Report E-2-11

CALIFORNIA MEDICAL ASSOCIATION
HOUSE OF DELEGATES

October 15-17, 2011

TITLE: CLINICAL ETHICS CONSULTANTS – TRAINING AND STANDARDS

Introduced by: Board of Trustees
Paul R. Phinney, MD, Chair

Author: Council on Ethical Affairs
Robert E. Peters, MD, Chair

Summary of Issue

At its 2010 meeting, the House of Delegates referred for study and report back Resolution 502-10, Clinical Ethics Consultants – Training and Standards:

Resolution 502-10

CLINICAL ETHICS CONSULTANTS – TRAINING AND STANDARDS

RESOLVED: That CMA study and report back to the 2011 House of Delegates on the training, scope of practice, standards for and credentialing of clinical ethicists as they apply to individuals working in hospital settings.

ACTION: Referred for study and report back
Priority: 3.3

Existing CMA Policy

None.

Discussion

The CMA Council on Ethical Affairs (“CEA”) studied and discussed Resolution 502-10 at its February 22, March 29, May 3 and June 10, 2011 meetings. The CEA considered the background material originally submitted by the author as well as other pertinent information gathered through a literature and resource search. The author of the resolution is a consultant to the CEA and participated in all discussions.

In recent years, clinical ethics consultations have been expanding exponentially in medical centers across the nation. This rapid growth has brought with it concern over the quality and
training of ethics consultants. As ethics consultations are being provided increasingly by a single individual, hereafter referred to as the “ethics consultant,” questions arise about the need for more uniform standards for ethics consultants and consultations, as well as concerns about the cost and feasibility of enforcing any such standards. This report offers a brief overview of the developments in the field of clinical ethics as a profession over the past decade and highlights the efforts on the part of some members of the discipline to formalize the profession with certification and credentialing processes. It explores the qualities suggested by some as being necessary to conduct effective ethics consultation and offers the perspective of those who resist formalizing the discipline with official status and defined standards. The liability incurred in the consultation process, as well as options available to address it, are also discussed. Finally, recommendations for further CMA action are offered.

**What Is the Scope of Health Care Ethics Consultation and What Is its Principal Goal?**

Historically, ethics committees were formed to provide consultation services for decisions to limit or withdraw life-sustaining treatment for neurologically devastated or dying patients.\(^1\) Later, they also began to provide bioethics education and consultation regarding relevant institutional policies. In more recent years, ethics committees and individual ethics consultants have begun offering consultation services that cover a much broader scope of issues. Consequently, the definition of health care ethics consultation services has expanded; it is currently defined by one professional group as “a set of services provided by an individual or a group to help patients, families, surrogates, health care providers or other involved parties address uncertainty or conflict regarding value-laden concerns that emerge in health care.”\(^2\) The central goal of ethics consulting is to, “improve the provision of health care and its outcome through the identification, analysis and resolution of ethical questions or concerns.”\(^3\)

**Current State of Ethics Consultation in United States Hospitals**

Bioethics consultation is now available in most hospitals. There are a wide range of structures, models, and methods. Consultations may be conducted by an independent consultant, a bioethics committee, or a subcommittee team. Consultants have generally been trained or are experienced in bioethics and typically, they have a background in medicine, law, philosophy, theology, public health, or a related field. Ethics committees usually operate under the auspices of the medical staff or administration and they are often responsible for services ranging from development of bioethics policies to providing bioethics education to individual case consultation.

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\(^3\) See ASBH 1998 Core Competencies Report, p. 6.
A 2007 study looked at the state of ethics consultation committees in United States hospitals. This study revealed that 95% of hospitals either had an ethics committee or were in the process of developing one (even hospitals with fewer than 100 beds). The study also found that considerable resources were invested in ethics consultations in the United States (approximately 29,000 individuals devoted more than 314,000 hours to ethics consultation per year). The most commonly used model of ethics consultation was a small-team model with a median of four individuals performing each consultation. A high proportion of individuals performing ethics consultation were clinicians (mostly physicians and nurses) with a very small proportion of non-clinicians. 41% of the individuals who performed ethics consultations had learned the necessary skills through practical experience with formal, direct supervision while only 5% had completed a fellowship or graduate degree program in bioethics. While many ethics consultation practices were similar across the board in goals of intervening to protect patient rights, accepting consultation requests from anyone and publicizing their services, practices were different in that 54% of committees made it a habit of seeing the patient, whereas the remainder did so infrequently or not at all. Only 59% of ethics committees required notification to patient or surrogates and 49% of committees used some form of voting method to make decisions. Many of the committees did not have explicit policies or procedures in place. Finally, some committees always recommended specific actions, some made no recommendations, and some offered a wide range of options.

**Suggested Standards for the Operation and Salient Characteristics of an Ethics Committee**

Despite the multiplicity of approaches to ethics consultation and committee structure in American hospitals, several characteristics have been identified for the successful operation of any ethics committee. The suggestions are: (1) easy access to the ethics committee and a plan for responding to requests; (2) a clear process for gathering necessary information needed for decision and appropriate arrangements to make sure all relevant stakeholders are heard; (3) a formal note in the medical record regarding the ethics consultation; (4) a standard format for any medical chart entries; (5) an ethics committee that is collaborative,

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5 Contrast Hoffman, D., et. al. (2000) Are Ethics Committee Members Competent to Consult? *Journal of Law, Medicine & Ethics*, 28(1) (hereafter “Hoffman 2000, Are Ethics Committee Members Competent to Consult?”), at p. 30, which states that their study indicated a general lack of institutional support for ethics committees, despite chairs’ perceptions of positive institutional support.

6 See Hoffman 2000, Are Ethics Committee Members Competent to Consult?, p. 30, which states that their study indicated a lack of formal educational preparation on the part of ethics committee members who perform consults (for example, in their study, fewer than 1/3 of committee members had a formally trained philosopher or bioethicist and only one chair had a degree in bioethics).

7 See ASBH 1998 Core Competencies Report, p. 14, which states there should be “adequate documentation.”

integrative and transparent in functioning; (6) institutional and peer oversight; (7) ensuring all clinical ethicists are qualified and competent; (8) maintaining standards for credentialing of clinical ethicists; (9) adequate compensation for services rendered; (10) formal training program for clinical ethicists; and (11) a robust quality improvement process. 

It is important to note that currently there is no uniform established method for structuring or conducting a successful ethics program or consultation. Indeed, the variety of methods, disciplines and diversity of members reflects the conditions that gave rise to contemporary bioethics. The lack of a coherent moral model for resolving ethical dilemmas, combined with technology, population diversity, and court rulings has demanded a process to resolve ethical dilemmas, and several have developed, spontaneously, and without any clear direction about how to do things beyond the opinions of respected scholars and the practical experience of what seems to work. One thing is clear, resolution cannot be via fiat; rather, effective resolution combines clinical judgment, listening skills, mediation and complex knowledge. To date, formal training programs are varied in their approach and methods of consultation. While differing schools of thought continue to coexist, the definition of “good practice” still eludes precise metrics.

Current Efforts to Standardize Ethics Consultation

The American Society for Bioethics and Humanities (ASBH) is the largest and most organized society of professionals in the field of Biomedical Ethics. It currently has approximately 1550 enrolled members (1400 domestic and 150 international). ASBH’s stated purpose is to, “promote the exchange of ideas and foster multidisciplinary, interdisciplinary, and interprofessional scholarship, research, teaching, policy development, professional development, and collegiality among people engaged in all of the endeavors related to clinical and academic bioethics and the health-related humanities.”

In 1996, ASBH formed a Task Force to develop standards for health care consultants that provide ethics consultations to patients, health care providers or others. The Task Force included 21 scholars in the field of health care ethics, policy and patient care and represented a cross section of professional fields including medicine, nursing, law, philosophy, and religious studies. The ASBH “Core Competencies for Health Care Ethics Consultation” was adopted and was published by ASBH in October 1998. The report sets forth the core competencies that the Task Force identified as necessary for doing health care ethics consultation and was intended to guide ethics consultants, educational programs that help prepare individuals, teams or committees to do ethics consultations, and all health care organizations that offer ethics consultation services. The original core competencies and pending revisions are briefly noted below:

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10 See About Us: Purpose of ASBH located at http://www.asbh.org/about/content/purpose.html.
The 1998 document produced by the Task Force on Standards for Bioethics Consultation suggests three general areas of competency that are necessary to provide bioethics consultation. Members of ethics committees may possess a limited set of the competencies described, as long as the committee as a whole has the complete set. For an individual conducting ethics consultation as a committee of one, however, the ASBH recommends that all three be mastered in the same person.12

The competencies include a set of skills, a body of knowledge, and a good character.13

Core Skills

ASBH suggests that four types of core skills are required for successful ethical consulting: (1) ethical assessment skills;15 (2) process skills;16 (3) interpersonal skills;17 and (4) the skills needed to run an ethics consulting service (including evaluative skills.)18

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12 See ASBH 1998 Core Competencies Report, p. 20, which states that ASBH recommends that any individual consultant should have all the core competencies required for ethics consultation.

13 Core Competencies for Health Care Ethics Consultation 2.4 Character and Ethics Consultation. American Society for Bioethics and Humanities, Glenview, IL 1998.


15 See ASBH 1998 Core Competencies Report, p. 23, which states that ethical assessment skills include such things as the ability to assess the social and interpersonal dynamics of the consultation (e.g., power relations, racial, ethnic, cultural and religious differences) and to identify relevant values of involved parties.

16 See ASBH 1998 Core Competencies Report, pp. 23-24, which states that process skills include such thing as the ability to use research tools to identify sources of ethics knowledge and to document consults clearly and thoroughly in internal ethics consultation service records as well as in patient records.

17 See ASBH 1998 Core Competencies Report, p. 22, which states that interpersonal skills include listening well and communicating interest, respect, support, and empathy to involved parties and enabling involved parties to communicate effectively and to be heard by other parties.

18 See ASBH 1998 Core Competencies Report, p. 34, which states that skills necessary to run an ethics consulting service include such things as negotiating and communicating realistic and appropriate criteria for evaluation of different kinds of consult (e.g., individual, team or group format; case or non-case content) and recognizing and analyzing possible structural or systemic barriers to effective consultation process in specific cases.
ASBH has proposed an idea of the type and extent of knowledge that ethics committee consultants should possess. These include moral reasoning and ethical theory, bioethical concepts, health care systems, professional codes, institutional ethics, and relevant health law. ASBH has suggested a model table of the type and level of knowledge that both members on an ethics committee must possess as a whole and the type and extent of knowledge that each individual ethics consultant should possess. The ASBH-suggested model table is included below for reference:

<table>
<thead>
<tr>
<th>KNOWLEDGE AREA</th>
<th>Individual/At Least One Member of Group Needs</th>
<th>Every Team Member</th>
<th>Every Committee Member Needs</th>
<th>Individual/At Least One Member Can Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moral Reasoning and Ethical Theory as it Relates to Ethical Consulting</td>
<td>Advanced</td>
<td>Basic</td>
<td>Basic</td>
<td>Not Required</td>
</tr>
<tr>
<td>Bioethical Issues and Concepts that Typically Emerge in Ethics</td>
<td>Advanced</td>
<td>Basic</td>
<td>Basic</td>
<td>Not Required</td>
</tr>
<tr>
<td>Health Care Systems as They Relate to Ethics</td>
<td>Advanced</td>
<td>Basic</td>
<td>Basic</td>
<td>Not Required</td>
</tr>
<tr>
<td>Clinical Context as it Relates to Ethics Consultation</td>
<td>Advanced</td>
<td>Basic</td>
<td>Basic</td>
<td>Not Required</td>
</tr>
<tr>
<td>Health Care Institution in which the Consultants work, as it Relates to Ethics Consultation</td>
<td>Advanced</td>
<td>Basic</td>
<td>Basic</td>
<td>Not Required</td>
</tr>
<tr>
<td>Local Health Care Institution’s Policies Relevant for Ethics Consultation</td>
<td>Advanced</td>
<td>Basic</td>
<td>Basic</td>
<td>Not Required</td>
</tr>
<tr>
<td>Beliefs and Perspectives of Patient and Staff Population where One Does Ethics Consultation</td>
<td>Advanced</td>
<td>Basic</td>
<td>Basic</td>
<td>Not Required</td>
</tr>
<tr>
<td>Relevant Codes of Ethics, Professional Conduct and Guidelines of Accrediting Organizations as They Relate to Ethics Consultation</td>
<td>Basic</td>
<td>Not Required</td>
<td>Not Required</td>
<td>Advanced</td>
</tr>
<tr>
<td>Health Law Relevant to Ethics Consultation</td>
<td>Basic</td>
<td>Basic</td>
<td>Basic</td>
<td>Advanced</td>
</tr>
</tbody>
</table>

According to ASBH, traits such as tolerance, patience, and compassion are relevant to effective consultation. Other characteristics called for include honesty, forthrightness, courage, prudence, integrity, and humility.

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19 See ASBH 1998 Core Competencies Report, p. 29.
The ASBH Core Competencies manual is currently being edited and revised, with release expected sometime in 2011. According to a memo of the Core Competencies Task Force, the new edition will change or clarify a number of standards and a new section will be added on emerging process standards for ethics consultation.

Some in the field reject the ASBH efforts. In addition, there is ongoing debate as to whether bioethics consultation is a “profession” that should be standardized given the variability in type and length of training, the lack of self-regulation, the lack of formal licensing procedure, and the lack of an official professional code of ethics.

**Formal Training or Credentialing Program for Individual Ethics Consultants**

The issue of credentialing is particularly controversial. While it is recognized that some programs have less-than-qualified persons participating in ethics consultation, the mechanism to identify and develop best practices is controversial. Assuring that any individual represents all three of the core competencies, especially those related to character and attitude, is a daunting task. Some argue that credentialing would provide institutions the appropriate amount of oversight over the ethics committees and individual consultants. Others argue that credentialing would stifle the richness and diversity of the field. ASBH experts state that the following components must be emphasized in any credentialing program: 1) knowledge; 2) interpersonal skills; 3) educational background; and 4) completion of an apprenticeship.

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22 See Hoffman 2000, Are Ethics Committee Members Competent to Consult?, p. 30 which states that their study indicated a lack of formal educational preparation on the part of ethics committee members who perform consults (for example, in their study, fewer than 1/3 of committee members had a formally trained philosopher or bioethicist and only one chair had a degree in bioethics).

23 See Dubler 2009, Clinical Ethics Consultation, p. 32, which suggests Clinical Ethicists should know the: (a) vocabulary and nomenclature of clinical medicine, (b) central concepts, principles and theories of bioethics, (c) relevant health law, (d) codes of professional ethics and (e) institutional policies and practices; See also Dubler, N. et. al. (2000) Credentialing Ethics Consultants; An Invitation to Collaboration, The American Journal of Bioethics, 7(2) (hereafter “Dubler 2000, Credentialing Ethics Consultants”), pp. 36-37; See also Hoffman 2000, Are Ethics Committee Members Competent to Consult?, p. 30.

24 See Dubler 2009, Clinical Ethics Consultation, p. 32, which suggests consultants should have training and proficiency in recognizing and managing the social, psychological and spiritual aspects of ethics consulting, and in the techniques of facilitation; See also Dubler 2000, Credentialing Ethics Consultants, p. 36.

25 See Dubler 2009, Clinical Ethics Consultation, p. 32, which suggests consultants should have participated in a formal training program to assure that they have the relevant knowledge; See also Dubler 2000, Credentialing Ethics Consultants, p. 36.
Liability Issues

When considering the field of clinical ethics, it is important to note the potential liability issues involved. It is difficult to provide a conclusive liability analysis due to the lack of standardization in the field. Nevertheless, potential and theoretical issues are identified for consideration.

Tort Liability

There have been a few instances where a legal ethics committee or bioethicist has been named as a defendant in a lawsuit. Though there is some evidence that those who have been sued have received some coverage under their institution’s policies of liability insurance, there is still a growing concern regarding liability issues.

Theoretically, a clinical ethicist or ethics committee could be held civilly liable for a number of torts based on theories of vicarious liability, tortious conduct or negligence.

26 See Dubler 2009, Clinical Ethics Consultation, p. 32, which suggests consultants should complete a supervised period of practice similar to a clinical fellowship; See also Dubler 2000, Credentialing Ethics Consultants, p. 37, which suggests the apprenticeship should be at least 1 year long.

27 See Bouvia v. Superior Court, 225 Cal. Rptr. 297, 297 (Cal. Ct. App. 1986) where Elizabeth Bouvia named an ethics committee (both as a whole and its members individually) as a defendant after physicians acting under the committee’s directions inserted a nasogastric tube in Bouvia against her wishes. For an extensive list of cases, see ASBH 2004 Ethics Consultation Liability Report, p. 7.


29 See Sontag, David. N., (2002) Are Clinical Ethics Consultants in Danger? An Analysis of the Potential Legal Liability of Individual Clinical Ethicists, University of Pennsylvania Law Review, (December) (hereafter “Sontag 2002, Potential Legal Liability of Individual Clinical Ethicists”), p. 688, which states the supervisory party may be held liable for actionable conduct of a subordinate or associate because of the relationship between the two. See also pp. 688-690 which states that any ethics committee or ethicist that has control over the conduct of a physician (such as when ethics committees issue binding decisions) may be held liable.

30 See Sontag 2002, Potential Legal Liability of Individual Clinical Ethicists, p. 692, which states a clinical ethicist may also be held liable for tortious conduct if he orders or induces the conduct or knows or should know of circumstances which would make the conduct tortious if it were his own. Consequently, if the ethicist orders a binding decision or issues a non-binding decision and attempts to persuade the physician or patient to accept the proposal, the ethicist could be found liable for an intentional tort committed by the physician.

31 Black’s Law Dictionary p. 434 (pocket ed. 1996) defines negligence as “the failure to exercise the standard of care that a reasonably prudent person would have exercised in the same situation.” See also Sontag 2002, Potential Legal Liability of Individual Clinical Ethicists, pp. 694-700, which states a court may decide that a clinical ethicist owes a duty to the patient to act in a reasonable fashion because the potential harm to the patient is clearly foreseeable. If a court determines that this duty is breached and that actual harm and causation can be established, an ethicist may be held liable.
Liability Insurance

Citing a few key reasons, some experts have suggested that liability insurance may be necessary in today’s litigious society. First, the ASBH’s core competencies (though voluntary) are widely accepted and may be considered by some courts to set the standard of practice. Second, the field of ethics is expanding quickly and more ethics consultants are performing consultations outside of their traditional employment role (and as such are not covered by institutional insurance policies). Finally, a professional liability policy may be a wise proactive measure that would cover most of the costs and legal fees in the event of a lawsuit.

Protections

Both state and federal law affords some protections against compelled disclosure of documents and information of organized medical staffs, medical societies and peer review bodies that meet certain requirements. Additionally, the law affords some protection for communications and records within the quality assurance context. Consequently, it is important for health care organizations to evaluate how all aspects of ethical consulting are built into the framework of the greater medical organization as some aspects of ethics consultation may fall within these protections depending on how the consultation methods are structured.

Metrics for Success

For several reasons, it has been difficult to both track success and develop metrics to see if the clinical ethics field is moving in the right direction and improving the quality of health care. For example, an ethics committee may contain a physician, a lawyer and a clergy member. This could be viewed as presenting problems as to what types of professional standards or duties each member of a committee can be held. It may also be seen as reflective of the interdisciplinary nature of committees and the strength of team inclusiveness. Because ethicists provide consultation in so many different settings and in so many different forms, it has been difficult to label one method as more successful than another. Rather, scholars acknowledge the contributions of various theories and methods which might dictate a particular approach depending on the problem case. Success is also relevant to the organizational support and culture, the relationships between the consultants and the physicians, staff and administration, and expectations. Several groups of scholars are attempting to develop some metrics.

32 See ASBH 2004 Ethics Consultation Liability Report, pp. 29-43, which discusses the considerations that should be made when choosing an appropriate individual liability insurance policy in depth.


34 See California Evidence Code §1157.

Conclusions

Formal structures to deal with ethical dilemmas that occur in the clinical practice of medicine have been in place for over 25 years in many centers. In most centers this has taken the form of an ethics committee, and the method for addressing these dilemmas has become known as an “ethics consultation.” Individuals participating in this activity are seen, by some, as becoming involved in the clinical practice of medicine, in so much as their recommendations and suggestions impact the course of clinical care that is delivered to an individual patient. And yet, despite over 40 years of history within the discipline, the field of bioethics, medical ethics, and clinical ethics has failed to congeal into a cohesive body, recognizing a single set of principles, methods, and definitions of success. Since 1970, the specialties of Emergency Medicine, Gerontology, Occupational Medicine, Palliative Care, and soon Hospitalist Medicine, just to name a few, have been conceptualized, created, and certified. And yet bioethics remains amorphous, despite the efforts of a dedicated cadre of bioethicists.

Clearly, there have been efforts to define the qualities and competencies in the field. The American Society of Bioethics and Humanities has done a fine job. However, ASBH’s set of competencies describes an ideal: someone with well developed skills, an extensive body of knowledge, and exemplary character. In the real world, this ideal individual is difficult to find.

While there is a strong voice to organize and move into a professional model, there are solid arguments for continuing the field without formal certification and professional specialization. Without identifying best practice, it is impossible to dictate compliance.

We recognize the efforts to formalize the discipline and applaud the efforts to further understand the nature of what it is that bioethicists do. Nevertheless, there is still not adequate consensus within the field on the appropriate means and qualifications of ethics consultants to make a strong recommendation for action at this point.

Recommendations:

Based on information presented by the Council on Ethical Affairs, the Board of Trustees recommends the following:

RECOMMENDATION 1: That the following substitute for Resolution 502-10 be adopted:

RESOLVED: That CMA acknowledge the diversity of forms and processes that currently exist in the area of medical ethics consultation and continue to monitor developments in the area of clinical ethics consultation, especially as it impacts the delivery of medical care; and be it further
RESOLVED: That the CMA Organized Medical Staff Section be made aware of the issues that exist in the area of medical ethics consultation and its impact on the delivery of medical care; and be it further

RESOLVED: That CMA be available for consultation with malpractice insurers and others exploring the legal and liability issues involved in clinical ethics consulting; and be it further

RESOLVED: That this report and related references be made available to CMA members and members of the CMA Organized Medical Staff Section; and be it further

RESOLVED: That CMA, when politically feasible and appropriate, support the concept of formal training for clinical ethics consultants but leave the determination of the substantive requirements of that position to individual health care institutions.

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Appendix

Existing Policy on Clinical Ethics Committees

While there is no existing CMA or AMA policy directly related to the training, scope of practice, standards for and credentialing of clinical ethicists, policy governing Clinical Ethics Committees does exist and provides a relevant background when studying Clinical Ethics Consultants.

AMA Policy E-9.115: Ethics Consultations

Ethics consultations may be called to clarify ethical issues without reference to a particular case, facilitate discussion of an ethical dilemma in a particular case, or resolve an ethical dispute. The consultation mechanism may be through an ethics committee, a subset of the committee, individual consultants, or consultation teams. The following guidelines are offered with respect to these services: (1) All hospitals and other health care institutions should provide access to ethics consultation services. Health care facilities without ethics committees or consultation services should develop flexible, efficient mechanisms of ethics review that divide the burden of committee functioning among collaborating health care facilities. (2) Institutions offering ethics consultation services must appreciate the complexity of the task, recognizing the potential for harm as well as benefit, and act responsibly. This includes true institutional support for the service. (3) Ethics consultation services require a serious investment of time and effort by the individuals involved. Members should include either individuals with extensive formal training and experience in clinical ethics or individuals who have made a substantial commitment over several years to gain sufficient knowledge, skills, and understanding of the complexity of clinical ethics. A wide variety of background training is preferable, including such fields as philosophy, religion, medicine, and law. (4) Explicit structural standards should be developed and consistently followed. These should include developing a clear description of the consultation service’s role and determining which types of cases will be addressed, how the cases will be referred to the service, whether the service will provide recommendations or simply function as a forum for discussion, and whether recommendations are binding or advisory. (5) Explicit procedural standards should be developed and consistently followed. These should include establishing who must be involved in the consultation process and how notification, informed consent, confidentiality and case write-ups will be handled. (6) In general, patient and staff informed consent may be presumed for ethics consultation. However, patients and families should be given the opportunity, not to participate in discussions either formally, through the institutional process, or informally. (7) In those cases where the patient or family has chosen not to participate in the consultation process, the final recommendations of the consultant(s) should be tempered. (8) In general, ethics consultation services, like social services, should be financed by the institution. (9) A consultation service should be careful not to take on more than it can handle, i.e., the complexity of the role should correspond to the level of sophistication of the service and the resources it has available. As a result, some services may offer only information and education, others a forum for discussion but not advice, others might serve a mediation role, and some might handle even administrative or organizational ethics issues. (IV, V) Issued June 1998 based on the report "Ethics Consultation," adopted December 1997.

AMA Policy H.385.956: Payment for Ethics Consultations

The policy of the AMA is that physician provision of clinical ethics consultations for the guidance of individual patients or physicians, apart from and beyond their duties as members of hospital ethics committees, is an appropriately compensable medical service. Payment for these services should be made when they are reported with the appropriate existing CPT consultation codes (and prolonged physician service codes, if appropriate). The AMA recognizes that this does
not address any aspect of payment for ethics consultations by non-physicians. (CMS Rep. 16-I-94; Reaffirmed: CMS Rep. 5, A-04)

CMA Policy BOT Min 10-11-85-4: Ethics Committees in Hospitals
CMA endorses the concept of the Ethics Committees in Hospitals: Observation, Education and Development ECHOED program, subject to observance of confidentiality regarding individual physician and patient records.\(^{36}\)

CMA Policy HOD808-92: Ethics Committees and Patient Care
CMA urges that ethics committees remain in their very helpful and proper role as an advisory body and not be allowed to become decision making committees or bodies concerning care of specific patients.

\(^{36}\) Although the ECHOED program no longer exists, this policy reflects CMA’s historical support of the concept of official hospital ethics committees.