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Documenting Clinical Ethics Consultation

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Article abstract

This short perspective piece is about the documentation of clinical ethics consultation in Canada. It is written at a time when the Canadian Association of Practicing Health Care Ethicists (CAPHE) is endeavoring to develop standards of practice for clinical ethics in Canada. This brief commentary is informed by my experience working in clinical ethics in three different provinces, but it is primarily an attempt to draw attention to the normative questions: How much and what kinds of information should be included in clinical ethics documentation? Where should ethics consultation reports be saved, and who should have access to them? These questions are, more fundamentally, about how we should balance concern for privacy, confidentiality, professional integrity, accountability and the promotion of trust. They are also about where clinical ethics fits within the broader Canadian health system.

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COMMENTAIRE CRITIQUE / CRITICAL COMMENTARY (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Documenting Clinical Ethics Consultation

Amanda Porter[a]

Résumé
Ce court article de perspective porte sur la documentation de la consultation en éthique clinique au Canada. Il est écrit à un moment où l'Association canadienne des éthiciens en soins de santé (ACESS) s'efforce d'élaborer des normes de pratique pour l'éthique clinique au Canada. Ce bref commentaire s'inspire de mon expérience de travail en éthique clinique dans trois provinces différentes, mais il s'agit surtout d'une tentative d'attirer l'attention sur les questions normatives : Quelle quantité et quels types d'informations devraient être inclus dans la documentation sur l'éthique clinique? Où les rapports de consultation éthique devraient-ils être conservés, et qui devrait y avoir accès? Ces questions portent, plus fondamentalement, sur la façon dont nous devrions équilibrer le souci de la vie privée, de la confidentialité, de l'intégrité professionnelle, de la responsabilité et de la promotion de la confiance. Elles concernent également la place de l'éthique clinique dans le système de santé canadien au sens large.

Mots-clés
documentation, éthique clinique, consultation, vie privée, confiance, confidentialité, professionnalisation

Abstract
This short perspective piece is about the documentation of clinical ethics consultation in Canada. It is written at a time when the Canadian Association of Practicing Health Care Ethicists (CAPHE) is endeavoring to develop standards of practice for clinical ethics in Canada. This brief commentary is informed by my experience working in clinical ethics in three different provinces, but it is primarily an attempt to draw attention to the normative questions: How much and what kinds of information should be included in clinical ethics documentation? Where should ethics consultation reports be saved, and who should have access to them? These questions are, more fundamentally, about how we should balance concern for privacy, confidentiality, professional integrity, accountability and the promotion of trust. They are also about where clinical ethics fits within the broader Canadian health system.

Keywords
documentation, clinical ethics, consultation, privacy, trust, confidentiality, professionalization

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INTRODUCTION

This short commentary is about the documentation of clinical ethics consultation in Canada. It is written at a time when the Canadian Association of Practicing Health Care Ethicists (CAPHE) is endeavoring to develop standards of practice for clinical ethics in Canada and I hope it will encourage practising health care ethicists to actively participate in that important process. This brief commentary is informed by my experience working in clinical ethics in three different provinces, but it likely does not reflect the experience of all in Canada and it is not primarily an empirical project. This is chiefly an attempt to draw attention to normative questions about clinical ethics documentation. Questions about how and where we should document clinical ethics consultation involve questions about how we should balance concern for privacy, confidentiality, professional integrity, accountability and the promotion of trust. They are also about where clinical ethics fits within the broader Canadian health system.

Clinical ethics remains a relative newcomer to the Canadian health care system. There has been extremely useful research on the function and services provided by ethics consultants, how they are resourced and where they sit within larger organizational structures in Canada. However, relatively little has been published about more fine-grained matters such as documentation.

As health care ethicists in Canada endeavor to develop standards of practice for clinical ethics work, we should openly engage the following questions:

1. **How much and what kinds of information should be included in ethics consultation reports?** For example, should we always include the patient's name? Should we include the names of all those who participated in a conversation? Should we include a lot of detail? Should reports primarily describe the timeline and process used by the ethics consultant, or should they also engage the content and substance of the case?

2. **Where should reports be saved and who should have access to them?** For example, when should reports be placed in a patient's health record? When is it appropriate to not place an ethics consult report in the patient's health record? Given that many ethics consultants in Canada are not located where they are providing ethics support and many do not have direct access to patient health records, is it appropriate to send consult reports to requestors via email? Should the patient be informed that a report was written? What about administrators, peer reviewers, and the public?

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In this commentary, I use the term 'ethics consultant' to mean anyone who is relied on by the health institution to provide ethics consultation services. This includes clinical ethicists for whom a central component of their job is responding to ethics consult requests, but it also includes health care providers or others who participate in ethics consults as part of their role on an institutional ethics committee. I use the term 'ethics consult' to refer to both more and less formal kinds of consultation, including large or small group meetings or one-on-one conversations, with or without the patient's involvement. By 'consult report' I mean a summarizing document, written by an ethics consultant following a consult. This commentary will be of interest to clinical ethics consultants and administrators with ethics support/services in their portfolios, as well as those involved in accreditation and the professionalization of clinical ethicists in Canada.

BALANCING PRIVACY, TRUST, CONFIDENTIALITY, TRANSPARENCY AND ACCOUNTABILITY

In my experience, it seems that how ethics consult reports are written and who is given access to them depends in part on what the report is for and the function of ethics consultation in that case (1,2).

In the Canadian jurisdictions where I have worked in clinical ethics, the bulk of requests for consultation have come from health care providers and/or administrators who are working through ethically challenging situations, rather than from patients or family members directly (3). Requestors often ask ethics consultants to participate in or facilitate a small group conversation, providing those in the circle of care a dedicated opportunity to come together to share information, improve mutual understanding, analyze their moral distress and possible options before they engage the patient or family further (4). In my own work, particularly where a group meeting occurred, requestors are often given a copy of an ethics consult report that is also saved internally on a secure site of the ethics program. Depending on the nature of the case, it may be placed in the patient's health record. Other times, it may just be shared with certain other members of the health care team, particularly if the consult related to internal disagreement or uncertainty within the team, and the report is serving an educational role. Sharing consult reports by secure email may be more common in areas where an ethics consultant does not have direct access to the health record, where the consultant covers a large geographic area and does not work out of the same location as the requestor, or where the health care team is itself spread across different facilities.

Recently, members of one of the institutional ethics committees that I sit on debated whether health care staff view ethics consultation meetings as safe spaces to explore complex cases in confidence, and whether they might, therefore, see a written consult report as a violation of their trust, particularly if the report includes their name, and particularly if the report is shared with or becomes accessible to others who were not present at the consult meeting.[1] The committee also noted that their institution's Minimum Documentation Standards policy requires that certain things not be documented in patient records such as "disagreements between team members, issues related to the availability of resources in the care area, subjective accusations, or communication with the health centre's legal counsel or risk manager." (5) The policy adds that "[i]nformation and the level of detail documented in the patient's permanent health record about a patient 's family members must be relevant to the patient's care." Reviewing this policy left some of us wondering if we were including too much information in our reports (6). Some committee members further wondered if documenting consult meetings in written reports might deter health care providers from asking for ethics consultation in the first place. While I think that many clinicians or administrators likely take comfort in ethics consultation being documented, further empirical research on these concerns may be useful.

Some have wondered whether provinces should move towards a system that gives legal protection to ethics consult reports such that they cannot be subject to freedom of information requests or compelled as evidence in legal cases, as has been done in some US states (7). Similar protections exist in Canada for some quality improvement information, on the grounds that their protection from public airing is necessary to ensure that health care providers feel free to come forward with information about adverse events. Protecting this information from wider view ultimately contributes to better patient safety (8)[2]. It seems worth asking whether ethics consult reports should be similarly protected in Canada.

I do not want to overstate the differences in practices among health ethics consultants in Canada. There appears to be a lot of common ground (3,9). Still, there do seem to be questions related to documentation (and access to documentation) that I think warrant broader conversation, particularly as they relate to accountability, trust and privacy. These questions also highlight a need for clarity regarding where ethics consultation fits within the health care system, and whether consults are sufficiently like quality improvement or other internal processes that a similar approach to documentation may be warranted.
Many have written about the importance of involving patients in ethics consultation processes, expressing concern that failing to involve the patient directly risks being unfair and biased and may violate patient confidentiality. I agree with others who have convincingly argued that ethics consultants should avoid doing "curbside" or "hallway consults" where they do not have a genuine opportunity to ask difficult questions and where only a small fraction of relevant information might be relayed (10). Nonetheless, it seems appropriate to continue offering health care providers and administrators support from ethics consultants, without simultaneously having to always engage the patient or substitute decision maker (SDM) directly. My own view is that, as a discipline, we are trying to normalize a process of pulling together team members who might not otherwise have an opportunity to sit down with each other, and limit situations where health care providers or administrators are making complex ethical decisions in isolation. This can sometimes be easier to do if a patient's or SDM's presence is not a required part of every ethics consultation process.

[1] I am grateful to members of the IWK Clinical Ethics Committee for raising these concerns during meetings from Spring to Winter 2019 (Halifax, NS).
[2] Similar Acts exist in other provinces. For a useful perspective, see the CMPA's "Evaluating and implementing quality improvement initiatives in surgery".

However, consults that do not involve patients or their SDMs directly also raise reasonable concern about patient confidentiality and informed consent. Should greater effort be made to raise the general public's awareness about the existence and involvement of ethics consultants in health care decision-making? In a context where ethics consultants are widely understood as part of the circle of care, and ethics consultations part of the background conditions of health care, like quality improvement staff, it may be less problematic to not directly engage the patient. Others may prefer to require express patient consent for the involvement of ethics consultants. Exploring concerns about patient (non)involvement is beyond the scope of this short commentary, but it seems worth flagging as it is tightly connected to the topic of clinical ethics processes and documentation, what it should include and who should have access.

CONCLUSION

As we work towards professionalization of health care ethicists and development of national standards of practice in Canada, it is a good time to draw greater attention to normative questions about documentation. Our processes can draw on insights from other disciplines (11). Consult reports can have diverse functions. Sometimes they are meant to improve mutual understanding across an interdisciplinary team, sometimes they are a mechanism for ethics education. They can sometimes help to demonstrate that a team has engaged internal resources to attempt to resolve disagreements with SDMs, or they enable ethics consultants to provide reasons and evidence for their concerns or recommendations. How we understand the function(s) of the report in each case will influence the writing style and level of identifying detail, as well as who is provided a copy or given access. It would be useful if we could both collect more empirical information about how ethics consultation is being documented in all areas of the country, but equally if we could open up conceptual analysis of what it is we want documentation to do and how to fairly and responsibly accomplish those goals.

In my own work, health care providers and administrators have reported that it can be useful to see a complex situation distilled into digestible ethics issues and language. A consult report can also clarify any action items that might have arisen in the course of a heated or emotional meeting. Still, the existence of these documents, the ease with which they can be shared and, in some cases, their status as public documents, raises certain concerns about professional integrity, privacy, confidentiality, trust and openness that I think warrants closer examination. I hope this short commentary serves as an invitation for further conversation.

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