

Findings from a National Survey on Ethics Programs in U.S. Hospitals

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Abstract

As hospitals have evolved and become more intricate, the ethical dilemmas they face have also increased in complexity. To address this, many institutions have implemented health care ethics programs (HCEPs) that extend beyond simple ethics consultation services, yet comprehensive research on these programs remains limited. A national, cross-sectional survey targeting a stratified sample of 600 U.S. hospitals was conducted to assess the presence, functions, activities, staffing, workload, funding, and principal challenges of HCEPs.

Out of 372 hospitals with completed surveys, nearly all (97%) reported having an HCEP. While clinical ethics support was nearly universal, other roles were less common: ethical leadership (35.7%), compliance oversight (29.0 percent), business ethics (26.2 percent), and research ethics (12.6 percent). HCEPs provided ongoing ethics education to diverse audiences, including all staff (77.0%), nurses (59.9 percent), attending physicians (49.0%), hospital executives (44.2%), medical trainees (20.3%), and the broader community (18.4%). Staff primarily engaged in reviewing existing policies rather than creating new ones. Ethics representation was present in executive leadership in 80.5 percent of hospitals, with HCEP involvement on other committees in 40.7%, community engagement in 22.6%, and leadership of large ethics quality improvement initiatives in 17.7 percent. Programs at major teaching and urban hospitals were generally more integrated, with broader scopes and more activities. Larger, academically affiliated, and urban hospitals employed more personnel dedicated to HCEP duties, and a greater proportion received financial compensation for this work. Resource limitations were the most frequently reported challenge overall, whereas underutilization was the main concern in hospitals with fewer than 100 beds. Strategies to address these challenges commonly included enhanced staff training and securing additional funding. Although these findings should be interpreted cautiously given the study's limitations, they offer valuable insight into the characteristics of health care ethics programs (HCEPs) in U.S. hospitals and the factors associated with these features, potentially informing strategies to strengthen such programs.

Keywords: Ethics programs, HCEPs, Ethical leadership, Business ethics, Research ethics

Introduction

Hospitals are multifaceted organizations facing a wide spectrum of ethical challenges, including those related to patient care, public health, professional conduct, employee relations, organizational operations, and

business practices. Depending on their governance, mission, and affiliations, some hospitals must also navigate ethics considerations related to government oversight, faith-based values, research activities, and the education of trainees.

Over the past four decades, ethicists, professional bodies, and regulatory organizations have emphasized that ethical concerns in health care extend beyond the clinician-patient relationship, calling for attention to the full range of issues hospitals encounter [1–4]. Traditionally, U.S. hospitals have addressed these matters through a fragmented system of committees and offices—for example, clinical ethics matters are often

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handled by ethics committees or consultation services, business and management issues by compliance or HR staff, and research ethics by institutional review boards (IRBs). These entities typically function in isolation, which can create gaps or overlap in addressing ethical issues [5].

In recent years, there has been growing support for adopting a unified, programmatic approach that integrates different aspects of health care ethics, including clinical, organizational, and research ethics [6]. The American Society for Bioethics and Humanities (ASBH) has endorsed this trend toward integration across subspecialties [6]. Notable examples include the VA's IntegratedEthics™ model, which replaces siloed ethics committees with a coordinated program managing ethics services across all domains [5], the Southern California Kaiser Permanente bioethics program, which links ethics with quality management and compliance [7], and the CHA/Ascension model, which connects ethics with leadership and institutional committees like HR, IRBs, and patient relations [8]. These integrated programs emphasize organizational ethics alongside clinical ethics, addressing issues such as resource allocation, advertising, employee relations, and research ethics, and focusing not only on individual decisions but also on systems, processes, culture, and organizational environment [5, 9, 10].

Integrated ethics programs differ from traditional ethics services in three main ways. First, they provide a coordinated “umbrella” structure rather than dispersed, isolated activities. Second, they address a broad range of ethical concerns across the organization, rather than focusing narrowly on specific domains. Third, they employ diverse strategies—including consultation, education, policy review, and engagement with other organizational programs—to achieve their goals.

Despite the movement toward integrated ethics programs, prior research in U.S. hospitals has largely focused on isolated structures or activities, such as clinical ethics consultations [11–14], hospital ethics committees [15–18], clinical ethics policies [19], compliance programs [20], research ethics committees [21], or research ethics consultations [22]. To date, no studies have examined the full spectrum of formally recognized entities that collectively support health care ethics—that is, HCEPs.

To address this knowledge gap, questions regarding hospital ethics programs were included in a national survey of ethics consultation services in U.S. hospitals

[23]. Because ethics consultation services are typically part of broader HCEPs, examining consultation alone provides an incomplete picture of program characteristics, including budget allocation and staffing, which are often assigned at the program level. While the parent survey focused primarily on ethics consultation, this report analyzes the wider context of HCEPs beyond consultation services.

Materials and Methods

This analysis is part of a larger national study of ethics consultation in U.S. hospitals [23], which replicated methods from an earlier national survey of hospital ethics consultation [11]. Full methodological details and the survey instrument are reported in the parent study [23].

Survey instrument

For this study, a health care ethics program (HCEP) was defined as any formally recognized hospital entity that supports ethics-related work, such as policy creation or educational initiatives. These responsibilities could be carried out by individual staff members, committees, offices, or other organizational structures, and the presence of an ethics consultation service was not required.

The intent of this definition was to capture all organized, programmatic ethics activities within hospitals, regardless of the label or structure used. To highlight that HCEPs may extend beyond clinical ethics, the survey first asked respondents to identify which ethical functions their program covered, offering options such as clinical ethics, business ethics, research ethics, regulatory compliance, ethical leadership, and other areas.

Respondents then completed multiple-choice items regarding the program's main functions. For educational activities, participants indicated the groups that received ongoing ethics instruction. Regarding policy work, they reported whether their HCEP helped develop new policies or reviewed existing policies periodically. Additional questions explored other roles, such as whether the program included an ethics representative at the executive level, provided ethics representation on other hospital committees, led ethics-related quality improvement projects, or engaged with the broader community.

Information about staffing and resources was also collected. Respondents reported the total number of individuals contributing to the HCEP, whether in paid or

unpaid roles, and the approximate hours each person spent weekly (<1, 1–4, 5–9, 10–19, 20–29, 30–39, or ≥40 hours). They indicated how many received dedicated salary or equivalent compensation and estimated the total full-time equivalent (FTE) support, where 1.0 FTE represented a full-time salary and 0.1 FTE roughly four hours per week. Funding sources for this support were also reported as percentages from categories such as the hospital, multi-hospital systems, universities, patient billing, or other sources.

To clarify oversight, respondents identified the senior administrator responsible for monitoring the HCEP, defined as someone who receives periodic reports and could intervene in case of major issues, distinct from the person managing the program. Participants rated this leader's level of awareness of HCEP activities on a 0–10 scale.

Finally, open-ended questions explored the primary challenges facing each HCEP and potential strategies to address them. The complete survey instrument is available elsewhere [23].

Hospitals without an ethics consultation service were asked if any other individual, committee, or office performed ethics-related functions, such as policy development or education. If so, these hospitals were classified as having an HCEP and completed a shortened survey consisting of 23 core questions and seven follow-up items.

Survey sample

Hospitals included in this study were selected from the 2016 American Hospital Association Annual Survey of Hospitals [24]. From this pool, a stratified random sample of 600 hospitals was drawn, categorized by bed size. Designated respondents at each hospital were contacted following a standardized procedure, as outlined previously [23].

Data analysis

Analyses were conducted using SAS version 9.3. To ensure representativeness given the stratified sampling, weights were applied by bed size using the degrees-of-freedom method, allowing inferences to the broader population of U.S. general hospitals [25]. Descriptive statistics summarized survey findings, and relationships between hospital characteristics and survey measures were examined using one-way ANOVAs with contrasts and chi-square tests. Multiple comparison adjustments were applied via the Scheffé method [26], with

significance defined at a two-sided p-value of 0.05. Results are presented as weighted percentages based on completed responses.

Beyond individual survey items, composite measures were created to capture program scope and activity. These included: the number of ethics domains addressed by a hospital's HCEP (0–5), the number of target audiences receiving ongoing ethics education (0–7), the range of policy-related activities (0–4), and other program activities (0–4). A “total workload” measure was estimated by aggregating the weekly hours spent on HCEP duties (paid or unpaid) across all staff. For each reported weekly hour range, the midpoint was multiplied by the number of staff in that range and summed across all ranges—for example, one staff member reporting 5–9 hours and another ≥40 hours would yield a total of $(1 \times 7) + (1 \times 40) = 47$ hours/week.

Responses that appeared implausible—such as unusually high or low estimates for hours, compensated staff, or FTEs—were flagged by one author and reviewed by two others; questionable entries were excluded when consensus was reached. Analyses are presented both including and excluding these responses.

Content analysis

Open-ended responses about HCEP challenges and proposed solutions were analyzed using a content analysis approach. A research assistant first reviewed all responses to develop initial codes, which were then refined by an author. Two coders applied the codes to all responses, with a third author reviewing for consistency. Discrepancies were resolved through discussion. Weighted percentages of hospitals providing responses aligned with each code were calculated, and illustrative examples are presented in the text.

Results and Discussion

Participating hospitals

Of the 600 sampled hospitals, one closed before data collection, leaving 599 eligible. Among these, 462 hospitals participated in some portion of the study, yielding a 77.1% response rate. Of the participating hospitals, 438 reported having an ethics consultation service and were administered the full online survey; 365 completed part or all of this survey. Sixteen hospitals reported having a HCEP without a consultation service and received a modified survey; seven provided at least one response, but only one answered beyond confirming

the presence of a HCEP. The remaining eight hospitals had neither a consultation service nor a HCEP and did not complete the survey. Prevalence estimates are based on the 462 participating hospitals, while detailed program characteristics derive from the 372 hospitals completing any portion of the survey. No significant differences were observed between sampled and participating hospitals or between survey completers and all participants regarding hospital characteristics [23].

HCEP prevalence

Among respondents, an estimated 97.1% of hospitals had a formally recognized HCEP. HCEP prevalence did not significantly differ by bed size, ownership type, academic affiliation, or urban versus rural location (**Table 1**).

Table 1. Prevalence and Scope of Health Care Ethics Programs (HCEPs) in U.S. General Hospitals

Hospital Category	Hospitals with a HCEP (N = 462), %	Content Areas Included in HCEP Scope (N = 291), %				
		Clinical Ethics	Business Ethics	Research Ethics	Regulatory Compliance	Ethical Leadership
Bed Size						
1–99 (ref)	96.0	100	16.7	0	27.8	27.8
100–199	97.4	90.9	36.4	13.6	27.3	34.1
200–299	98.8	96.2	36.5	23.1	38.5	50.0
300–399	98.5	100	31.1	26.7**	33.3	46.7
400–499	97.7	97.0	30.3	36.4**	18.2	60.6
500+	99.3	97.0	25.3	35.4**	28.3	36.4
Ownership						
Government (Federal)	100.0	97.0	66.2	19.8	29.8	93.9
Government (non-Federal)	98.3	96.6	37.7	3.9	16.0	43.4
Investor-owned; for-profit	97.5	96.8	15.0	3.8	26.8	27.6
Nongovt. Not-for-profit (Church)	99.7	97.7	26.6	15.8	31.1	40.6
Nongovt. Not-for-profit (Other)	95.4	96.9	22.0	16.0	33.5	29.2
Academic Affiliation						
Major Teaching	100.0	98.9	33.1	44.8**	33.8	52.2
Minor Teaching	99.5	96.6	31.6	17.8**	32.2	50.2
Non-Teaching (ref)	95.6	97.1	21.8	5.2	26.4	24.2
Location						
Urban	98.8	96.6	30.5	27.4*	29.7	44.7
Rural (ref)	95.0	96.0	24.0	16.0	28.0	16.0
Total	97.1	97.0	26.2	12.6	29.0	35.7

* $p < .01$

** $p < .0001$

Scope of HCEPs

Nearly all hospitals (97.0%) reported that their HCEP encompassed clinical ethics functions. Fewer hospitals included other areas within their HCEP's remit: ethical leadership (35.7%), regulatory compliance (29.0%), business ethics (26.2 percent), and research ethics (12.6%). Across hospital categories, the only statistically significant variation was observed for inclusion of research ethics, as detailed in **Table 1**.

On average, HCEPs addressed 2.3 content areas (median = 2, range 0–5). One content area was included in 43.6 percent of hospitals, two areas in 25.1%, three areas in 18.2%, four areas in 6.7 percent, and all five areas in 5.1%. The number of content areas covered differed significantly according to the hospital's academic affiliation and whether it was located in an urban or rural setting (**Table 2**).

Table 2. Scope and Activities of Health Care Ethics Programs (HCEPs)

Hospital Category	Ethics Content Areas (Mean)	Target Educational Audiences (Mean)	Policy Work (Mean)	Other Activities (Mean)
Bed Size				
1–99 (ref)	1.7	2.8	2.3	1.4
100–199	2.0	3.3	2.3	1.7
200–299	2.4**	2.7	2.4	1.8
300–399	2.4	3.3	2.6	1.8
400–499	2.4	4.2	3.2	2.2
500+	2.2	3.7	2.8	1.8
Ownership				
Government (Federal) (ref)	3.1	2.0	2.9	2.0
Government (non-Federal)	2.0	3.1	2.2	1.3
Investor-owned; for-profit	1.7	2.4	1.7	1.5
Nongovt. Not-for-profit (Church)	2.1	3.5	2.6	1.8
Nongovt. Not-for-profit (Other)	2.0	3.1	2.5	1.7
Academic Affiliation				
Major Teaching	2.5****	4.0*	3.1****	2.0***
Minor Teaching	2.3****	3.5*	2.8****	1.8***
Non-Teaching (ref)	1.7	2.7	2.1	1.4
Location				
Urban	1.8**	2.7*	2.7****	1.9****
Rural (ref)	2.1	3.3	1.8	1.1
Total	2.3	3.1	2.4	1.6

* p < .05

** p < .01

*** p < .001

**** p < .0001

Activities of HCEPs

Hospitals reported that their HCEPs provided ongoing ethics education to a variety of audiences, including all staff (77.0%), nurses (59.9%), staff physicians (49.0%), hospital leadership or management (44.2%), other non-clinical staff (40.2%), medical residents (20.3%), and the broader community or general public (18.4%). These proportions were generally consistent across hospital categories, with the exception of staff physicians and

medical residents, which showed significant variation (**Table 3**).

Regarding the number of target audiences per HCEP, 36.8% of hospitals provided education to a single audience, 18.3% to two or three audiences, 29.9% to four or five, and 14.0% to six or seven audiences. Across all hospitals, the average number of target audiences was 3.1 (median = 3, range 1–7). Differences in the number of educational audiences were significantly associated with both academic affiliation and hospital location (**Table 2**).

Table 3. Target audiences for ongoing ethics education provided by health care ethics programs (N = 278)

Hospital Category	All Staff (%)	Leadership/ Management (%)	Staff Physicians (%)	Medical Residents (%)	Nurses (%)	Non-Clinical Staff (%)	Community/ General Public (%)
Bed Size							
1–99 (ref)	88.2	47.1	41.2	0.0	58.8	35.3	11.8
100–199	61.5	46.2	59.0	28.2**	61.5	51.3	25.6
200–299	74.5	33.3	39.2	25.5**	54.9	29.4	11.8
300–399	66.7	40.0	53.3	40.0**	55.6	42.2	28.9
400–499	83.9	61.3	71.0	54.8**	77.4	48.4	25.8

500+	67.4	35.8	65.3	62.1**	64.2	48.4	31.6
Academic Affiliation							
Major Teaching	67.2	35.1	67.7**	70.9**	73.3	53.7	28.2
Minor Teaching	71.2	52.3	64.9**	31.7**	70.8	45.9	16.5
Non-Teaching (ref)	82.3	39.9	35.5	5.3	50.5	34.3	18.3
Location							
Urban	70.1	40.9	58.3*	45.3**	62.6	43.7	24.4
Rural (ref)	79.2	41.7	41.7	12.5	54.2	41.7	29.2
Total	77.0	44.2	49.0	20.3	59.9	40.2	18.4

* p < .01

** p < .0001

Health care ethics programs were actively engaged in multiple policy-related functions. Over half of hospitals reported that their HCEP led the formulation of new policies (52.2%) and provided support to others in developing policies (57.4%). A larger proportion oversaw scheduled reviews of existing policies (75.5%) or assisted colleagues in conducting these reviews (55.1%). The extent of involvement varied across hospitals based on institutional characteristics, as summarized in **Table 4**.

When considering the variety of policy tasks performed, HCEPs addressed an average of 2.4 types of policy work (median = 2, range 1–4). In detail, 26.2% of hospitals engaged in a single policy activity, 35.2% handled two, 10.9% undertook three, and 27.7% were involved in all four types. Differences in policy engagement were significantly linked to both the hospital's academic affiliation and whether it was located in an urban or rural setting (**Table 2**).

Table 4. Policy and other activities of health care ethics programs

Hospital Category	Policy Activities (N = 276)				Other Activities (N = 244)			
	Lead Policy Development (%)	Assist Policy Development (%)	Lead Policy Review (%)	Assist Policy Review (%)	Executive Leadership Rep (%)	Rep on Other Committees (%)	Lead Large-Scale Ethics QI (%)	Community Outreach (%)
Bed Size								
1–99 (ref)	50.0	43.8	81.3	50.0	92.9	21.4	7.1	14.3
100–199	41.0	66.7	71.8	51.3	65.7***	54.3***	22.9	25.7
200–299	56.3	54.2	68.8	56.3	88.9	40.0	26.7	26.7
300–399	64.4	68.9	71.1	60.0	63.2	63.2***	26.3	28.9
400–499	77.4	87.1	80.6	71.0	75.0	75.0***	32.1	39.3
500+	59.8	79.4	68.0	76.3	63.1	60.7***	25.0	33.3
Academic Affiliation								
Major Teaching	69.1	90.2***	74.3	71.6	56.7*	84.0***	32.4***	29.8
Minor Teaching	57.7	74.9***	79.1	64.9	79.9	43.0	28.5***	29.2
Non-Teaching (ref)	45.8	40.3	73.2	45.8	84.6	32.2	6.9	16.2
Location								
Urban	59.7	72.3***	71.9***	66.4***	70.3	58.6**	27.0***	31.1
Rural (ref)	47.8	47.8	65.2	43.5	81.8	27.3	4.5	18.2
Total	52.2	57.4	75.5	55.1	80.5	40.7	17.7	22.6

* p < .05

** p < .01

*** p < .0001

Beyond educational and policy functions, HCEPs were involved in several other activities. An ethics representative held a position within executive leadership in 80.5% of hospitals, while 40.7% provided ethics representation on other hospital committees. Engagement in community outreach was reported by 22.6% of hospitals, and 17.7% of HCEPs led large-scale quality improvement initiatives related to ethics. The prevalence of these activities varied depending on hospital characteristics, as detailed in **Table 4**. On average, HCEPs undertook 1.6 “other” activities (median = 1, range 1–4), with 61.5% performing one activity, 19.7% performing two, 14.7% performing three, and 4.1% engaged in all four activities. Differences in these activities were significantly associated with both academic affiliation and hospital location (**Table 2**).

Staffing, workload, and financial support

In the previous year, hospitals reported an average of 11 individuals (median = 8, range 0–110) performing work for HCEPs, whether paid or unpaid. Most staff contributed minimal time: 8.0 individuals spent less than 1 hour per week, 3.0 spent 1–4 hours, 0.4 spent 5–9 hours, 0.3 spent 10–19 hours, 0.2 spent 20–29 hours, 0.05 spent 30–39 hours, and 0.1 individual spent 40 or more hours weekly. Full-time dedication to HCEP work was uncommon, occurring in only 5.9% of hospitals: 4.9% had one full-time staff member, 0.3% had two, 0.2% had three, 0.4% had four, and 0.3% had five. The total number of individuals involved in HCEPs varied across hospitals based on their characteristics, as shown in **Table 5**.

Additional roles of HCEPs

Beyond educational and policy-related functions, HCEPs were involved in a range of other activities. An ethics representative was part of the executive leadership in 80.5% of hospitals, and 40.7% of HCEPs provided ethics representation on other hospital committees. Community outreach initiatives were conducted by 22.6% of hospitals, while 17.7% led large-scale quality improvement projects focused on ethics. The prevalence of these activities differed according to hospital characteristics, as summarized in **Table 4**. On average, HCEPs carried out 1.6 other activities (median = 1, range 1–4), with 61.5% performing one activity, 19.7% performing two, 14.7% performing three, and 4.1% engaged in all four. Variations in these activities were significantly associated with academic affiliation and hospital location (**Table 2**).

Staffing, workload, and compensation

In the preceding year, hospitals reported an average of 11 individuals (median = 8, range 0–110) involved in HCEP work, whether compensated or volunteer. Most staff contributed minimal hours: 8.0 individuals averaged less than 1 hour per week, 3.0 averaged 1–4 hours, 0.4 averaged 5–9 hours, 0.3 averaged 10–19 hours, 0.2 averaged 20–29 hours, 0.05 averaged 30–39 hours, and 0.1 individual averaged 40 or more hours weekly. Full-time work dedicated to HCEP functions was uncommon, occurring in just 5.9% of hospitals: 4.9% had one full-time staff member, 0.3% had two, 0.2% had three, 0.4% had four, and 0.3% had five. The total number of individuals engaged in HCEP activities varied by hospital characteristics, as detailed in **Table 5**.

Table 5. Staffing, workload, and compensation in Health Care Ethics Programs (HCEPs)

Hospital Category	Mean Number of Individuals Performing HCEP Work (Paid/Unpaid) N=269	Average Workload (Person- Hours/Week) N=251	Mean Number of Individuals Receiving HCEP-Specific Compensation N=228§	Estimated FTEs Allocated to HCEP Work N=188§
Bed Size				
1–99 (reference)	6.6	5.6	0.1	0
100–199	10.0	19.8	0.7	0.1
200–299	15.2****	50.8	1.1	0.1
300–399	18.9****	39.2	0.7	0.1
400–499	15.5	76.3	1.3	0.7
500+	20.8****	104.0****	2.1***	1.0****

Academic Affiliation				
Major teaching	19.3****	109.6****	2.1**	1.0****
Minor teaching	13.9****	29.6	0.6	0.2
Non-teaching (reference)	7.9	17.3	0.5	0
Location				
Urban	17.1****	41.8**	0.9**	0.2*
Rural (reference)	9.4	6.6	0.1	0
Total	11.0	29.1	0.6	0.2

*p < .05; **p < .01; ***p < .001; ****p < .0001

§Values calculated after removing implausible responses

The calculated average total workload for health care ethics programs—representing the sum of all paid and unpaid person-hours per week contributed by HCEP personnel in the previous year—was 29.1 hours, ranging from 0.5 to 1,595 hours, with a median of 9 hours; differences by hospital type are detailed in **Table 5**.

On average, 1.6 staff members per hospital received dedicated salary support or comparable financial compensation for HCEP duties (such as consulting fees or a portion of salary), though this number ranged from 0 to 21, with a median of 0. In 61.6% of hospitals, no staff received specific compensation for HCEP work; one staff member was compensated in 16.7% of hospitals, two staff in 6.5%, three in 5.0%, and four or more in 10.2%. The mean total full-time equivalent (FTE) for HCEP work was 0.3, with a range of 0 to 15 and a median of 0. In most hospitals (76.3%), no FTE was dedicated, 17.1% reported FTE between 0 and 1.0, 4.5% reported 1.1 to 2.0 FTE, and 2.1% reported three or more FTE.

Some survey responses for workload, compensated staff, and FTE were considered unrealistic due to extreme values or internal inconsistencies. For example, one hospital reported 42 individuals each working 20–29 hours weekly with no other hours reported, while another listed seven individuals working less than one hour weekly yet indicated one person received salary support and FTE totaled two.

Excluding implausible responses did not change workload findings, but altered the figures for compensated staff and total FTE. After removing unrealistic answers (N = 228), the average number of compensated staff dropped to 0.6 (range 0–21, median 0); 71.1% of hospitals had no staff receiving HCEP-specific pay, 16.0% had one, 7.2% had two, 2.4% had three, and 3.3% had four or more. Compensation levels varied by hospital size, academic status, and urban/rural location (**Table 5**).

For estimated FTE (N = 188 after removing 17 implausible responses), the mean was 0.2 (range 0–7, median 0). FTE was zero in 83% of hospitals, between 0.001 and 1.0 in 11.4%, 1.1–2.0 in 3.8%, and three or more in 1.4%, with variation by bed size, academic affiliation, and location (**Table 5**).

Projecting from survey responses, approximately 32,000 individuals nationwide were engaged in HCEP-related work in the year preceding the survey.

Regarding funding, when financial support was provided for HCEP work, it primarily came from the hospital (72.9%), followed by multi-hospital systems (23.3%), universities or schools (0.9%), patient billing (0.4%), and other sources (2.5%).

Oversight of ethics programs

In most hospitals, the responsibility for overseeing health care ethics fell to the Chief Executive Officer (28.4%), followed by the Chief Medical Officer (23.8%), Chief Nursing Officer (18.7%), Chief Operating Officer (4.7%), or another designated senior leader (24.4%). Administrators' familiarity with the hospital's ethics activities was rated on average at 8.1 out of 10, where 0 indicated no awareness and 10 represented full awareness.

Key challenges identified in HCEPs

Among the 372 hospitals completing portions of the survey, 232 respondents provided open-ended descriptions of the foremost challenge facing their HCEP. These responses were grouped into five categories: shortages in resources (including time, budget, staffing, recruitment, and training), underuse of ethics services (staff not knowing about or understanding the services, failing to recognize the benefits, or perceiving no need), unclear program scope or objectives, lack of backing from organizational

leadership, and miscellaneous other challenges. **Table 6** presents the percentages of hospitals reporting each type of challenge alongside sample illustrative responses. Small hospitals (1–99 beds) were much more likely to report underutilization as their principal concern (50%) compared with the largest hospitals (500+ beds, 16.5 percent) ($p < 0.01$). Non-teaching hospitals (44.3 percent) and rural hospitals (38.9 percent) also cited underuse more frequently than major teaching hospitals (9.0 percent) and urban hospitals (19.6 percent)

($p < 0.0001$). In contrast, larger hospitals, urban facilities, and major teaching institutions more often highlighted limited resources as their top challenge (63.3 percent of hospitals with 500+ beds vs. 42.9 percent of hospitals with 1–99 beds; 69.5 percent major teaching vs. 47.9 percent non-teaching; 55.6 percent urban vs. 44.4 percent rural), though these differences were not statistically significant. Overall, resource limitations emerged as the most commonly reported challenge, while underutilization predominated in smaller hospitals.

Table 6. Most significant obstacles reported by health care ethics programs (HCEPs) (N = 232)

Major challenge category	% of hospitals ^a	Examples from respondents
Insufficient resources (staffing, funding, time, onboarding, and education)	48.5%	- Committee members, particularly physicians, often lack adequate time and preparation - “Demand for our services keeps rising as people learn about us, but we have no extra budget to expand capacity, broaden education efforts, or proactively identify new needs.” - “There simply aren’t enough people or hours to cover the entire hospital.”
Low demand and underuse of ethics services	34.0%	“Ethics support is only sought when someone wants backup for a tough call. Many attending physicians don’t understand why a consultant would ever challenge their judgment, even in highly complex cases.”
Miscellaneous barriers	22.1%	- Building trusting relationships across the organization - Elevating ethics to the same priority level as quality and performance metrics
Unclear mission or scope of the ethics program	4.6%	- Uncertainty about boundaries with other services (e.g., palliative care, social work) - Confusion between clinical ethics and compliance/regulatory (“ECO”) issues
Limited institutional leadership commitment	3.8%	“The biggest hurdle is genuine institutional buy-in—money, staff, and real support from the C-suite. Right now ethics is seen as a ‘nice-to-have’ rather than something worth seriously investing in and growing.”

^a Percentages represent weighted population estimates. Respondents could describe more than one type of challenge, so columns sum to more than 100%.

Strategies to address challenges

When asked what might help their hospital address or manage its most significant challenge, respondents’ answers grouped into eight categories: securing additional resources (such as more time, personnel, or other necessities); staff training; stronger leadership support; publicity or marketing efforts; quality improvement initiatives; evidence demonstrating the

program’s value; regional or national guidance or mandates; or other solutions not captured by these categories. **Table 7** presents the percentage of hospitals citing each category along with illustrative quotes. Notably, government hospitals were more likely than for-profit hospitals to identify training as a helpful strategy (Federal government: 0.45; Non-federal government: 0.62; For-profit: 0.18; $p < 0.01$).

Table 7. Proposed strategies for overcoming challenges of Health Care Ethics Programs (HCEPs) (N = 232)

Type of Strategy	% of Hospitals ^a	Illustrative Quotes
Staff training	37.2	Webinars covering ethical issues in rural settings; online courses; internal training programs or hiring a lead clinical ethicist; educating medical staff about the components and procedures of ethics consultations
Additional resources (time, personnel, or other needs)	30.3	Increasing budgetary support for clinical ethics; ongoing discussions with administration and exploring philanthropic funding; ultimately emphasizing the importance of adequate funding

Other solutions	29.5	Stabilizing teams through leadership that fosters a shared purpose; implementing triggers for ethics consultations; ensuring physicians respect ethics committee recommendations even when they conflict with personal judgments
Enhanced leadership engagement	9.4	Presenting a strategic Bioethics plan to the hospital board and providing annual reports to the board
Data demonstrating HCEP value	8.0	Avoid evaluating ethics services solely by patient satisfaction or traditional quality metrics; building a strong business case to justify an ethicist position
Publicity and marketing	6.0	Developing marketing materials; promoting awareness of the ethics committee's role and functions
Regional or national support/mandates	5.5	Participation in state networks; adherence to regulatory or accreditation mandates; aligning with national standards for adequate program support
Quality assurance/improvement	5.2	Creating quality measures to assess the impact of ethics consultations; formalizing processes for curbside consults; incorporating ethics knowledge into performance standards

a Percentages reflect population estimates adjusted for sampling; multiple codes could be applied per response, so totals exceed 100%.

This national survey of a random sample of U.S. hospitals provides a detailed description of the characteristics of health care ethics programs (HCEPs) beyond ethics consultation, focusing on prevalence, scope, activities (including education, policy, and other functions), staffing, workload, financial compensation for program personnel, reporting structures, the greatest challenges faced, and potential solutions.

Limitations

Several limitations should be acknowledged. First, the study may overestimate the proportion of hospitals with HCEPs, since hospitals lacking such programs may have been less likely to identify a “best informant” and participate. Nevertheless, there were no significant differences in demographic variables between participating and non-participating hospitals [23]. Second, among hospitals reporting a HCEP, only one without an ethics consultation service responded to the survey questions, meaning the results provide minimal insight into hospitals without consultation services. Third, data were collected from a single respondent per hospital, which may not capture all HCEP activities, particularly if programs operate in silos [5]. Additionally, unlike ethics consultation (EC), which has standardized definitions and practices, HCEPs lack widely accepted definitions or standards; although a broad definition was provided in the survey, respondents likely interpreted the term differently. Finally, responses regarding salary or compensation may be unreliable due to missing data and implausible answers.

Prevalence, scope, and activities of HCEPs

Despite these limitations, this study represents the first systematic national survey of HCEPs in U.S. hospitals, providing a baseline for future research. The high prevalence of HCEPs (97%) aligns with expectations, considering that 93% of hospitals had ethics committees by 1999, and reflects the broad survey definition encompassing all organized ethics activities.

Regarding scope, nearly all HCEPs included clinical ethics functions, whereas functions such as ethical leadership, research ethics, regulatory compliance, and business ethics were reported in only a minority of hospitals. This may reflect either that these functions exist outside the HCEP or are not formally addressed at all. For instance, research ethics may be handled by internal or external IRBs separate from HCEPs; while only 12.6% of hospitals reported research ethics under HCEPs, other hospitals may address it independently. Similarly, only a minority reported ethical leadership, business ethics, or regulatory compliance as part of HCEPs, though these activities likely occur elsewhere in the hospital. For example, compliance programs, which often integrate ethics and regulatory adherence, are widely implemented but may not be formally linked to HCEPs [27–29].

HCEPs were more actively engaged in some activities than others. Most were responsible for ongoing ethics education for staff, particularly nurses, but fewer provided education to other audiences. Policy work predominantly involved reviewing existing policies, with less frequent involvement in developing new policies or assisting others with policy review. Although most HCEPs had representation in executive leadership, fewer participated in other committees, led hospital-wide

quality improvement initiatives related to ethics, or engaged in community outreach.

Extent of integration of HCEPs

The results provide initial insights into how integrated HCEPs are across U.S. hospitals. Fully integrated ethics programs are generally characterized by a coordinated structure, wide-ranging scope, and the use of multiple strategies to interact with other departments and personnel throughout the institution. While this survey did not assess structural coordination directly, it did capture information on the breadth of HCEPs' scope and activities. Most hospitals reported that HCEPs had a relatively narrow scope, typically covering only one or two of the listed content areas; by contrast, 11.8% of hospitals had programs that addressed four or five areas. Moreover, the average number of content areas was higher in academic medical centers, suggesting that these hospitals tend to operate broader HCEPs.

A similar trend was observed regarding program activities. Most HCEPs provided education to only a few designated target audiences, yet in 14.0% of hospitals, the HCEP reached six or seven audiences. In terms of policy-related work, while most programs engaged in only one or two types, 27.7% participated in all four categories. Regarding other activities, only 4.1% of hospitals undertook all four listed functions. Across these measures—content areas, target audiences, policy involvement, and other activities—the degree of integration appeared higher in urban and academically affiliated hospitals, indicating that HCEPs in these settings are generally more comprehensive and interconnected.

Staffing, workload, and compensation

Caution is warranted when interpreting data on staffing and compensation, due to missing responses and some implausible answers, which suggest that respondents may have been uncertain about the questions or misunderstood them. Nonetheless, some noteworthy observations emerge. The estimated number of individuals performing HCEP work in the year before the survey was 32,000, compared with 27,000 performing ethics consultation [23], indicating that roughly 84% of HCEP personnel also engage in consultation activities. Hospitals that were large, teaching-oriented, or urban allocated substantially more resources to HCEPs than smaller or non-teaching institutions, including a higher number of personnel, more hours devoted to HCEP work,

greater financial compensation for program staff, and higher total FTEs. Compensation differences were especially pronounced: hospitals with 500+ beds and major teaching hospitals averaged 1.0 FTE, compared with 0 FTEs for smaller or non-teaching hospitals. It is important to note that the survey captured only staff receiving explicit financial compensation for HCEP work (e.g., consulting fees or salary percentage). Personnel performing HCEP duties voluntarily, as collateral assignments, or within administrative/protected time may have been fully “compensated” in practice without receiving direct payment. Moreover, percent effort allocation is common in academic settings but less familiar elsewhere, potentially leading to underestimation of compensation in non-academic hospitals.

Challenges and potential solutions

Resource limitations were the most commonly cited challenge overall; however, in hospitals with fewer than 100 beds, underutilization was reported most frequently. Underutilization encompassed low staff awareness, insufficient understanding of HCEP functions, limited recognition of their value, or a perceived lack of necessity. This finding aligns with a 2007 national survey of critical access hospitals, which included 381 administrators: only 60% reported having an ethics committee or consultation service, and 28% did not perceive a need for such services despite their absence [30]. Whether underutilization is problematic likely depends on whether clinical staff are sufficiently competent to address ethical issues independently and in a manner that adequately meets stakeholder needs; this study cannot determine that, but it identifies an important area for further investigation.

Conclusion

Navigating the ethical complexities of hospital operations is inherently challenging due to the diverse stakeholders and multifaceted organizational structures involved. Our findings indicate that nearly every U.S. hospital operates a health care ethics program (HCEP), yet these programs show considerable variation in their scope, activities, personnel, workload, and compensation practices. Only a small proportion of HCEPs can be characterized as fully integrated, employing a coordinated, systematic approach that spans multiple ethical domains and actively links with other hospital

functions. Across hospitals, insufficient resources emerge as the primary barrier to effective HCEP functioning, while in smaller facilities, the most pressing issue is limited utilization of available ethics services. These insights provide a foundation for ongoing dialogue regarding the optimal design, integration, and resourcing of HCEPs to support ethically sound patient care in hospital settings.

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Ethics Statement: This study was performed in accordance with relevant guidelines and regulations. The survey was reviewed and determined to be exempt from IRB review by the Chesapeake (now Advarra) IRB and the Office of Human Subjects Research Protection (OHSRP) at the National Institutes of Health. The OHSRP determination specified that Federal regulations for the protection of human subjects do not apply to this study. The OHSRP determination of Not Human Subjects Research is based on the interpretation of 45 CFR 46 under "Research Involving Coded Private Information or Biological Specimens" [31] and Guidance on Engagement of Institutions in Human Subjects Research [32]. The activity was designated EXEMPT, and was entered in the OHSRP database (Exempt #13456).

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