITTEE ON BIOETHICS, 2017–2018

Robert C. Macauley, MD, MDiv, FAAP, Chairperson

Gina Marie Geis, MD, FAAP

Naomi Tricot Laventhal, MD, FAAP

Douglas J. Opel, MD, MPH, FAAP

William R. Sexson, MD, MAB, FAAP

Mindy B. Statter, MD, FAAP

LIAISONS

Mary Lynn Dell, MD, DMin – *American Academy of Child and Adolescent Psychiatry*

Douglas S. Diekema, MD, MPH, FAAP – *American Board of Pediatrics*

Ginny Ryan, MD – *American College of Obstetricians and Gynecologists*

Nanette Elster, JD, MPH – *Legal Consultant*

STAFF

Florence Rivera, MPH

ABBREVIATIONS

AAP: American Academy of Pediatrics

ASBH: American Society for Bioethics and Humanities

IEC: institutional ethics committee

REFERENCES

1. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions*. Washington, DC: US Government Printing Office; 1983
2. American Academy of Pediatrics Infant Bioethics Task Force and Consultants: guidelines for infant bioethics committees. *Pediatrics*. 1984;74(2):306–310
3. The Joint Commission. *Hospital Accreditation Standards*. Oakbrook Terrace, IL: The Joint Commission; 2012
4. Health Care Financing Administration; Department of Health and Human Services. Medicare and Medicaid programs; hospital conditions of participation: patients' rights. *Fed Regist*. 1999;64(127):36070–36089
5. Fox E, Myers S, Pearlman RA. Ethics consultation in United States hospitals: a national survey. *Am J Bioeth*. 2007;7(2):13–25
6. Dubler NN, Liebman CB. *Bioethics Mediation: A Guide to Shaping Shared Solutions, Revised and Expanded Edition*. Nashville, TN: Vanderbilt University Press; 2011
7. American Society for Bioethics and Humanities. *Core Competencies for Health Care Ethics Consultation*. Glenview, IL: American Society for Bioethics and Humanities; 2010
8. DuVal G, Clarridge B, Gensler G, Danis M. A national survey of U.S. internists' experiences with ethical dilemmas and ethics consultation. *J Gen Intern Med*. 2004;19(3):251–258
9. Barina R, Trancik EK. Moving ethics into ambulatory care: the future of Catholic health care ethics in shifting delivery trends. *Health Care Ethics USA*. 2013;21(2):1–5
10. American Society for Bioethics and Humanities. *Code of Ethics and Professional Responsibilities for Healthcare Ethics Consultants*. Glenview, IL: American Society for Bioethics and Humanities; 2014. Available at: [http://asbh.org/uploads/publications/ASBH%20Code%20of%](http://asbh.org/uploads/publications/ASBH%20Code%20of%20)

20Ethics.pdf. Accessed November 3, 2017

11. Adams DM. Ethics expertise and moral authority: is there a difference? *Am J Bioeth.* 2013;13(2):27–28
12. Agich GJ. Authority in ethics consultation. *J Law Med Ethics.* 1995; 23(3):273–283
13. Murphy CA. Searching for proper judicial recognition of hospital ethics committees in decisions to forego medical treatment. *Gold Gate Law Rev.* 1990;20(2):319–344
14. Sontag DN. Are clinical ethics consultants in danger? An analysis of the potential legal liability of individual clinical ethicists. *Univ PA Law Rev.* 2002; 151(2):667–705
15. Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. *JAMA.* 1997;277(7):553–559
16. Bruce CR, Smith ML, Tawose OM, Sharp RR. Practical guidance for charting ethics consultations. *HEC Forum.* 2014; 26(1):79–93
17. Dubler NN. The art of the chart note in clinical ethics consultation and bioethics mediation: conveying information that can be understood and evaluated. *J Clin Ethics.* 2013;24(2): 148–155
18. Spielman B. Has faith in health care ethics consultants gone too far? Risks of an unregulated practice and a model act to contain them. *Marquette Law Rev.* 2001;85(1):161–221
19. Magill G. Quality in ethics consultations. *Med Health Care Philos.* 2013;16(4): 761–774
20. Kesselheim JC, Johnson J, Joffe S. Ethics consultation in children's hospitals: results from a survey of pediatric clinical ethicists. *Pediatrics.* 2010;125(4):742–746
21. Tarzian AJ; ASBH Core Competencies Update Task Force 1. Health care ethics consultation: an update on core competencies and emerging standards from the American Society for Bioethics and Humanities' core competencies update task force. *Am J Bioeth.* 2013; 13(2):3–13
22. American Society for Bioethics and Humanities Clinical Ethics Task Force. *Improving Competencies in Clinical Ethics Consultation: An Education Guide.* 2nd ed. Glenview, IL: American Society for Bioethics and Humanities; 2009
23. Carrese JA, Antommara AH, Berkowitz KA, et al; American Society for Bioethics and Humanities Clinical Ethics Consultation Affairs Standing Committee. HCEC pearls and pitfalls: suggested do's and don'ts for healthcare ethics consultants. *J Clin Ethics.* 2012;23(3):234–240
24. Moon M, Taylor HA, McDonald EL, Hughes MT, Carrese JA. Everyday ethics issues in the outpatient clinical practice of pediatric residents. *Arch Pediatr Adolesc Med.* 2009;163(9):838–843
25. Interprofessional Education Collaborative Expert Panel. *Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel.* Washington, DC: Interprofessional Education Collaborative; 2011
26. Opel DJ, Wilfond BS, Brownstein D, Diekema DS, Pearlman RA. Characterisation of organisational issues in paediatric clinical ethics consultation: a qualitative study. *J Med Ethics.* 2009;35(8):477–482
27. Foglia MB, Pearlman RA. Integrating clinical and organizational ethics. A systems perspective can provide an antidote to the "silo" problem in clinical ethics consultations. *Health Prog.* 2006; 87(2):31–35
28. Spencer EM. A new role for institutional ethics committees: organizational ethics. *J Clin Ethics.* 1997;8(4):372–376
29. Fox E, Bottrell MM, Berkowitz KA, Chanko BL, Foglia MB, Pearlman RA. IntegratedEthics: an innovative program to improve ethics quality in health care. *Innov J.* 2010;15(2):1–36
30. Foglia MB, Fox E, Chanko B, Bottrell MM. Preventive ethics: addressing ethics quality gaps on a systems level. *Jt Comm J Qual Patient Saf.* 2012;38(3): 103–111
31. Ells C. Healthcare ethics committees' contribution to review of institutional policy. *HEC Forum.* 2006;18(3):265–275
32. Kodish E, Fins JJ, Braddock C III, et al. Quality attestation for clinical ethics consultants: a two-step model from the American Society for Bioethics and Humanities. *Hastings Cent Rep.* 2013; 43(5):26–36
33. Burda M. Certifying clinical ethics consultants: who pays? *J Clin Ethics.* 2011;22(2):194–199
34. Fox E. Strategies to improve health care ethics consultation: bridging the knowledge gap. *AMA J Ethics.* 2016; 18(5):528–533
35. Pope TM. Legal briefing: healthcare ethics committees. *J Clin Ethics.* 2011; 22(1):74–93
36. Annas G, Grodin M. Hospital ethics committees, consultants, and courts. *AMA J Ethics.* 2016;18(5):554–559