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TARGET ARTICLE



Clinical Ethics Fellowship Programs in the U.S. and Canada: A Descriptive Study of Program Characteristics and Practices

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ABSTRACT

To address the current lack of knowledge about clinical ethics fellowship programs (CEFPs), we surveyed all 36 programs in the U.S. and Canada. The number of CEFPs has grown exponentially over the last 40 years and far exceeds previous estimates. Commonalities among CEFPs include: 88.8% require an advanced degree or rarely accept applicants without one; 91.7% of programs do not restrict applicants to a specific background such as medicine or philosophy; and 88.9% of programs compensate fellows. CEFPs vary widely on numbers of fellows trained in the last 3 years (1–111), numbers of consultations performed by each fellow (0–450), and salaries paid (\$0–\$95,000). Less than half of programs meet CEFP standards established by ABPD. Nonpaying programs and larger programs tend to have lower admission standards and lower expectations for fellows. We hope these data will help inform CEFP standards that promote quality and consistency without stifling desirable diversity and innovation.

KEYWORDS

Professional ethics; education; ethics committees; health care delivery; health policy

INTRODUCTION

While clinical ethicists are now commonplace in hospitals in both the U.S. and Canada (Danis et al. 2021; Fox et al. 2021; Frolic and Practicing Healthcare Ethicists Exploring Professionalization (PHEEP) Steering Committee 2012), there are no widely agreed upon standards for how clinical ethicists should be trained. Many look to the clinical ethics fellowship program (CEFP) as the gold standard (Ethicists Strive 2022; Wasson 2022), yet little is known about these programs, their programmatic objectives, how they are structured, and how they operate beyond the fact that they vary widely (Bibler et al. 2024; Moore and Horner 2020). Published reports about CEFPs have mostly consisted of descriptions of individual programs (Moore and Horner 2020; Bibler et al. 2024; Crites and Horsburgh 2020; Siegler, Lantos, and Roberts 2002; Langlois, Makkar, and Szego 2022; Andolfi et al. 2020) or informal descriptions of a small number of programs based on convenience samples (Ethicists Strive 2022; Moore and Horner 2020). Perhaps the most rigorous attempt to publish systematic data about ethics training programs is a “crowdsourcing project” by the Association of Bioethics Program Directors (ABPD), the results of which appear in a searchable

database on the organization’s website (Association for Bioethics Program Directors 2024). However, the ABPD database is far from comprehensive, and lists primarily academic programs, many of which are research-focused and do not include clinical ethics training.

The study reported here is the first to survey all CEFPs in the U.S. and Canada. Our primary aim is to help fill the current knowledge gap by describing in detail the characteristics and practices of these programs. This study also has an important secondary aim: to provide needed data to inform the development of standards for CEFPs—something which will be critical to the development of an accreditation process for clinical ethics fellowships in the future. We addressed the following research questions:

1. What are the characteristics and practices of CEFPs in the U.S. and Canada?
2. What are the opinions of CEFP directors regarding accreditation and funding?

This article is the first of two articles describing this study and will focus on the first research question. A separate article (Fox and Wasserman 2024) focuses on the second question.

METHODS

The protocol for this study was reviewed and deemed exempt by the institutional review board of Oakland University.

Sample

The study population consisted of all directors of CEFPs in the U.S. and Canada that had at least one fellow enrolled in the program in at least one of the three years prior to survey administration (i.e., between July 1, 2020-June 30, 2023). To identify programs that potentially met our inclusion criteria, we first performed a series of internet searches using the terms “clinical ethics fellow/fellowship,” “ethics fellow/fellowship,” and “bioethics fellow/fellowship.” Once we identified a potential CEFP, we reviewed descriptions of the program available online to determine if they included a clinical training component. Fellowships that focused exclusively on research or scholarship and did not include clinical training were excluded from the study.

To ensure that our list of fellowships was complete and accurate, we sent the list to the American Society for Bioethics and Humanities’ (ASBH’s) Clinical Ethics Consultation Affinity Group (CECAG) listserv, an email discussion forum with approximately 1,000 members. We asked CECAG members to review the fellowship list and let us know of any programs that should be included that were missing. After incorporating feedback, we had a list of 47 fellowships that potentially met the inclusion criteria and were invited to participate in the study.

Of these 47 programs, 11 were excluded after we communicated with the program and determined that they did not meet the inclusion criteria for the study, leaving 36 eligible programs. Of the 11 programs that were excluded, five did not include a clinical component, and six did not meet the requirement of having at least one fellow enrolled in at least one of the three years prior to survey administration. Of the six that did not have fellows in the last three years, two had had clinical ethics fellows in the past and expected to have more in the future, and two were new programs that were just enrolling their first class at the time of survey administration in 2023, and two expected to enroll their first class in 2024. In all, at the time data collection began, we had identified 42 current or future CEFPs in the U.S. (36) and Canada (6), of which 36 met our criteria to be included in the study. (In addition, after data collection began, we identified two additional programs, one of which is currently

recruiting fellows and one that plans to enroll fellows in the near future.)

Survey Development

Survey development began with a literature review relevant to the research questions. Most items on the survey were developed *de novo*, but some were modified versions of items from two other surveys: (1) ABPD’s online database, described above (Association for Bioethics Program Directors 2024); and (2) The 2022 GME Track Program Survey, conducted by the American Medical Association and the American Association of Medical Colleges (GME Track program Survey 2022). For example, the ABPD survey (which applied to various types of education programs including fellowships) contained the question “Do graduates receive a certificate or diploma upon successful completion?” We modified this question for our survey so that it applied specifically to fellowships. As another example, the GME Track Program Survey item “Average hours per week residents/fellows in year one of the program participate in structured didactic activities” became “On average, how many hours per work-week do trainees participate in scheduled structured didactic activities?”

Draft survey questions were presented to members of a workgroup (see acknowledgments) who provided feedback and suggestions on content, wording, and priority of items for inclusion in the survey. We also obtained early input from two clinical ethicists from Canada to ensure that our wording was appropriate for Canadian respondents.

Cognitive interviewing

We conducted cognitive interviews with nine individuals who had backgrounds similar to the expected study participants but were not expected to participate, such as former CEFP directors or associate directors. The purpose of cognitive interviewing was to identify questions that were problematic for respondents, assess whether respondents interpreted the questions as intended, and identify potential ways to improve the questions. The cognitive interviewing protocol entailed a research assistant meeting with respondents via Zoom, asking them to take the survey in real time during the call, observing them to identify any difficulties, and asking them questions as they went through the items. Respondents were encouraged to “think aloud,” to identify anything that was unclear, and for certain questions, to answer specific prompts. The research team met after each round of three

interviews to discuss the results and made changes to the survey accordingly.

Final survey

The final survey included 64 primary questions about the characteristics of CEFPs, many of which had subparts, divided into the following sections: identifying information about the fellowship, general program characteristics, admission requirements, teaching staff characteristics, trainee characteristics, trainee working hours and benefits, training characteristics, and program graduates. (The survey also included questions about accreditation and funding, which are described in a separate article.) See [Online Supplemental Materials](#) for a complete list of online survey questions.

Data collection

To administer the survey, we sent an email to CEFP directors via online survey software (Qualtrics), with personalized follow-up emails from EF, as necessary. The initial email included a description of the study and a link to the online survey. Nonrespondents were sent up to three reminder emails. When there was no response from the initial respondent, another representative of the CEFP was contacted to assist with determining the appropriate person to take the survey. Data collection began in July of 2023 and ended in October. During the data cleaning process, we recontacted 6 respondents by email to clarify and confirm or change unclear responses.

Data Analysis

We analyzed the data using SPSS, version 28.0.0.0. We used descriptive statistics to summarize program characteristics. We used a conventional content analysis approach for qualitative survey data in which responses to open-ended questions were manually coded line-by-line, with similar codes raised into categories based on input from members of the research team. To examine associations between program characteristics, we primarily used a series of one-way analyses of variance (ANOVAs) to evaluate the association between program characteristics. To address significant skewness, we employed nonparametric tests or bootstrapped sampling distributions, though these did not affect the results, and therefore for simplicity were not reported. For each test, the critical value was set *a priori* at .05 (two-sided). These inferential statistical tests should be read with caution given the limitations of this study (see Limitations section below, under Results).

RESULTS

The 36 CEFPs in this study included 30 U.S. programs and 6 Canadian programs. All 36 completed the survey for a response rate of 100%.

In 30 CEFPs (83.3%), the survey was completed by the program's current director. In the other 6 programs, the survey was completed by the former program director (3, 8.3%) or by another person designated by the current director to take the survey on their behalf (3, 8.3%).

General Characteristics of Clinical Ethics Fellowship Programs

Study participants were asked to indicate whether or not their fellowship program met the following definition: "For the purposes of this survey, a clinical ethics fellowship program is defined as a professional development program that prepares trainees to enter practice as a professional clinical ethicist who is competent to perform clinical case consultations as a lead or solo consultant." All but 2 respondents (5.6%) answered in the affirmative. The other two explained that their programs trained fellows to practice clinical ethics but did not explicitly prepare fellows to serve as a lead or solo consultant.

Half of the programs used the term "clinical ethics" in their program's name (16, 50.0%), while the other programs used alternative terms such as "clinical, organizational, and research ethics" (2, 5.6%), "health-care ethics" (1, 2.8%), "health care ethics" (1, 2.8%), bioethics (3, 8.3%), medical ethics (2, 5.6%), "clinical bioethics" (1, 2.8%) or simply "ethics" (8, 22.2%). Several program names suggested a subspecialty focus: pediatric ethics (2, 5.6%), surgical ethics (1, 2.8%), and neuroethics (1, 2.8%). All but one program was termed a "fellowship."

Of the 36 programs, 6 (16.7%) offered more than one different fellowship "track," defined as an optional area of focus or specialization within a broader clinical ethics fellowship. The tracks offered were pediatric vs. adult tracks, community-based vs. hospital-based tracks, a track for clinicians vs. non-clinicians, an accelerated clinical track with less organizational ethics exposure, a surgical track, and a transplant track.

The CEFPs were of the following types: university-based (15, 41.7%); community-based, university-affiliated (12, 33.3%), community-based, not university affiliated (8, 22.2%), Federal government-based (1, 2.8%).

Out of the 36 programs, 26 (72.2%) accepted at least one new fellow into the program within the last

12 months, and 10 programs (27.8%) did not accept new fellows—6 due to lack of funding (16.7%), 2 due to lack of qualified candidates (5.6%), one because it is a two-year fellowship that only accepts new fellows every other year (2.8%) and 1 unknown (2.8%). As for accepting fellows in the next 12 months, 25 programs (69.4%) plan to accept new fellows, 2 programs (5.6%) do not expect to accept new fellows (1 due to lack of funding and 1 because they hired for a two-year fellowship), and 9 programs (25.0%) are unsure, mostly due to uncertainty about funding (7 programs, 19.4%).

Figure 1 depicts the 40-year history of CEFs in the U.S. and Canada based on the year when programs enrolled their first fellow. The number of programs has grown exponentially, more than doubling every 10 years. More than half of all CEFs were established within the last 10 years.

We asked in what month in the past year new fellows started the program (if applicable). Among the 26 programs that specified a month, 16 (61.5%) indicated that fellows started in July, 5 (19.2%) in August, 3 (11.5%) in September, and 1 each (3.8%) in October and January.

Figure 2 shows the minimum length of training for CEFs, which ranged from 7 to 24 months with a mean of 16.0 months ($SD = 5.5$). The maximum length of training ranged from 10 months (1 program) to 36 months (2 programs) with a mean of 23.1 months ($SD = 5.3$). The typical amount of time it takes fellows to complete their first year ranged from 7 to 12 months with a mean of 11.7 months ($SD = 1.0$). The typical amount of time it takes fellows to complete their second year ($N = 23$) ranged from 4 to 12 months with a mean of 10.9 ($SD = 2.3$).

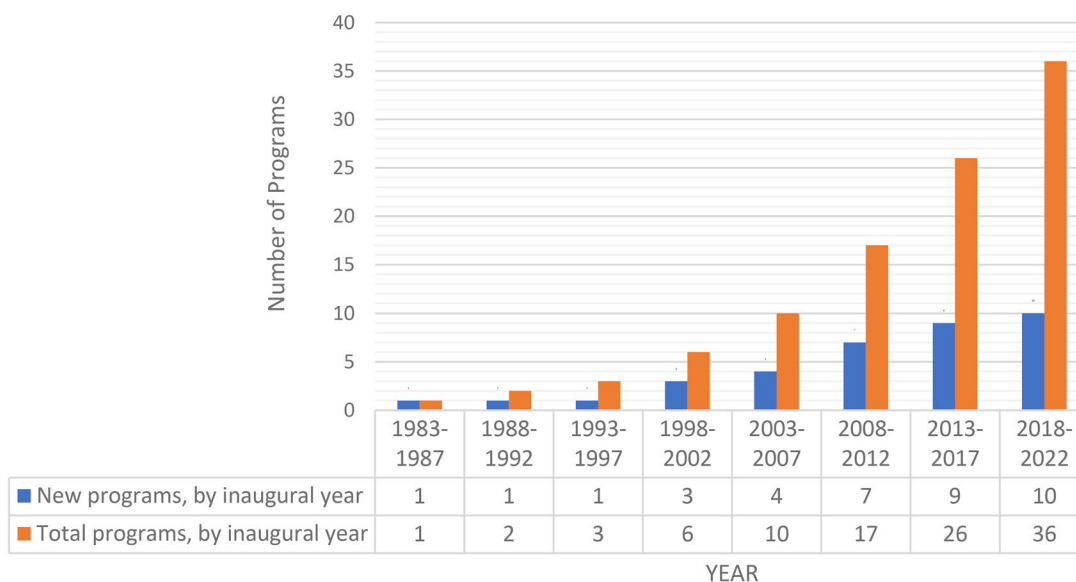


Figure 1. Growth of clinical ethics fellowship programs in the U.S. and Canada.

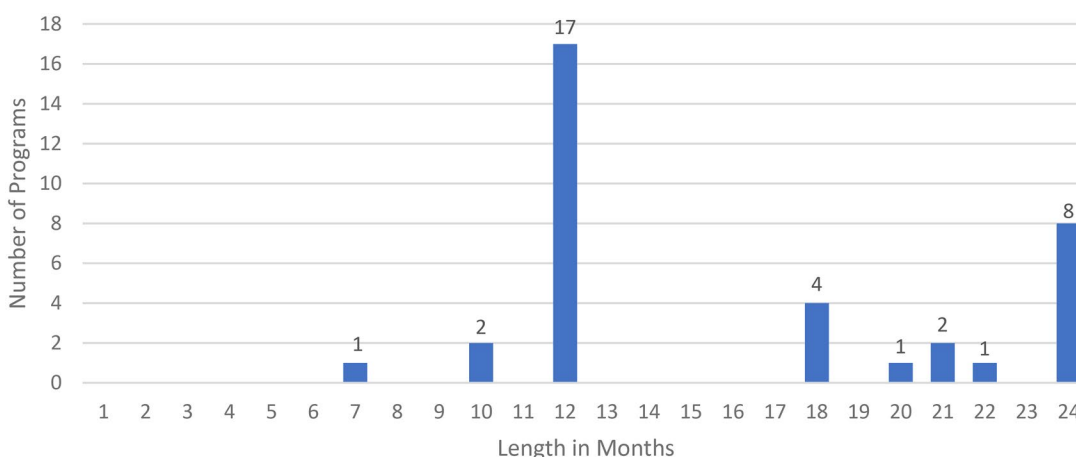


Figure 2. Minimum length of clinical ethics fellowship programs in the U.S. and Canada ($N = 36$).

Table 1. Goals and minimum proficiencies for clinical ethics fellowship programs (N = 36).

How important are each of the following goals for your clinical ethics fellowship program?							What is the minimum level of proficiency all fellows are expected to achieve?			
	Not at all Important Rating = 1	Slightly Important Rating = 2	Moderately Important Rating = 3	Very Important Rating = 4	Extremely Important Rating = 5	Mean Rating (SD)	No Proficiency Rating = 0	Basic Proficiency Rating = 1	Advanced Proficiency Rating = 2	Mean Rating (SD)
	Frequency (%)						Frequency (%)			
Ethics consultation ¹	–	–	1 (2.8)	6 (16.7)	29 (80.6)	4.8 (0.5)	–	13 (36.1)	23 (63.9)	1.6 (0.5)
Ethics education ³	–	1 (2.8)	6 (16.7)	15 (41.7)	14 (38.9)	4.2 (0.8)	1 (2.8)	18 (50.0)	17 (47.2)	1.4 (0.6)
Ethics policy work ²	–	3 (8.3)	6 (16.7)	17 (47.2)	10 (27.8)	3.9 (0.9)	3 (8.3)	23 (63.9)	10 (27.8)	1.2 (0.6)
Ethics research and publication ⁵	–	5 (13.9)	10 (27.8)	12 (33.3)	9 (25.0)	3.7 (1.0)	3 (8.3)	22 (61.1)	11 (30.6)	1.2 (0.6)
Ethics program management ⁴	6 (16.7)	10 (27.8)	10 (27.8)	8 (22.2)	2 (5.6)	2.7 (1.2)	16 (44.4)	19 (52.8)	1 (2.8)	0.6 (0.6)

1. responding to requests to help resolve ethical concerns on behalf of a healthcare organization

2. developing and interpreting ethics-related policies on behalf of a healthcare organization

3. developing and providing educational programming on behalf of a healthcare organization

4. leading and administering an ethics program on behalf of a healthcare organization

5. producing scholarly work related to healthcare ethics

Mission and Goals of CEFPs

Survey participants were asked to share their CEFP's formal mission statement, if any. Of the 36 programs, 17 (47.2%) shared a statement that clearly stated the mission and/or goals of the fellowship, 16 (44.4%) indicated their fellowship did not have a mission statement, and 3 (8.3%) provided general information about their fellowship that did not describe the program's mission or goals. Mission statements commonly mentioned preparing fellows to become an ethicist (11 programs, 64.7%), to perform ethics consultations (9, 52.9%), to fill an academic role (7, 41.2%), or to be a leader in the field (4, 23.6%).

Participants were asked to rate the importance of various goals for their CEFP. Results are shown in Table 1. All programs considered preparing their fellows to perform ethics consultation to be an important goal, and all but one program considered this goal to be either very important or extremely important (35, 97.2%). A majority of programs also considered preparing fellows for education, policy work, and research/publication to be either very important or extremely important. However, only 10 programs (27.8%) considered preparing fellows for ethics program management to be either very important or extremely important.

Participants were also asked to indicate, for these same activities, the minimum level of proficiency that all fellows are expected to achieve (see Table 1). All programs indicated that their fellows were expected to achieve at least basic proficiency at ethics consultation, and 23 (63.9%) indicated that fellows were expected to achieve advanced proficiency. Most programs also expected their fellows to achieve at least basic proficiency in education, policy work, research/publication, and program management.

Admission requirements of Clinical Ethics Fellowship Programs

Regarding admission requirements for CEFPs, 15 programs (41.6%) required a doctor's degree (of which 2 accepted only PhDs in philosophy and/or bioethics, 1 accepted only MDs, and 2 required a terminal degree but occasionally accepted ABD PhD candidates); 12 programs (33.3%) required at least a master's degree (of which 12 preferred but did not require a doctor's degree), 8 (22.2%) required only a bachelor's degree (including 1 that only accepted currently enrolled medical students and 5 that generally accepted applicants with an advance degree but occasionally made exceptions); and 1 (2.8%) had no degree requirement.

Survey participants were also asked whether specific clinical experience was required, preferred, or not expected prior to entry into their CEFP. Three programs (8.6%) required prior clinical experience; 23 (65.7%) preferred prior clinical experience; and 10 (28.6%) did not expect fellows to have previous clinical experience. The types of prior clinical experience that were required or preferred varied widely. For example, some programs required or preferred fellows to have spent time in hospital settings or interacting with patients, while others required or preferred fellows to be licensed as a clinician or to have completed specific clinical training.

Respondents also listed a wide variety of other types of prior experience that they preferred fellows to have including experience with research, teaching, project management, surgery, conflict resolution, Catholic health care ethics, bioethics coursework, and broad life experience.

The required elements of a fellow's application process were as follows: CV or resume (36 programs, 100%), interview(s) (36, 100%), letter(s) of

Table 2. Importance of various criteria in clinical ethics fellowship programs' admissions process (N = 36).

	Not at all important N (%) Rating = 1	Slightly important N (%) Rating = 2	Moderately important N (%) Rating = 3	Very important N (%) Rating = 4	Extremely important N (%) Rating = 5	Mean (SD)
Candidate's formal education relevant to healthcare ethics (e.g., formal coursework)	2 (5.6%)	5 (13.9%)	3 (8.3%)	17 (47.2%)	9 (25%)	3.7 (1.2)
Candidate's prior clinical experience relevant to healthcare ethics (e.g., hospital work)	2 (5.6%)	7 (19.4)	17 (47.2%)	8 (22.2%)	2 (5.6%)	3.0 (0.9)
Candidate's personal qualities (e.g., character traits and interests)	0	0	1 (2.8%)	13 (36.1%)	22 (61.1%)	4.6 (0.6)

recommendation or reference check (34, 94.4%), statement of interest or cover letter (33, 91.7%), writing sample(s) (21, 58.3%), transcript (6, 16.7%), and presentation (1, 2.8%).

Participants were asked to rate the importance of three criteria in their CEFP's admission process: the candidate's formal education relevant to healthcare ethics (e.g., formal coursework), the candidate's prior clinical experience relevant to healthcare ethics (e.g., hospital work), and the candidate's personal qualities (e.g., character traits and interests). Results are shown in Table 2. The most highly rated criterion was personal qualities, which 100% of programs rated as at least moderately important. Only 3 programs (8.3%) rated any other criterion as more important than person qualities. Half of programs (18, 50%) considered formal education to be more important than clinical experience, while 11 programs (30.6%) considered formal education and clinical experience to be equally important and 7 programs (19.4%) considered clinical experience to be more important. Two thirds of programs (24, 66.7%) considered all three criteria to be at least moderately important.

Respondents listed a wide variety of desired personal qualities for fellows including interpersonal skills (25, 69.4%), cognitive skills (21, 58.3%), and specific "attributes, attitudes, and behaviors" listed in ASBH's *Core Competencies* report (ASBH 2011) such as compassion, honesty, and humility (25, 69.4%). Respondents also mentioned other desired traits not emphasized in the *Core Competencies* document such as maturity, the ability to work independently, and passion for ethics.

Characteristics of CEFP Directors and Teaching Staff/Faculty

All CEFPs had a program director, except one had two co-program directors. All program directors held either a doctor's degree (33, 91.7%) or a master's degree (3, 8.3%) as their highest degree. Many (13, 36.1%) self-reported more than one advanced degree. Collectively, the 36 program directors held the following advanced degrees: PhD = 21, MD = 8, JD/LLB = 6, DBe = 1, other doctor's degree = 2, MA/MS/MHS = 8, other master's = 7.

The total number of individuals who served as teaching staff (defined as "qualified individuals who have been clearly designated by the program to provide instruction, supervision, and timely assessments of trainees' progress in meeting program requirements and who are regularly dedicating a portion of their time to such activities this year") was 242. The number of teaching staff per program ranged from 1 to 42 with a mean of 6.9 (SD = 7.0) and a median of 5. On average, in each program, teaching staff included 2.6 physicians, 1.1 philosophers, 0.7 attorneys, 0.6 nurses, 0.3 social workers, 0.2 hospital chaplains, 0.3 other health care providers, 0.3 theologians, and 0.4 "other." The average number of teaching staff with HEC-C certification ranged from 0 to 7 with a mean of 2.1 (SD = 2.2). Out of 33 programs that provided HEC-C certification data, 10 (30.3%) had no certified teaching staff, 7 (21.2%) had 1, 7 (21.2%) had 2, 5 (15.2%) had between 3 and 5, and 4 (12.1%) had between 6 and 7. The total number of teaching staff with HEC-C certification was 68.

We asked respondents to estimate the average number of hours per week that each member of their CEFP's teaching staff is expected to spend performing educational activities on behalf of the fellowship this year, including contact hours and preparation time. Responses for the 185 staff members for whom data was reported ranged from 0.4 to 40 hours per week with a mean of 6.5 (SD = 7.0).

Number of Fellows Enrolled in CEFPs

The frequency of CEFPs with various numbers of fellows currently enrolled are shown in Figure 3. The distribution was extremely skewed to the right, owing to outliers with high numbers of fellows: the number of fellows per program ranged from 0 to 16 with a mean of 2.4 (SD = 3.5), median of 1, and mode of 1. Almost one fifth of programs (8, 19.4%) had no fellows currently enrolled, and more than half of programs (19, 52.8%) had either 1 or 2 fellows enrolled. The total number of fellows enrolled across all programs was 86, of which 63 (73.3%) were in their first year and 23 (26.7%) were in their second year. Of the 28 programs with fellows, 23 (82.1%) had at least one first-year fellow, 15 (53.6%) had at least one

second-year fellow, and 8 (28.6%) had both first- and second-year fellows enrolled.

Figure 3 also shows the number of programs with various numbers of fellows enrolled in the last 3 years. The total number of fellows enrolled in the last 3 years ranged from 1 to 111 with a mean of 7.8 (mean = 3, SD = 18.4). Summed across all programs, the total number of fellows enrolled in the last 3 years was 278. About half of these fellows (137, 49.3%) were trained in one of the two largest programs.

Demographic Characteristics of Clinical Ethics Fellows

We asked survey participants to provide aggregate demographic information about all the fellows that

were enrolled in their CEFP in the last 3 years. Regarding primary professional backgrounds, of the 269 fellows for whom data was available, 138 (51.3%) were physicians, 39 (14.5%) were philosophers, 21 (7.8%) were nurses, 14 (5.2%) were attorneys, 9 (3.3%) were theologians, 7 (2.6%) were social workers, 7 (2.6%) were hospital chaplains, 6 (2.2%) were other health care providers, and 28 (10.4%) were listed as “other.” Most programs had trained fellows from more than one professional background in the last 3 years. The exceptions included 7 programs that had each trained only 1 fellow in the last 3 years, 1 program that had trained only physicians in the last 3 years but was open to non-physicians, 3 programs that had trained only philosophers in the last 3 years but were open to non-philosophers, 2 programs that were only

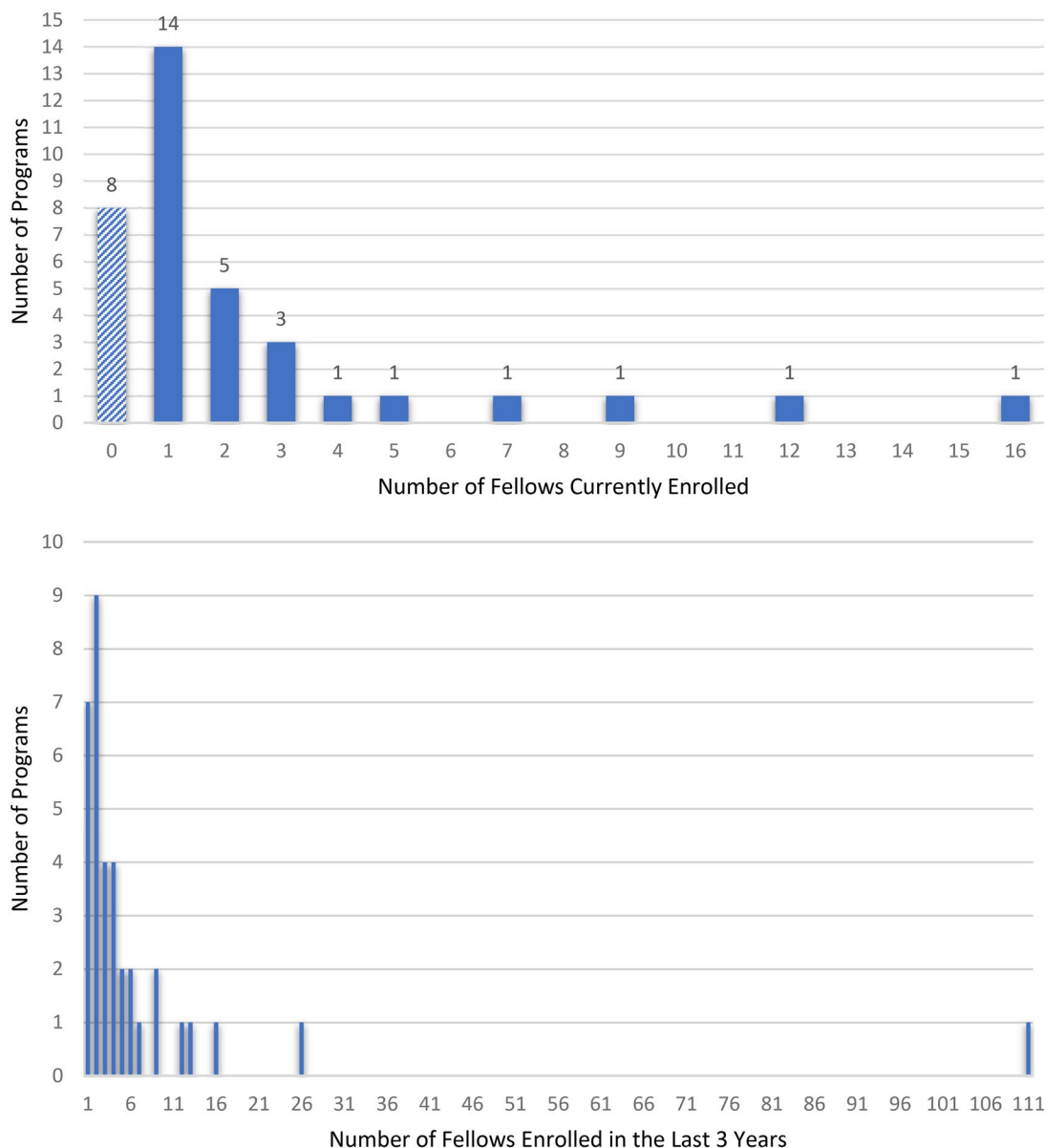


Figure 3. Number of clinical ethics fellowship programs with various numbers of fellows currently enrolled and enrolled in the last 3 years (N = 36).

open to philosophers and 1 program that was only open to medical students.

We also asked participants to specify the races, ethnicities, and genders of the fellows that their CEFPP had enrolled in the last 3 years. With regard to race, data was available for 267 fellows. Respondents indicated that 153 (57.3%) of these fellows identified as White, 51 (19.1%) identified as Asian, 26 (9.7%) identified as Black or African American, 12 (4.5%) identified as Multiracial, 2 (0.7%) identified as American Indian or Alaska Native, 0 identified as Native Hawaiian or Other Pacific Islander, 17 (6.4%) identified as “other,” and 6 (2.2%) were “unknown.” All programs reported racial diversity except for 8 small programs that had enrolled fewer than 5 fellows in the last 3 years. Ethnicity data was available for 234 fellows, of whom 218 (93.2%) identified as Not Hispanic or Latino, 7 (3.0%) identified as Hispanic or Latino, and 9 (3.8%) were listed as “unknown.” Gender data was available for 270 fellows, of whom 163 (60.4%) identified as a woman, 99 (36.7%) identified as a man, 3 (1.1%) identified as non-binary, and 5 (1.9%) were listed as “unknown/other.”

Clinical ethics fellows’ Work Hours, Compensation, and Benefits

The average number of weeks per year that trainees served as an ethics fellow ranged from 6 to 52 with a mean of 41.0 (SD = 13.3) and a median of 48 in year one and a mean of 41.1 (SD = 13.8) and a median of 48 in year two. In the 34 programs that answered the year-one question, the number of weeks fellows served was <20 weeks in 3 (8.8%), 20–29 in 4 (11.8%), 30–39 in 1 (2.9%), 40–49 in 19 (55.9%) and ≥50 in 7 (20.6%). The most common response (mode) was 48 (10 programs, 29.4%).

The average number of hours per week that trainees served as ethics fellows ranged from 8 to 60 with a mean of 33.0 (SD = 12.5) in year one and 34.1 (SD = 10.4) in year two. In the 34 programs that answered the year-one question, the number of hours per week served was <10 in 2, 10–19 in 5, 20–29 in 1, 30–39 in 8, and ≥40 in 18. The mode was 40 (16 programs). If we define full-time to mean ≥30 hours per week, 76.5% of programs were full time.

The average number of days per month that fellows were “on call” for ethics consultations ranged from 0 to 20 with a mean of 8.9 (SD = 6.3) in year one and a mean of 9.8 (SD = 5.5) in year two. In the 33 programs that answered the year-one question, fellows had no “on call” hours in 5 (15.2%), 1–5 hours in 7,

(21.2%), 6–10 hours in 8 (24.2%), 11–15 hours in 7 (21.2%) and ≥16 hours in 6 (18.2%).

We asked how many additional hours trainees are “on call” beyond their usual work hours when they are working a normal workweek and are also “on call” that week. Responses ranged from 0 to 128 with a mean of 41.5 (SD = 51.9) and a median of 14.5 for year one and 55.0 (SD = 54.3) and a median of 32 for year two. In the 28 programs that answered the year-one question, trainees had no additional “on call” hours in 11 (39.3%), 1–10 additional hours in 1 (3.6%), 11–20 additional hours in 5 (17.9%), 21–100 in 4 (14.3%), and 101 or more in 7 (25.0%). While responses were largely similar for year two, in two programs fellows had no additional hours in year one but did have additional hours in year two.

Trainees were compensated with a salary or stipend in 32 CEFPPs (88.9%), including 2 that paid some trainees but not others. Only 4 programs (11.1%) did not offer any trainees a salary or stipend. Reported salaries (N = 31) varied widely, ranging from \$2,500 to \$95,000 USD/year. Reported salaries also varied within programs: most two-year programs (53.6%) paid second-year fellows more than first-year fellows, and more than one third of all programs (35.5%) paid different salaries to different fellows in the same year. For first year fellows the mean minimum salary was \$49,400 (SD = 20,800) and the mean maximum salary was \$57,600 (SD = 20,400), whereas for second year fellows the mean minimum was \$51,000 (SD = 21,700) and the mean maximum was \$58,600 (SD = 21,000). Combining both years, maximum salaries were distributed as follows: <\$40,000 (3 programs, 9.7%), \$40,000–49,999 (4 programs, 12.9%); \$50,000–\$59,999 (9 programs, 29.0%); \$60,000–\$79,999 (7 programs, 22.6%); \$≥\$80,000 (8 programs, 25.8%). The mean maximum salary was \$59,400. Fellows’ salaries were most often funded by hospitals (80% of programs) and were less often funded by philanthropy (20.0%), universities (13.3%), government (6.7%) or grants/other sources (6.7%).

Regarding paid time off (PTO) for vacation or personal days, 6 programs provided no PTO (including the 4 nonpaying programs), and 28 programs gave PTO but for 7 of these the amount was variable or unspecified (e.g., “as needed”). Among the 21 programs that specified a numeric value above zero, the range was 10–28 days with a mean of 18.3 (SD = 5.1). Regarding paid time off for medical leave, parental leave, and/or caregiving leave, 12 programs (including the 4 nonpaying programs) provided no PTO beyond the amount provided for personal days and 22 programs gave additional paid time off but for 13 of

these the amount was variable or unspecified. Among the 9 programs that specified a numeric value above 0, the range was 10–60 days with a mean of 27.2 (SD = 19.5).

We asked participants how much annual funding their CEFP makes available to each fellow for conferences or other professional development activities. Specific dollar amounts were provided by 28 programs as follows: \$0 (4 programs), \$500–\$999 (5 programs), \$1,000–1,999 (4 programs), \$2,000–\$2,999 (7 programs), \$3,000–\$3,999 (3 programs), \$4,000–\$4,999 (3 programs), and \$5,000 (1 program). Four more programs did not mention specific dollar amounts but indicated they fund travel for at least one (3 programs) or two (1 program) conferences per year. Four programs commented that, in addition to the amount specified, they provide funding on a case-by-case basis and/or if the fellow is presenting at a conference.

Most CEFPs provided other benefits to fellows including health insurance (26 programs, 74.3%) and disability insurance (22 programs, 62.9%).

Curricular Content and Training Methods of CEFPs

Three quarters of respondents (27, 75.0%) indicated that their CEFP has a clearly written curriculum describing how program goals are achieved. Among those programs with a curriculum, 23 programs (85.2%) contained program descriptions, 24 (88.9%) contained program objectives, 8 (29.6%) contained course-level descriptions, 7 (25.9%) contained course-level objectives, 23 (85.2%) contained methods of evaluation, 19 (70.4%) contained topic outlines, and 23 (85.2%) included competencies required for graduation.

All but 5 CEFPs (86.1%) indicated that they specifically train their fellows to become proficient in each of 11 ASBH core competencies for ethics consultation (ASBH 2011). (See survey instrument for wording of these competencies). Of the 5 programs that did not, 3 trained their fellows to be proficient in 10 of the 11 competencies, 1 in 8 competencies, and 1 in 7. All programs trained their fellows in assessment skills and analysis skills; 97.2% trained in process skills, evaluation and quality improvement skills, knowledge of moral reasoning, knowledge of healthcare ethics issues and concepts, knowledge of clinical context, knowledge of local healthcare organizations and policies, and knowledge of health law; and 91.7% trained in knowledge of healthcare systems.

Most CEFPs were described as on-site training programs (28, 77.8%), while 7 (19.4%) were described as hybrid training programs and 1 (2.8%) was

described as a remote/on-line training program. The hybrid training programs were described as follows: “30% onsite,” “on site for last year, remote for 2 years prior,” “on-site: 60%,” “clinical ethics consultations are onsite, MA clinical ethics coursework is online,” and “recently we have permitted PhD candidates to participate remotely (unpaid) before in person clinical work.”

At 20 of the 36 CEFPs (55.6%), fellows received all of their required clinical experience at a single teaching site. Fellows had required clinical experience at two sites in 7 programs (19.4%), at three sites in 3 programs (8.3%), and at four or more sites in 6 programs (16.7%).

We asked what percentage of fellows’ clinical time, on average, was devoted to the inpatient hospital setting as opposed to other clinical settings. The percentage for the inpatient setting ranged from 0% (1 program) to 100% (7 programs) with a mean of 83.2% (SD = 23.7). More than half of programs (22 or 61.1%) devoted 90% of their clinical time or more to the inpatient hospital setting.

We also asked how many hours per workweek that trainees participated in scheduled structured didactic activities. The range was 0 to 16 and the mean was 4.5 (SD = 3.5) in year one and 3.7 (SD = 3.7) in year 2.

Consultations and Other Activities Performed by Clinical Ethics Fellows

We asked several questions about the number of consultations that fellows observed or performed. Specifically, we asked about the smallest number, the largest number, and the typical number of consultations that fellows participated in as a non-participant observer, as a solo consultant, as the lead consultant, and as the primary author of the main consult note. Results are shown in Table 3. For all types of consultations, the distribution was extremely positively skewed. Of special interest is the typical numbers of consultations that fellows performed as lead consultant and as solo consultant, since our definition of a clinical ethics program referenced competency in these areas. In the 28 programs that answered the question about lead consultation, the number was 0 in 4 (14.3%), between 1 and 29 in 11 (39.3%), between 30 and 59 in 7 (25.0%), between 60 and 119 in 2 (7.1%), between 120 and 239 in 2 (7.1%), and >240 in 2 (7.1%). For the question about solo consultation, the number was 0 in 10 programs (35.7%), between 1 and 29 in 11 (42.3%), between 30 and 59 in 3 (10.7%), between 120 and 239 in 2 (7.1%), and >240 in 2 (7.1%).

Table 3. Ethics consultations observed and performed by clinical ethics fellows.

	Number of consultations observed (non-participant)			Number of consultations performed as a solo consultant			Number of consultations performed as a lead consultant			# of consultations where fellow was primary author of main consult note		
	Smallest # performed by any fellow (N = 22)	Largest # performed by any fellow (N = 21)	Typical # performed by program fellows (N = 27)	Smallest # performed by any fellow (N = 21)	Largest # performed by any fellow (N = 20)	Typical # performed by program fellows (N = 26)	Smallest # performed by any fellow (N = 21)	Largest # performed by any fellow (N = 20)	Typical # performed by program fellows (N = 26)	Smallest # performed by any fellow (N = 22)	Largest # performed by any fellow (N = 21)	Typical # performed by program fellows (N = 27)
Mean	47.6	87.1	60.9	24.9	49.5	32.2	27.9	56.9	45.1	49.3	89.6	72.0
Median	30	50	40	15	15	10	15	25	23.5	30	60	50
SD	55.7	99.6	64.3	47.0	80.1	60.2	46.4	76.1	58.9	64.4	107.0	80.5
Range	2–200	2–400	2–250	0–150	0–300	0–250	0–175	0–300	0–250	1–250	1–450	1–350

In addition to consultation, CEFPs offered or required a variety of other activities and programs, as shown in Table 4. Most programs required fellows to round with clinical teams, give educational presentations, participate in structured case discussions, attend ethics committee meetings, perform policy work, and participate in a research project. Write-in responses for “other” required activities included formal coursework (2 programs,) research ethics consultations (1 program), moral distress rounds (1 program), a journal article (1 program), and a “consortium project” (1 program).

Participants were also asked whether their CEFP required or offered other types of “specific, structured programming” (see Table 4). Most programs required fellows to participate in a faculty mentorship program, and most programs either required or offered a peer-to-peer mentoring program, a program to develop policy skills, a program to develop teaching skills, and/or a program to foster transdisciplinary work. Write-in responses for “other” included a required “accreditation experience,” required “protected research time,” and an optional “rotation at another clinical ethics fellowship program in the region.”

CEFP Evaluation and Outcomes

CEFPs used the following methods in the last 3 years to evaluate fellows: performance feedback at regular intervals (33, 91.7%), self-assessment/self-reflection (27, 75.0%), specialty teaching staff/faculty ratings (25, 69.4%), portfolio system (11, 30.6%), in-service/in-training examination (7, 19.4%), objective structured clinical examinations/OSCEs (6, 16.7%), patient surveys (4, 11.1%), 360-degree evaluation (3, 8.3%), none (2, 5.6%).

CEFPs used the following assessments in the last 3 years to assess their effectiveness in achieving established outcomes: tracking of graduates’ placement in full or part-time employment in the profession or in a related profession (28, 77.7%), assessment of graduates’ satisfaction with the program (22, 61.1%), tracking of retention rates for the program (16, 44.4%), performance on the Healthcare Ethics Consultant-Certified (HEC-C) certification exam (14, 38.9%), assessment of employers’ satisfaction with program graduates (5, 13.9%), none (3, 8.3%).

In a majority of CEFPs (22, 61.1%), graduates receive a certificate upon successful completion of the program. In one program (2.8%), graduates receive a diploma, in 12 programs (33.3%), graduates receive neither a certificate nor a diploma, and in one program (2.8%), no one had graduated from the program yet, so the question was not applicable.

We asked participants to indicate the current status of all the fellows that their program enrolled in the last

Table 4. Activities and programming offered or required by clinical ethics fellowship programs.

	Required N (%)	Optional N (%)	Not Offered N (%)
Activities performed by clinical ethics fellows in addition to ethics consultation (N = 35)			
Rounding with clinical teams on units	24 (68.6)	9 (25.7)	2 (5.7)
Giving educational presentations	32 (91.4)	2 (5.7)	1 (2.9)
Participating in structured case discussion sessions (other than consultations)	30 (85.7)	5 (14.2)	–
Attending ethics committee meetings	30 (85.7)	4 (11.4)	1 (2.9)
Policy work	20 (57.1)	12 (34.3)	3 (8.3)
Research project	23 (65.7)	12 (34.3)	–
Quality improvement project	11 (37.1)	21 (58.3)	3 (8.3)
Other	8 (22.9)	1 (2.9)	–
Specific, structured programming offered by clinical ethics fellowship programs (N = 34)			
Faculty mentorship program for fellows	20 (58.8)	5 (14.7)	7 (20.6)
Peer-to-peer mentoring program	7 (20.6)	12 (34.3)	13 (38.2)
Program to develop ethics program management skills (e.g., program administration, QI project leadership, community/organizational advocacy)	2 (5.9)	12 (34.3)	18 (52.9)
Program to develop policy skills	8 (23.5)	11 (32.4)	13 (38.2)
Program to develop teaching skills	17 (50.0)	6 (17.6)	9 (26.5)
Program to foster transdisciplinary work	16 (47.1)	6 (17.6)	10 (29.4)
Hospice/home care experience	3 (8.8)	12 (34.3)	17 (50.0)
MPH, MBA, PhD or other advanced degree taken in conjunction with the ethics fellowship	2 (5.9)	9 (26.5)	21 (61.8)
Research rotation or experience	9 (26.5)	10 (29.4)	15 (44.1)
Other	2 (5.9)	1 (2.9)	–

3 years. Of the 35 programs that answered this question, 28 reported that all of their fellows had either successfully completed the program or were still enrolled. Of the remaining 7 programs, 6 reported that a single fellow had withdrawn from the program in good standing, and 1 reported that two fellows had withdrawn from the program amidst performance or conduct concerns. No program reported that any fellows had been dismissed from the program for performance or conduct concerns.

Participants were asked what the fellows who had successfully completed their program in the last 3 years did in the first year following their fellowship. Of the 33 programs that answered this question and that had at least one fellow successfully complete the program within the last 3 years, 30 (90.9%) reported that at least one fellow was employed within the first year in a job that includes responsibilities as a clinical ethicist. Data was reported on 102 fellows who had successfully completed their fellowship. Of these 102 fellows, 62 (60.8%) were employed in a job that included responsibilities as a clinical ethicist in their first year following graduation, 29 (28.4%) were employed in a job that did not include responsibilities as a clinical ethicist, 4 (3.9%) were pursuing academic education related to progressing as a clinical ethicist, 3 (2.9%) were unemployed, 2 (2.0%) were enrolled in another training program, 1 (1.0%) was engaged in military service, and 1 (1.0%) was unknown.

Associations between program characteristics

We examined associations between various program characteristics, as shown in Table 5. We were

particularly interested in characteristics that might reasonably be expected to relate to level of competency that program graduates achieve: namely, (1) expected ethics consultation proficiency that programs expected graduates to achieve, (2) highest degree required for admission, (3) minimum number of months required to complete the program, (4) average weeks per year, (5) average hours per week, and (6) the typical number of consultations performed as lead consultant. We were also interested in exploring the relationship between program characteristics and the numbers and professional backgrounds of fellows enrolled.

The most striking differences we found were between the 4 programs that did not offer a salary or stipend to fellows (nonpaying programs) and the other 32 paying programs. Compared to paying programs, nonpaying programs had lower expectations for ethics consultation proficiency, lower educational requirements for admission, shorter minimum program lengths, fewer weeks per year, fewer hours per week, and far fewer consultations performed as lead consultant. Nonpaying programs also trained more fellows by a factor of 10 and trained a much higher percentage of physicians as well as a much lower percentage of philosophers. For some characteristics, the divergence between paying and nonpaying programs was so pronounced that there was little or even no overlap. For example, in the 4 nonpaying programs, the minimum time required to complete the program ranged from 7–10 months, whereas all paying programs required at least 12 months. Unexpectedly, many (though not all) of these differences were statistically significant despite the very small size of the nonpaying group.

Table 5. Associations between various program characteristics.

Program Characteristics	Expected ethics consultation proficiency ^a Mean (SD)	Highest required degree ^b Mean (SD)	Minimum # of mo. to complete program Mean (SD)	Average weeks per year Mean (SD)	Average hours per week Mean (SD)	Typical # of consults as lead consultant Mean (SD)	# of fellows in the last 3 years Mean (SD)	% of these fellows who were physicians Mean (SD)	% of these fellows who were philosophers Mean (SD)
Nonpaying (N = 4)	1.2 (0.5)	0.8 (0.5)***	9.2 (1.5)**	27.8 (15.2)**	18.2 (14.8)**	10.0 (17.3)	38.8 (48.9)***	72.2 (33.8)***	1.4 (0.2)
Paying (N = 32)	1.7 (0.5)	2.4 (0.7)	16.9 (5.3)	44.1 (10.0)	35.0 (11.0)	49.7 (61.1)	3.9 (3.4)	14.5 (27.9)	39.8 (38.4)
Large programs (>3 fellows enrolled last year) (N = 6)	1.3 (0.5)	1.2 (1.2)**	13.5 (4.8)	27.6 (19.3)*	16.6 (13.3)***	2.5 (5.0)	30.7 (39.9)***	46.3 (43.2)*	5.1 (9.9)*
Small programs (≤3 fellows enrolled last year) (N = 30)	1.7 (0.5)	2.3 (0.7)	16.5 (5.6)	43.3 (10.6)	36.0 (10.2)	52.9 (61.0)	3.1 (2.4)	15.9 (0.3)	41.9 (38.8)
Does not meet definition of clinical ethics fellowship (N = 2)	1.0 (0.0)	1.0 (0.0)	15.5 (7.8)	22.0 (19.8)	24.0 (22.6)	0.0 (0.0)	21.0 (7.1)	11.5 (16.3)	18.6 (20.8)
Meets definition of clinical ethics fellowship (N = 34)	1.7 (0.5)	2.2 (0.8)	16.0 (5.8)	45.6 (17.9)	33.8 (12.1)	50.8 (69.4)	6.9 (18.6)	21.5 (34.3)	36.8 (38.9)
University-based (N = 15)	1.8 (0.4)	2.1 (1.0)	15.7 (6.4)	38.7 (12.7)*	29.6 (13.5)	57.5 (73.2)	13.1 (27.8)	40.3 (41.8)**	29.3 (44.9)
Community-based (N = 20)	1.6 (0.5)	2.2 (0.7)	16.0 (5.0)	46.9 (5.4)	35.5 (11.4)	35.5 (39.9)	3.3 (2.9)	7.5 (16.6)	40.8 (33.6)
United States (N = 30)	1.7 (0.5)	2.2 (0.9)	16.2 (5.7)	41.2 (12.4)	33.1 (12.8)	49.9 (63.1)	8.6 (20.1)	24.6 (35.6)**	37.6 (40.0)
Canada (N = 6)	1.5 (0.5)	2.0 (0.0)	15.0 (5.0)	47.4 (4.2)	32.4 (11.4)	18.8 (2.5)	3.5 (3.3)	2.8 (6.8)	25.0 (27.4)

^ano proficiency = 0, basic proficiency = 1, advanced proficiency = 2.^bno degree = 0, bachelor's = 1, master's = 2, doctor's = 3.* $p \leq .05$.** $p \leq .01$.*** $p \leq .001$.

Similarly, compared to other programs, the 2 programs that indicated they did not meet the definition of a clinical ethics fellowship (because their programs trained fellows to practice clinical ethics but did not explicitly prepare fellows to serve as a lead or solo consultant) had lower expectations for ethics consultation proficiency, fewer weeks per year, and fewer hours per week. In both of these programs, fellows did not perform any consultations as a lead or solo consultant.

University-based programs were similar to community-based programs except that university programs had fewer weeks per year and trained a higher percentage of physicians. United States and Canadian programs were also similar, except U.S. programs trained a higher percentage of physicians.

DISCUSSION

This study is the first to describe in detail the characteristics of CEFPs. By achieving a 100% response rate, our data constitute a report on the entire population of CEFPs, including their structural characteristics, programmatic goals, admission requirements, faculty characteristics, trainee characteristics, trainee working hours and benefits, training methods, and evaluation activities.

Key Finding #1: Proliferation of CEFPs

The first major finding of our study is that the number of CEFPs in the U.S. and Canada is far greater than the numbers previously described in the literature and is growing rapidly. Moore and Horner (2020) listed 7 CEFPs in the U.S., while ABPD's database (2023) lists 12 U.S. and Canadian programs with a clinical ethics component. We identified more than 3 times that number. In addition to the 36 CEFPs we surveyed, we know of 2 new programs that enrolled fellows in 2023, 2 new programs that are recruiting fellows for 2024, and 6 more programs that hope to enroll fellows in the near future, for a total of 46 current or planned CEFPs. Moreover, we found that the number of CEFPs has grown exponentially over the past 40 years, more than doubling every 10 years.

The number of individuals trained in CEFPs also far exceeds previous estimates. Guerin et al. (2020) identified 60 individuals for their survey of CEFPG graduates, while Moore and Horner (2020) suggested that the total number of graduates from all CEFPs "likely hovers around 100." In stark contrast, CEFPs in our study enrolled a total of 278 fellows in the last 3 years alone. The total number of former fellows is

certainly many times greater, given that the 3 largest programs have existed for 15–40 years.

The proliferation of CEFPs is consistent with broader trends in the bioethics field. In the last 25 years, clinical ethics has been steadily progressing toward professionalization as a new discipline, with the development of practice standards, a code of ethics, core competencies, and a certification process for healthcare ethics consultants. During this same period there has been a dramatic rise in the number of ethics consultations performed in hospitals each year. A recent national study of U.S. hospitals (Fox et al. 2021) showed that the number of ethics consultations performed each year almost doubled between 2000 and 2018. Meanwhile, there has been a growing recognition that traditional ethics committees are inadequate to address the complex ethical issues that arise in modern healthcare. Increasingly, ethics consultations are being performed by trained ethicists, especially in major teaching hospitals, where 45.8% of clinical ethics consultations are now provided by individual ethics consultants as opposed to ethics committees or teams (Fox et al. 2021). Thus, the rapid proliferation of CEFPs may reflect a growing need and demand for trained clinical ethicists.

Key Finding 2: Commonalities among CEFPs

CEFPs in this study have much in common. Characteristics that a large proportion of CEFPs share include the following:

1. Ethics consultation proficiency: All CEFPs consider preparing their fellows to perform ethics consultation to be an important goal and expect their graduates to develop at least a basic level of proficiency in performing ethics consultation.
2. ASBH core competencies: All CEFPs aim to train their fellows in all or almost all of the ASBH core competencies for healthcare ethics consultation.
3. Advance degree requirement: Almost all CEFPs (88.8%) either require a master's or doctor's degree or prefer an advanced degree and only rarely accept applicants without one.
4. Multidisciplinary: A large majority of CEFPs (91.7%) accept applicants from multiple disciplines. Only a few programs restrict applicants to a specific professional background (medicine or philosophy).
5. At least one year long: Program length varies widely, but the vast majority of CEFPs (91.7%) require fellows to complete between 12 and 24 months.

6. Broad in scope: Though several CEFPs focus on a particular content area, such as surgical or pediatric ethics, 88.9% are not specialized in this way.
7. Small in size: With only 5 exceptions, CEFPs are small, enrolling an average of 3 or fewer fellows per year.
8. Fellow compensation and benefits: All but 4 CEFPs offer fellows a salary or stipend. CEFPs also typically provide other benefits such as paid time off, health and disability insurance, and funds for conferences.
9. Hospital experience: Except in 4 CEFPs, fellows spend most of their clinical time in hospital settings.
10. Consultation experience: In all but 3 CEFPs, fellows observe consultations, perform consultations as a lead consultant, and write up consultation notes.
11. "On call" experience: Fellows are "on call" for ethics consultations in all but 5 CEFPs.
12. Non-consultation experience: CEFPs generally require students to perform other activities such as giving educational presentations and attending ethics committee meetings.
13. Performance feedback: CEFPs almost universally give fellows performance feedback at regular intervals.
14. Professional placement: A high percentage of CEFPs (90.9%) have produced one or more graduates who were employed as a clinical ethicist within their first year after completing their fellowship.

These findings provide a useful starting point for the development of CEFPP standards. Understanding common programmatic norms is essential for grounding discussions about which practices are worth standardizing. Data about how things are currently done provides an empirical baseline for comparison and invites reflection about why current practices exist and the pros and cons of possible alternatives. This information can also help standards developers anticipate potential challenges and design standards that are relevant and feasible in light of existing norms.

However, while knowledge of existing norms is critical, it would be a mistake to assume that a particular practice should be established as a standard just because it is common. Common practices are not always best practices. And not all practices need to be standardized. Instead, educational standards are most useful and defensible when there is reason to believe they relate to levels of competency or other desired outcomes.

Key Finding 3: Heterogeneity among Clinical Ethics Fellowships

Another important, though unsurprising, finding of our study is that in certain respects, CEFPs exhibit considerable heterogeneity. Characteristics that varied widely include program type (programs comprise a mix of university-based, community-based programs, and Federal government-based programs), teaching sites (in slightly more than half of programs, fellows received all of their required clinical experience at a single site, whereas in the remaining programs, fellows were trained at multiple clinical sites), and specific programmatic activities (e.g., slightly over half of programs require fellows to participate in a research project). There were also wide disparities in, for example, numbers of fellows trained, numbers of consultations performed, and salaries paid. The finding of heterogeneity resonates with the limited existing literature on CEFPs. While some prior articles have noted the diversity across programs (Bibler et al. 2024; Moore and Horner 2020), our research provides a more granular and evidence-based understanding of this diversity.

Differences among programs can be beneficial for several reasons. For example, diversity allows programs to tailor their curriculum and training experiences to meet the unique needs of their local communities or healthcare systems. On the other hand, our finding of heterogeneity raises questions about the potential need for standardization and underscores the challenges of developing accreditation processes for CEFPs. Significant differences between programs may be associated with significant differences in quality and/or the level of proficiency that graduates achieve, especially for characteristics that might be expected to relate to academic level, intensity, or rigor such as educational hours and consultation volume.

Key Finding #4: Variable Adherence to Program Standards

One way to assess program quality is to examine adherence to established standards. ABPD has published a list of program standards specific to CEFPs (ABPD 2024). Our results suggest that several of these standards are not being consistently met. For example, ABPD standards require that “The Fellowship Program is at least 11 months full-time or the equivalent. In our study, 4 programs had a minimum length of 10 months or less, and several one-year programs were less than half-time. ABPD standards also require that

“All Fellows serve as the lead consultant for at least 30 clinical ethics consultation cases.” Less than half of programs meet this requirement.

Some might argue that the finding that so many programs are failing to meet a particular standard is evidence that the standard is unrealistic or overly stringent and needs to be changed—for example, maybe ABPD should only require that fellows perform 5 or 10 consults as lead consultant. We believe this would be a mistake. Standards should not be set at the level of the lowest common denominator among programs. Establishing too low a bar for standards can result in mediocrity becoming the norm. Programs have largely developed independently, so it is natural to expect that best practices developed by one program may not yet have been adopted by others. The goal of standardization should not be to preserve the status quo but to “lift all boats.”

Key Finding #5: Two Tiers of Programs

Our analysis of relationships between characteristics revealed that two types of programs differed from other programs across multiple measures that might reasonably be expected to relate to graduates’ competency levels: (1) fellowship programs that did not compensate their trainees and (2) larger programs with more than 3 fellows enrolled in the last year. The nonpaying programs and the larger programs tended to have lower admission standards and lower expectations for fellows with respect to program length, program hours, and number of consultations performed. On several measures these two groups barely overlapped with other programs. These findings suggest there may in fact exist two different tiers of CEFPs to which different standards apply.

Limitations

This study has several important limitations. While our use of total population sampling and achievement of a 100% response rate both minimize the possibility of response bias, some bias may have been introduced when respondents skipped specific questions. Another limitation is the possibility of memory recall bias, as respondents self-reported program characteristics largely from memory and might have struggled to remember specific details accurately. Respondents may also have been motivated to provide socially desirable responses to enhance perceptions of their training program. In addition, this study’s intrinsic characteristics limit the utility of statistical analyses. Given the small size of our study population and the even smaller size of subgroups within that population, analyses may lack

requisite levels of statistical power. The validity of inferential statistics can be further undermined by skewed data distributions and/or lack of homogeneity of variance across groups that violate the assumptions underpinning the statistical tests. Thus, the results of inferential statistical tests should be read with caution. However, given that this study included 100% of eligible programs, analyses are conducted on the population, not a sample. Observed differences in groups are therefore actual and not probabilistic.

CONCLUSION

This study is the first to describe in detail the characteristics and practices of CEFPs. Data about current practices plays a crucial role in informing the development of standards by providing empirical insights into the landscape of existing programs, their commonalities, and their differences. Understanding what most programs share in common provides a starting point for discussions of norms and best practices. Understanding disparities in current practices helps identify areas where certain programs may be falling short, where standards may need to be developed or improved, or where different types or tiers of standards may be appropriate.

Standard setting requires a nuanced approach that balances the need for consistency and quality across programs with the need to allow programs to tailor their teaching methods to meet diverse needs of the field. One of the biggest challenges will be to set the bar high enough to encourage best practices without stifling desirable diversity and innovation. We hope that the data in this study will prove useful to the development of standards for CEFPs that are robust, evidence-based, practical, reflective of best practices, and responsive to the diverse perspectives that make up our field.

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