HEC Forum
https://doi.org/10.1007/s10730-024-09534-5

The Structure of Clinical Ethical Decision-Making: A Hospital System Needs Assessment

Leana G. Araujo[1] · **Martin Shaw**[2] · **Edwin Hernández**[1]

Accepted: 30 May 2024

Abstract

Bioethical dilemmas can emerge in research and clinical settings, from end-of-life decision-making to experimental therapies. The COVID-19 pandemic raised serious ethical challenges for healthcare organizations, highlighting the need to conduct needs assessments of the bioethics infrastructures of healthcare organizations. Clinical ethics committees (CECs) also create equitable policies, train staff on ethics issues, and play a consultative role in resolving the difficulty of complex individual cases. The main objective of this project was to conduct a needs assessment of the bioethics infrastructure within a comprehensive hospital system. A cross-sectional anonymous online survey, including quantitative and qualitative formatted questions. The survey was sent to five key leaders from the organization's hospitals. Survey questions focused on the composition, structure, function, and effectiveness of their facilities' bioethics infrastructure and ethics-related training and resources. Positive findings included that most facilities have active CECs with multidisciplinary membership; CECs address critical issues and encourage team members to express clinical ethics concerns. Areas of concern included uncertainty about how CECs function and the process for resolving clinical ethics dilemmas. Most reported no formal orientation process for CEC members, and many said there was no ongoing ethics education process. The authors conclude that if CECs are a critical institutional resource where the practice of medicine and mission intersect, having well-functioning ethics committees with trained and oriented members demonstrates an essential commitment to the mission. The survey revealed that more needs to be done to bolster the bioethics infrastructure of this institution.

Keywords Clinical ethics committee · Bioethics · Infrastructure · Ethical decision-making

✉ Martin Shaw
martin.shaw@ahu.edu

[1] Administration Department, AdventHealth University, Orlando, FL, USA

[2] Center for Ministry Education and Research, AdventHealth University, Orlando, FL, USA

Published online: 08 June 2024

Background

The field of bioethics focuses on identifying, studying, and resolving conflicts among competing values or goals in the health-related life sciences. These ethical dilemmas can emerge in research and clinical settings and may involve scientists, human subjects, physicians, healthcare professionals, patients, and their families. The recent pandemic's ethical challenges from resource allocation, priority-setting, and physical distancing (World Health Organization, 2023) bring complex and often conflicting issues to light. A recent publication suggests significant long-term effects experienced by physicians may be from moral injury due to "difficult decisions made, high mortality, futility of treatment and moral/ethical dilemmas during the pandemic" (Della Monica et al., 2022). A robust bioethics infrastructure enables healthcare organizations to create fair and equitable policies even in the most difficult times. It gives leaders a forum to discuss and evaluate their critical decisions affecting patients and their institutions. A key component of the ethics committee is to review current patient cases with ethical dilemmas and make recommendations regarding a patient's care plan. Attention to ethical issues also impacts hospitals financially, particularly end-of-life decisions (Duncan et al., 2019). Advances in medical care that prolong life raise an important ethical question: "How much is too much?"—highlighting the need for compassionate processes that lead to sound ethical judgments for patients and families (Akdeniz et al., 2021). While there is consensus that competency in bioethics is vitally important for physicians (Carrese & Sugarman, 2006), there is also widespread recognition that healthcare professionals lack formal training in this area (Barman et al., 2020).

The COVID-19 pandemic raised serious ethical challenges for healthcare organizations. Among these are the need to develop ethical policies and procedures for distributing scarce critical care resources and vaccines; how to protect the health and morale of front-line healthcare workers, especially during waves of high hospitalization; and how to triage access to noncritical care for patients during the pandemic (McGuire et al., 2020). The pandemic also illuminated longstanding health disparities and structural inequalities, both in the United States and globally. Higher infection and death rates among communities of color have been well documented (Hasan Bhuiyan et al., 2021), demonstrating that "the risks of COVID-19 are not evenly distributed in American society," as the ethicist Gerald Winslow noted (Winslow, 2020).

CECs in the United States serve as the primary mechanism for processing ethical issues occurring in healthcare practice (Aulisio, 2016; Moon, 2019). A CEC is an independent multidisciplinary body established by a healthcare institution whose members may include physicians, nurses, formally trained ethicists, therapists, care managers, chaplains, administrators, risk managers, palliative care team members, attorneys, and community representatives. Ethics committees meet regularly to discuss individual clinical cases, review or develop institutional policies that address ethical issues related to patient care, and promote education efforts to clinical staff to ensure appropriate decision-making practice in bioethics

(Hospitals, 1992). There is a need to monitor and evaluate CECs for effectiveness. The better we know and understand our institutional context, the greater our capacity to make it more just and humane. Healthcare institutions must be attentive to equity issues and the quality of care that patients receive; we must steward resources carefully and protect front-line workers. CECs play a crucial role in all these endeavors.

Purpose and Objectives

The primary purpose of this project was to:

- Conduct a system-wide needs assessment of the bioethics infrastructure.

The secondary purposes of this assessment were to:

- Understand the level of awareness and effectiveness of the various components of a CEC.
- Ascertain the importance of bioethics' role in the clinical setting.
- Assess the level of clinical ethics training and needs of committee members.
- Identify the most common clinical ethics issues that committees address.
- Identify current processes for resolving clinical ethics issues.
- Identify human and material resources to advance bioethics programs.

Methods

Study Design and Participant Recruitment

This needs assessment used a cross-sectional anonymous online survey, using questionnaires with numerically rated items and open-ended questions (Ponto, 2015). Personal identifiable information (PII) was not collected, investigators did not link individual responses to specific facilities of employment, and questions regarding individual's roles were analyzed in aggregate to protect the respondents' anonymity. A convenience sampling method was utilized, as the investigators were primarily interested in understanding the bioethics infrastructure of a specific large hospital system through the experience of key informants: the chief executive officer (CEO), chief medical officer (CMO), chief nursing officer (CNO), risk management coordinator, and lead chaplain.

An email invitation with the anonymous link to the online Qualtrics survey was distributed to 215 key informants from 66 facilities. These facilities included hospitals, regional and corporate offices, medical groups, and hospices. The first part of the data collection took place between February 26 and March 15, 2020. Data collection was paused due to the COVID-19 pandemic when institutional leaders had to shift their priorities to deal with pandemic-related issues affecting their hospitals. Data collection resumed on May 14, 2020, and concluded on June 2, 2020.

Respondents were asked to complete the survey based on their knowledge and expertise. Thus, they had the option of skipping questions. The survey consisted of questions adapted from other published surveys in the field and questions created by the research team (Fox et al., 2007; Frolic et al., 2013). The survey's questions aimed to provide an accurate assessment of current ethical practices within the respective facility. Question formats were mainly pre-established lists of choices where participants were asked to either select one list option or select all that apply. The selection of all that applies aimed to measure the overall ranking order of selected items and the degree to which a criterion was valued by respondents. The average time to complete the survey was 10 to 12 minutes.

Ethics

This quality assessment project was data-driven and intended to bring prompt benefits to this specific large healthcare organization's bioethics program. It was not subject to review as research, as defined under federal regulations (45CFR46.102 (d)). Therefore, it did not merit IRB oversight. The assessment did not increase any risk for the participants, and confidentiality steps were considered. The findings were shared with the institution leadership to create awareness of the state of bioethics infrastructure and encourage the phase of quality improvements.

Data Analysis

Descriptive statistics and figures were used to summarize and describe the bioethics infrastructure within this large hospital system. For clarity and ease of interpretation, the frequencies of respondents' selections were determined and depicted as percentages. The "check all that apply" format questions reflect the percentage of respondents who selected the specific option referenced.

Results

The total number of key informants who participated was 132 (61.4% response rate). The sample consisted of the following key informants: 38% were lead chaplains, 20% were CEOs, 15% were CNOs, 14% were CMOs, 11% were risk management coordinators, and 2% were clinical and administrative staff, described as "other" in this paper.

Composition and Structure

Of the 66 facilities invited, 51 facilities participated in our survey (77.3%). A total of 42 facilities (82.3%) reported that they had CECs as of spring 2020. 67% of respondents indicated a CEC at their facility, 21% said there was no CEC at their facility, and 12% were not sure.

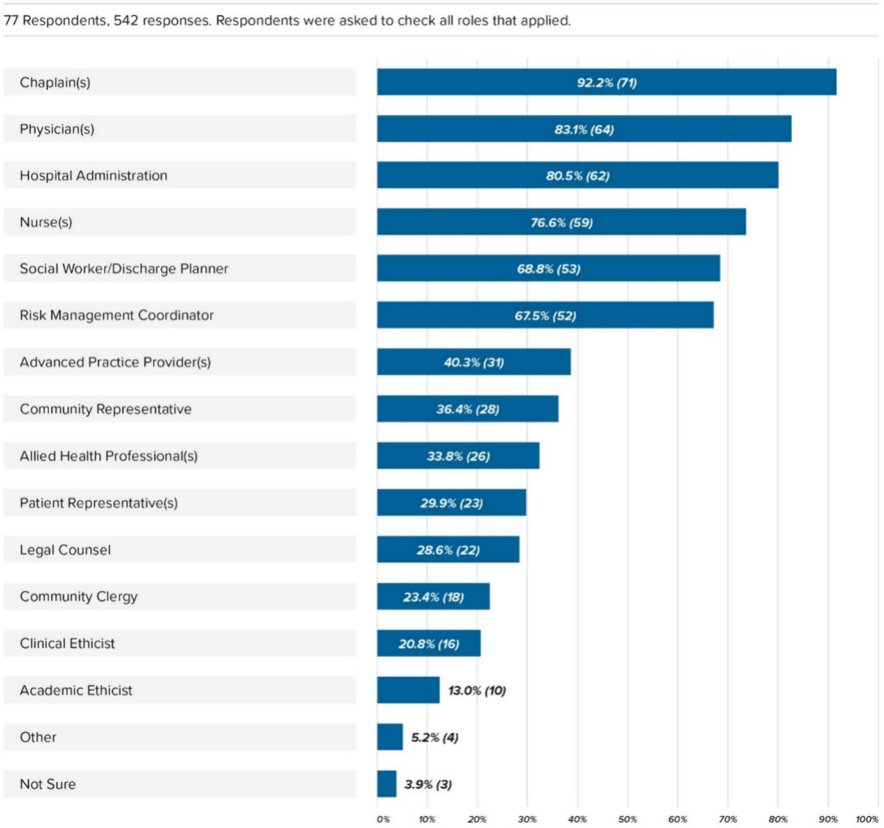

Fig. 1 Membership Composition of Ethics Committees

Figure 1 indicates the most likely membership composition of CEC in the participant's experiences. When asked to rank the most likely chairs of the CEC, 25 of the participants indicated a physician chaired the CEC, 11 were unsure, while 8 selected chaplains and risk management.

Figure 2 depicts the responses regarding the frequency of the facilities' CEC meetings. The highest percentage (40%) of the respondents said that the CEC met as needed. The survey asked who provided oversight for clinical ethics at their respective facilities. Respondents selected not sure (24%), risk management/coordinator (19%), physicians (18%), hospital administrator (17%), chaplains (9%), other (8%), case manager (4%), and nurse (1%). We wanted to know if committees had access to a clinical ethicist outside of their facilities. 53% of the respondents said yes, 29% were unsure, and 18% indicated no.

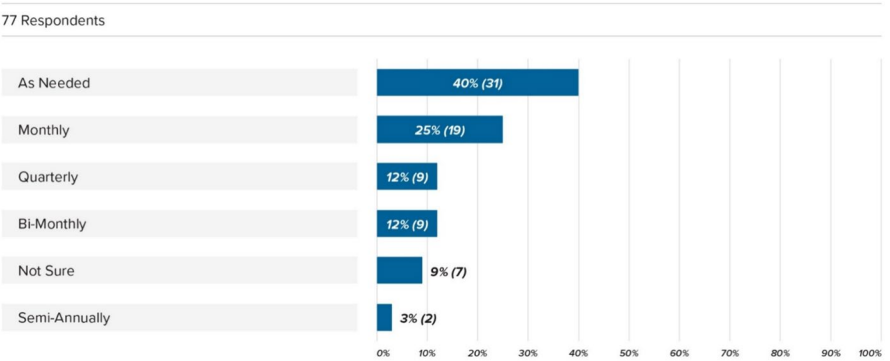

Fig. 2 Schedule for Committee Meetings

Fig. 3 Employees in my facility are encouraged to express clinical ethical concerns

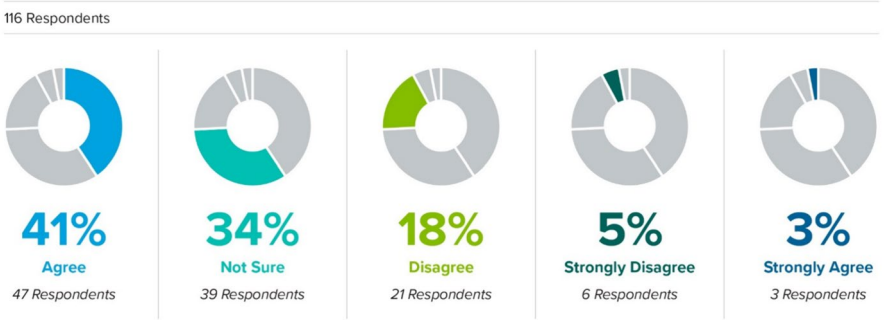

Fig. 4 Employees in my facility are aware of the process on how to resolve any clinical sthics dilemma

Function and Responsibilities

Figures 3 and 4 indicate respondents' agreement level with their facility's willingness to report ethical concerns and the awareness of how to engage in the ethical process. 77% of respondents strongly agree or agree that they are encouraged to express their ethical concerns; however, only 44% strongly agree and agree that employees in their facility are aware of the process to remedy their ethical concerns. When the responses were examined by the role of the respondent (from most to least likely to agree), 55% of CEOs, 50% of risk management coordinators, 38% of chaplains, 37% of CNOs, and 35% of CMOs agreed that employees were aware of the process for resolving clinical ethics dilemmas.

Clinical Issues

In Fig. 5, respondents were provided a list of common CEC issues and asked to indicate the most commonly addressed issues within their facility. End-of-life, surrogate decision-makers, and futility of care were the most prevalent selections. Matters related to COVID-19 were not anticipated when the survey was designed, so it was not included. Participants indicated that the CEC has responsibility over the following areas: consultation on active cases (93.5%), policy development and review (61.0%), retrospective case review (48.1%), and education (46.8%).

Effectiveness of Bioethics Components

Respondents were asked to rate the clinical ethics infrastructure at their respective facilities on a scale of 1 (poor) to 10 (excellent). 40% scored 7–10, 20% scored 5–6, and 40% scored 1–4. In Fig. 6, participants were asked to rate the effectiveness of specific bioethics components. When the effectiveness of the ethics components was examined by the role of respondents, we found that the highest scores (7 to 10 rating) were given by CMOs (69%), followed by chaplains (66%), CEOs (60%) and CNOs (53%). When asked if their CEC was evaluated for effectiveness, 62% were unsure, 29% selected never, and 9% indicated annually.

Beneficial Resources

The survey asked participants to rank resources that would benefit the clinical ethics process. 77 Respondents indicated 1. Clinical Ethics Conferences (72.7%), 2. Periodic Case conferences (70.1%), 3. basic tutorials (67.5%), 4. external ethicist access (49.4%), 5. cultural competency (40.3%), and an internal ethicist (33.8%), with 7.8% not sure.

Ethical Consultations

Our survey asked respondents about who performs ethics consultations in their facilities. Most respondents (41) said the full committee performed consultations in their

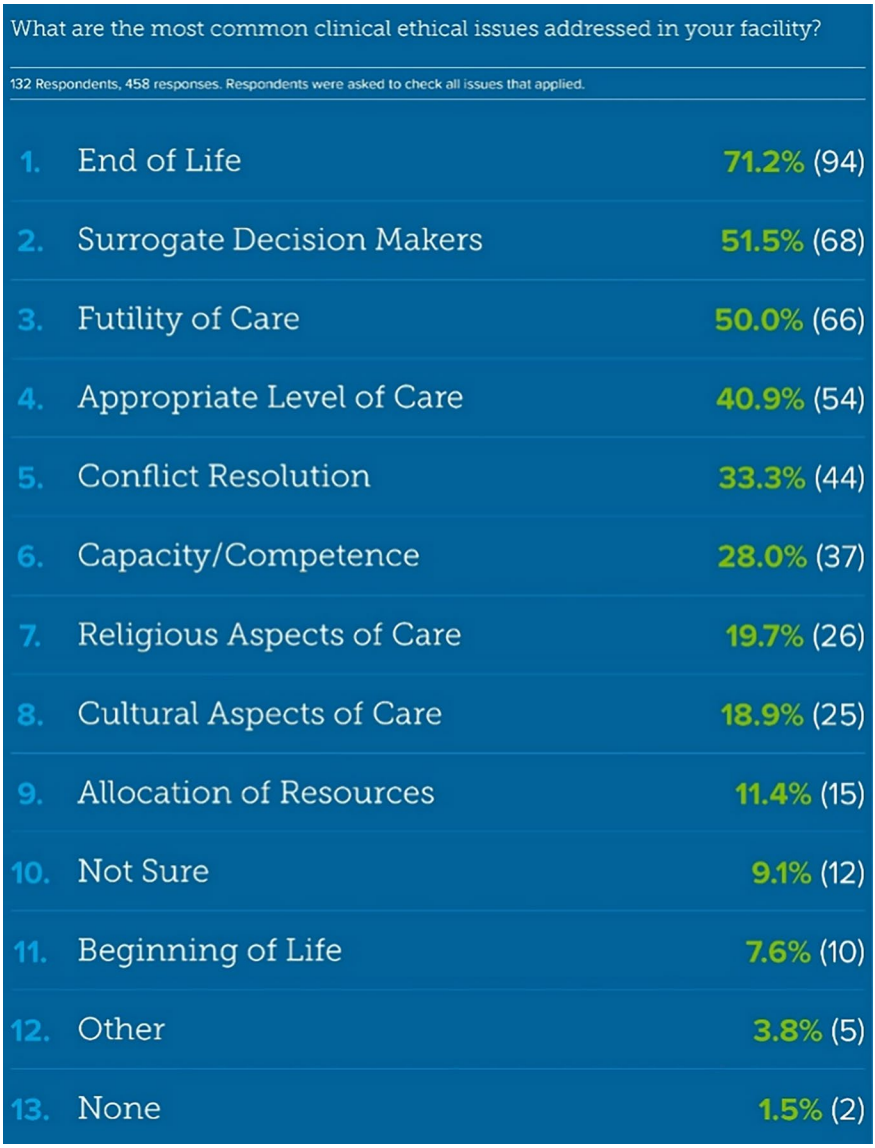

Fig. 5 Commonly addressed ethical issues within facility

facilities, followed by those who assigned this task to a subcommittee (37 responses). The last-mentioned option was an ethics consultant (12 responses). There were 31 respondents who were unsure who provided ethics consultations, and 13 respondents said that ethics consultations were not performed at their facility. Participants were also asked about the roles that could initiate a consultation request within their facility. Respondents indicated physicians (93.5%), case managers (90.9%), nurses (89.6%), hospital administrators (84.4%), risk managers (81.8%), chaplains (77.9%), family

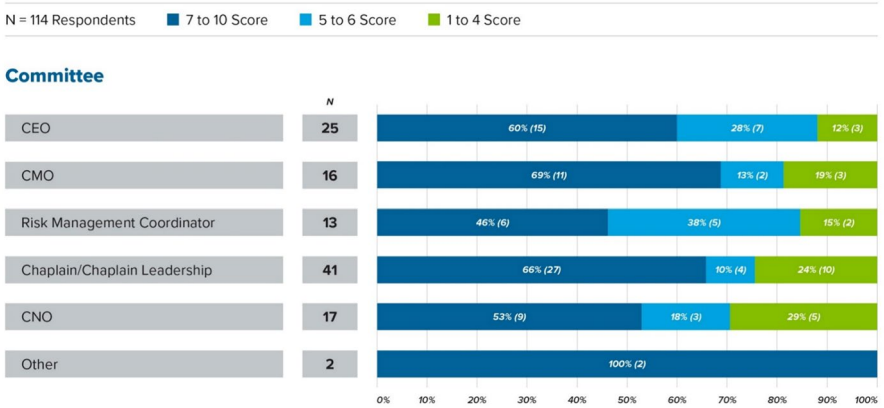

Fig. 6 Rate the effectiveness of the following components of a bioethics infrastructure that exists within your facility (By Key Informat's Role)

(74.0%), patients (70.1%), and non-clinical staff (51.9%). When asked whether ethical consultation reports were placed in the patient's chart after a completed consultation, 44% of respondents were unsure, 42% said yes, and 14% said no. The survey asked participants what happens when clinical ethics issues are not resolved. 49.4% indicated consultation with an organizational resource, 33.8% were unsure, 19.5% said consultation with a resource outside of the organization is sought, 10.4% provided their own response, and 6.5% said the issue remains unresolved.

Education and Training

One of the major functions of the ethics committee is to provide education to members, clinical staff, and patients regarding ethical issues (Moon, 2019). The survey asked respondents about the ethics training they had received to gauge the number of ethically trained professionals. 52.3% of participants indicated they had at least one undergraduate/graduate ethics course, 49.2% had attended a conference on the topic of ethics, 41.7% had participated in at least one webinar, 35.6% took continuing education courses, whereas 12.1% indicated they had no prior training, 8.3% provided their own response, and no respondent reported receiving a degree in ethics. The survey also inquired about the training implemented for current ethics committee members. 55% of respondents indicated there was no formal orientation for new CEC members, 32% were unsure, and 13% indicated a formal orientation at their respective facility. 43% reported no ongoing educational process for CEC members, 29% were unsure, and 29% indicated an educational component.

Discussion

Major Findings of the Study

In this system-wide needs assessment of their bioethics infrastructure, most respondents were aware of the existence of formal ethics committees (CEC). CECs consist of a diverse membership composition of professionals, and the meetings were scheduled as needed. Chaplains were the most prevalent members mentioned, with physicians being the chairs. Those trained as ethicists were least represented on committees; however, leaders seemed to have varying access to external ethicists when needed. Employees were encouraged to express clinical ethical concerns, but many expressed a lack of knowledge about who provides oversight for clinical ethics at their respective facilities and the formal process for resolving clinical ethics dilemmas. The ethical issues receiving the largest number of selections were related to the end of life, followed by the surrogate decision-makers.

Most participants were clear on the main functions and responsibilities of the CECs described in the following order of significance: consultation on active cases, policy development and review, retrospective case review, and education. Mainly, the full committee performed ethics consultations in their facilities. Less than half of the participants reported ethical consultations being documented within the patient's record. This healthcare organization's policies for recording an ethical consultation in a patient's electronic medical record varied from hospital to hospital. The existence of policies is an indicator that ethics conversations, processes, and guidelines are embedded in the institution's culture. Less than half of survey respondents rated the overall clinical ethics infrastructure as excellent or somewhat positive. Most reported no formal orientation process for CEC members, and many said there was no ongoing ethics education process.

Compare and Contrast

Even though this large hospital system corporate office does not have a policy requiring hospitals to establish ethics committees, most of the respondents were aware of the existence of formal ethics committees to address ethical patient care issues. A study of United States hospitals published in 2021 showed that healthcare ethics programs existed in 97% of the hospitals responding to a national survey (Danis et al., 2021). Despite the positive aspect of most facilities of this hospital system having bioethics support when compared with the national findings listed above, this hospital system has a lower affirmative rate of 67%, in addition to 12% not sure.

The literature suggests that members of an ethics committee should not only "encompass a wide range of clinical experiences, personal backgrounds, and professional perspectives" but also combine "personal integrity and a willingness to discuss and debate the ethical issues raised in the provision of health care" while putting personal views aside (Larcher et al., 2010). In this large organization, the

chaplains had the most prevalent membership mentioned, followed by physicians and then nurses, with physicians serving primarily as the chairs of the CECs. Those trained as ethicists (whether clinical or academic) were least represented on committees. In the present assessment, the oversight responsibilities show diversity among the professionals, with the risk manager/coordinator representing most of the oversight responsibilities, followed by physicians, hospital administrators, and chaplains, respectively. Although the chaplains had the most prevalent membership mentioned, they were the largest group to demonstrate the uncertainty about who provided oversight for clinical ethics at their facilities.

In general, ethics committees' responsibilities can be divided into three major functions: ethics consultations, bioethics training, and revision and/or development of ethics policies. Participants indicated their intelligibility on the functions and responsibilities of the CECs. In fact, a recent systematic literature review found that ethics consultations were the most impactful functions of a CEC (Crico et al., 2021). Documentation of when an ethics consultation occurs, particularly concerning a specific patient's clinical situation, is important (Hajibabaee et al., 2016; Lachman, 2010). In the current study, the findings show that the full committee performed ethics consultations in their facilities, followed by those who assigned this task to a subcommittee. Only 42% said that the occurrence of an ethical consult was documented in the patient's record, reinforcing the lack of a formal process or the deficiency in demanding the application of a process for resolving clinical ethics issues. An electronic health record resource would help staff document ethics consultations while providing a framework to address efficiency, safety, and quality improvement (Sanelli-Russo et al., 2018). At the same time, steps should be taken to educate physicians and other healthcare workers about how to limit harm by ensuring patient privacy is protected and valued (Satkoske & Parker, 2010). This information can enhance the patient-physician relationship and the patient's care.

The presence of resources does not change the importance of educating and training the committee members as well as the health care professionals within the hospital (Crico et al., 2021; Powell, 1998). While education is listed as a primary function of CECs, these findings clearly show that despite important ethical service representation, very little education and orientation is required for ethics committee members participations, nomination, or renewal of their membership within these facilities.

CECs address many major issues, including patients' rights, equity of resources, patient confidentiality and safety, conflict of interest, ethics of privatization, informed consent, beginning and end of life, and health care team ethics (Alkabba et al., 2012). Ethics committees also oversee cases related to new drug development and standard treatments, application of priority-setting criteria, resource allocation, and futility of care (Magelssen et al., 2017). Although there was some overlap, our participants identified slightly different ethical concerns from what is typically found in the bioethics literature. For local hospital leaders, it is also possible that global ethical concerns, such as equitable access to health care, seem less pressing than immediate, bedside clinical issues, such as identifying a decision-making surrogate or managing the end of life. The issue receiving the largest number of responses was related to the end of life, followed by responses for surrogate decision-makers.

Currently, CECs are the primary mechanism for managing ethical issues in clinical care (Aulisio, 2016; Hajibabaee et al., 2016), which raises their responsibility to disseminate their importance and functions in the institution. In this large hospital system, most respondents strongly agreed or agreed that employees were encouraged to do so, demonstrating that there is a culture of openness. Nevertheless, an area of concern includes uncertainty about the process for resolving clinical ethics dilemmas from respondents. This uncertainty highlights the need to improve communication with staff members in the process of channeling concerns or dilemmas. The field of clinical ethics does not offer a standard way to assess CECs' functions and effectiveness (Crico et al., 2021). This study supports this finding, as respondents reported not knowing how, or even if, their ethics committee is evaluated for effectiveness. It is expected that, in a large healthcare system, there would be some heterogenic variation in practice, given the unique nature of each facility's culture. However, there is room to standardize best practices across individual facilities to inform corporate ethical policy. The authors suggest the need to understand how well the CEC is functioning and create a continuous assessment as part of a process improvement initiative to implement educational efforts of best practices.

The medical challenges created by COVID-19 accentuate the all-important prerogative of strengthening ethics infrastructure system-wide and the stipulation of continued assessment of the bioethics infrastructure. Investing in these efforts will better prepare institutions for future pandemics and unexpected events. This large health organization sees CECs as vehicles that help to ensure each facility has a deliberative decision-making and educational body promoting diversity, equity, inclusivity, and accessibility for daily bioethics decisions.

Limitations

The needs assessment outlined above is subject to a few limitations. Due to the design and anonymous data gathering, findings were unable to capture the various perspectives unique to each facility. The survey was designed and executed in the early weeks of the COVID-19 pandemic in the United States. Thus, no questions about ethical challenges arising from the pandemic were included. The assessment was collected via a cross-sectional survey design, which, by its very nature, limits the data to be reflective of the time it was collected. In general, healthcare bioethics literature does not reference many empirical assessments or studies. As a result, investigators were left to determine a protocol for this study using methodologies commonly used in other disciplines.

Recommendations

Additional research could go beyond the analysis or perspective of individual respondents (i.e., what CMOs or CNOs think generally) and provide facility-level analysis, especially at larger facilities. Facility surveys could also focus on obtaining data that elicit the perspectives of front-line staff. Regardless, healthcare leaders

should take into consideration how systemic multi-factors affect the effectiveness of a bioethics program. Practically, hospital systems should consider proactive engagement in the monitoring, development, and delivery of ethics education, policy, and consultation. Future research would do well to conduct a needs assessment across different health systems. Ethics and policy are inextricably linked to organizational values. Therefore, it is imperative that future research conduct cross-system analysis to obtain a diverse sample from different organizations to better understand the current bioethical healthcare trends.

Conclusion

In conclusion, this needs assessment provided the essential information to this large hospital/health system leadership to identify, understand, and enact change within the organizational bioethics infrastructure. It also marks a key contribution to the current bioethics literature, as it represents a health system taking the initiative to achieve a detailed understanding of the inner workings of bioethics within their facilities. It is the hope that this article provides a template for other systems or facilities to replicate and conduct a similar study in their organizations.

Acknowledgements We thank the leaders who took the time to participate in this study and complete the survey. These individuals—CEOs, CMOs, CNOs, risk managers, and chaplains—are indispensable in advancing CECs.

Declarations

Conflict of interest The authors declare that they have no relevant financial or material interests related to the study and information described in this paper.

References

Akdeniz, M., Yardımcı, B., & Kavukcu, E. (2021). Ethical considerations at the end-of-life care. *SAGE Open Medicine, 9*, 205031212110009.

Alkabba, A. F., Hussein, G. M., Albar, A. A., Bahnassy, A. A., & Qadi, M. (2012). The major medical ethical challenges facing the public and healthcare providers in Saudi Arabia. *J Family Community Med, 19*(1), 1–6.

Aulisio, M. P. (2016). Why did hospital ethics committees emerge in the US? *AMA Journal of Ethics, 18*(5), 546–553.

Barman, B., Srivastava, T. K., Sarma, A., & Nath, C. K. (2020). Effectiveness of formal training in bioethics of 3rd semester undergraduate medical students in recognizing bioethical issues and principles in patient care. *Journal of Family Medicine and Primary Care*, *9*(6), 2871–2876.

Carrese, J. A., & Sugarman, J. (2006). The inescapable relevance of bioethics for the practicing clinician. *Chest, 130*(6), 1864–1872.

Crico, C., Sanchini, V., Casali, P. G., & Pravettoni, G. (2021). Evaluating the effectiveness of clinical ethics committees: A systematic review. *Medicine Health Care and Philosophy, 24*(1), 135–151.

Danis, M., Fox, E., Tarzian, A., & Duke, C. C. (2021). Health care ethics programs in U.S. Hospitals: Results from a national survey. *BMC Medical Ethics, 22*(1), 1–14.

Della Monica, A., Ferrara, P., Dal Mas, F., Cobianchi, L., Scannapieco, F., & Ruta, F. (2022). The impact of Covid-19 healthcare emergency on the psychological well-being of health professionals: A review of literature. *Annali Di Igiene, 34*(1), 27–44.

Duncan, I., Ahmed, T., Dove, H., & Maxwell, T. L. (2019). Medicare cost at end of life. *American Journal of Hospice and Palliative Medicine®*. https://doi.org/10.1177/1049909119836204

Fox, E., Myers, S., & Pearlman, R. A. (2007). Ethics consultation in United States hospitals: A national survey. *American Journal of Bioethics, 7*(2), 13–25.

Frolic, A., Andreychuk, S., Seidlitz, W., Djuric-Paulin, A., Flaherty, B., Jennings, B., & Peace, D. (2013). Implementing a clinical ethics needs assessment survey: Results of a pilot study (Part 2 of 2). *HEC Forum, 25*(1), 61–78.

Hajibabaee, F., Joolaee, S., Cheraghi, M. A., Salari, P., & Rodney, P. (2016). Hospital/clinical ethics committees' notion: An overview. *J Med Ethics Hist Med, 9*, 17.

Hasan Bhuiyan, M. T., Mahmud Khan, I., Rahman Jony, S. S., Robinson, R., Nguyen, U.-S.D.T., Keellings, D., Rahman, M. S., & Haque, U. (2021). The disproportionate impact of COVID-19 among undocumented immigrants and racial minorities in the US. *International Journal of Environmental Research and Public Health, 18*(23), 12708.

Hospitals, J. C. A. M. F. (1992). Joint Commission Accreditation Manual for Hospitals.

Lachman, V. D. (2010). Clinical ethics committees: Organizational support for ethical practice. *Medsurg Nursing, 19*(6), 351–353.

Larcher, V., Slowther, A.-M., & Watson, A. R. (2010). Core competencies for clinical ethics committees. *Clinical Medicine, 10*(1), 30–33.

Magelssen, M., Miljeteig, I., Pedersen, R., & Førde, R. (2017). Roles and responsibilities of clinical ethics committees in priority setting. *BMC Medical Ethics*. https://doi.org/10.1186/s12910-017-0226-5

McGuire, A. L., Aulisio, M. P., Davis, F. D., Erwin, C., Harter, T. D., Jagsi, R., Klitzman, R., Macauley, R., Racine, E., Wolf, S. M., Wynia, M., & Wolpe, P. R. (2020). Ethical challenges arising in the COVID-19 pandemic: An overview from the association of bioethics. *The American Journal of Bioethics*. https://doi.org/10.1080/15265161.2020.1764138

Moon, M. (2019). Institutional ethics committees. *Pediatrics*. https://doi.org/10.1542/peds.2019-0659

McGuire, A. L. et al. (2020). Ethical challenges arising in the COVID-19 pandemic: An overview from the Association of Bioethics Program Directors (ABPD) Task Force. *The American Journal of Bioethics*, *20*(7), 15–27.

Ponto, J. (2015). Understanding and evaluating survey research. *Journal of Advanced Practitioner Oncology, 6*(2), 168–171.

Powell, L. T. (1998). Hospital ethics committees and the future of health care decision making. *Hospital Materiel Management Quarterly, 20*(1), 82–90.

Sanelli-Russo, S., Folkers, K. M., Sakolsky, W., Fins, J. J., & Dubler, N. N. (2018). Meaningful use of electronic health records for quality assessment and review of clinical ethics consultation. *Journal of Clinical Ethics, 29*(1), 52–61.

Satkoske, V. B., & Parker, L. S. (2010). Practicing preventive ethics, protecting patients: Challenges of the electronic health record. *Journal of Clinical Ethics, 21*(1), 36–38.

Winslow, G. (2020). Fairness in a pandemic. Retrieved October, 22, 2023, from https://ihpl.llu.edu/blog/fairness-pandemic

World Health Organization. (2023). Ethics and COVID-19. Retrieved 11 October, 2023, from https://www.who.int/teams/health-ethics-governance/diseases/covid-19