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A review of clinical ethics consultations in a regional healthcare system over a two-year timeframe

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Abstract

Background Clinical Ethics Consultations (CECs) are used by healthcare systems to offer healthcare practitioners a structured level of support to approach ethical questions. The objective of this study was to detail the elements of surveyed CECs and offer guidance in the approach to future ethics consultations at a regional healthcare system.

Methods This cohort study has a qualitative and quantitative retrospective approach, surveying ethics consultations through the dates of 4/27/22 to 4/26/24. A documentary sheet was created, and information was entered via online data-gathering forms. The cases are from a range of specialties within a regional healthcare system servicing Minnesota, Wisconsin, and North Dakota.

Results 103 CECs were performed within the study period across the regional healthcare system. Consultations were identified through retrospective review of the internal CEC database, and patient information was collected through the medical record. Decision-making was often performed by a substitute decision-maker ($N=54$), occurring in 70.1% of cases with known decision makers. CECs were documented in an ethics-specific note in the patient medical record in 37 of 82 (45.1%) documented patient cases. It was common for physicians to mention the ethics consultation in their patient notes, occuring in 51 of 82 (62.2%) of documented patient cases. Age was recorded in 92.0% ($N=91$) of unique patient cases; the median age was 62 years. Ethical questions concerning end-of-life care were the most common cause for consultation ($N=35$, 34%), and CECs were most commonly requested in general medicine or hospitalist departments ($N=38$, 45.2%). Most consultations resulted in resolution at time of initial consultation with the ethics call team.

Conclusions Recommendations for increased frequency and timing of policy review are given based on the results of the data presented. Using interpretation of the CECs in this study, we offer recommendations towards the use and documentation of ethics consultations in the era of open notes, open the door towards areas of future research, and ultimately promote use of CECs for more favorable patient outcomes.

Keywords Clinical ethics consultation (CEC), Clinical ethics, Open notes, Regional health system

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Background

Clinical Ethics Consultations (CECs) are being implemented by a growing number of healthcare institutions to provide an approach to clinical decision making when providers are faced with ethical challenges. At most large hospitals, these consults are handled by a trained on-call ethics team familiar with legal and ethical ramifications, as well as hospital policy when applicable. At larger teaching hospitals, these committees are often largely made up of academics who are closely tied to universities, while clinicians, chaplains, and community members often make up a significant part of the committees as well [1, 2]. Presumably, in committees serving smaller hospitals over more rural areas, there would be more clinician and community staffing due to limited supply of academic clinical ethicists and budgets. This may have an effect on the frequency of consultation, type of consultation, and department comfortability with consultation.

Regional hospital systems continue to contend with many stakeholders, including legal considerations, changing patient documentation standards, and a host of differences in ethical standards between a care team and a patient care representative. One of the main ways to deal with these competing interests has been high usage of CEC in both large and small hospitals over the last 20 years [3]. As hospitals and the systems governing them continue to grow in both size and complexity, trained committees support care teams in balancing these (often competing) factors more easily. This rise in usage has corresponded to an increase in "user satisfaction" with 94% of health care teams reporting positive perceptions of their healthcare ethics team [4]. Ethics committees have been a staple of most large, urban hospitals and health systems since the 1990s after endorsement by the American Medical Association and the American Hospital Association in 1984 [5]. There has been extensive research on these systems, how they work, and recommendations for their continued improvement as a part of the larger health system.

However, there are still information gaps in the realm of smaller health systems working outside large urban centers. Information about the types of consults, departments choosing to make those consults, and bodies of reference used by smaller volunteer ethics committees. The goal of this study is to characterize the ethics consultations performed by volunteer ethics committees for a regional medical provider from April 2022 to April 2024. The intent being to provide clearer information for future ethics consult documentation, institutional policy, and ethics consult service procedure to promote satisfactory patient outcomes.

Methods

Subjects

The study analyzes the CECs that were performed by the Essentia Health ethics committee members in the years 2022 to 2024 across their respective range of Essentia healthcare institutions. The Essentia Health market encompasses 14 hospitals and 78 clinics across Minnesota, North Dakota, and Wisconsin [6]. These consultations are predominantly a volunteer service providing consultation and support on individual cases where ethical issues have been raised in an inpatient or outpatient setting. The committees include physicians, chaplains, certified healthcare ethicists, pharmacists, social workers, and former healthcare professionals, and currently have an average of 12 staff that take part in monthly meetings to discuss cases from the previous month. Some members have formal academic training, advanced ethics degrees beyond the system healthcare protocol, but this is not required to be a part of any of these committees. All members are offered the opportunity to shadow the on-call team prior to being on-call themselves. The committees are also responsible for ethics training, creation of ethics policy, and guidelines across the healthcare system.

CECs are offered as an on-call service performed via phone or in-person by two committee members during that particular period. Working in conjunction with the attending physician, the committee members discuss stakeholders, and potential ethical and legal ramifications of the case. While every case is unique, it is typical for a meeting between the ethics team, family (or surrogates), and committee members to take place, as well as a private meeting by the ethics team to discuss the issues and make a formal recommendation for the case. The recommendation is then for the consulting committee member to write up a summary to add to the medical record. No template is currently in use for note-writing physicians or committee members to write consultation notes in the chart, and documentation is not a requirement by either state law or hospital policy.

Data collection

Consultation records were retrieved from a data set populated by Microsoft Forms submissions entered by the committee member or physician who worked on the case. Consultations from 04/27/22 to 04/26/24 were included; this followed a novel collaboration between the ethics committee at Essentia Duluth, and the ethics team of St. Mary's Medical Center. This coincided with a new written ethics form, a tool that is currently in use by the ethics committees across the Essentia system. All CECs during that period were included in this study.

We collected the following information for each case: patient length of stay, cause for consultation, department

Table 1 Patient length of stay and admit-to-discharge CEC related metrics ($n=72$)

Patients length of stay once admitted in median days	Time from patients hospital admission to CEC in median days	Time from CEC to patient hospital discharge in median days
22.0 (1-187)	**8.5** (0-124)	**7.0** (0-179)

min-max minimum to maximum number of days

seeking consultation, patient representative, availability and date of advance directive. Inpatients who were hospitalized for a length shorter than one full day were rounded up to one day for length of stay calculation.

Results

103 consultations from 04/27/22 to 4/26/24 were identified throughout the study period, all involving encounters with patients. Of the 103 consultations, 99 involved unique patients while 4 were secondary consultations that occurred during the patient's hospital stay. All 103 consultations were included in the analysis, though patients who had multiple consultations in one hospital stay were excluded in data sets including length of stay and CEC milestones, median age, and discharge disposition. Another patient was omitted from this data set as the consultation occurred during a hospitalization that was ongoing at the time of data analysis. Patient age was available in 91 (92.0%) unique patient cases, with a median patient age of 62 years, a youngest age of 0 years (newborn), and an oldest age of 96 years. Of 99 identified unique patient cases, 73 were admitted to the hospital. It was not possible to determine the admission status of 20 patients due to lack of identifiable data. It was also recorded that 6 cases where patients were not admitted to an inpatient facility. The mean time of hospital stay was 35.8 days (SD 42.1) and a median of 22 days (IQR 8.5–42). Patients were hospitalized a mean time of 16.6 (SD 22.6) days and a median time of 8.5 days (IQR 2-21.5) before the consultation. Following the consultation, patients remained hospitalized for a mean 18 (SD 29.8) days and median of 7 (IQR 2–20) days. It was not possible to determine length of time between CEC initiation and resolution, as these values were not recorded in the ethics notes. Of the total 73 hospitalized patients, a total of 24 (32.9%) were documented as deceased on discharge disposition, with the remaining 49 (67.1%) documented as alive. Table 1 summarizes the median length of stay and CEC time related metrics. The shortest admission time was 1 day, which was held by two cases: an orthopedic surgical patient and a neonate.

The majority of the consultations ($N=58$, 56.9%) were requested at the healthcare system's largest hospital, a regional level 1 trauma center. Almost all CEC requests presented with more than one ethical question. Questions surrounding end-of-life issues were the most common reason for consultation ($N=35$, 34.0%). Other common causes for consultation included question of appropriate decision maker ($N=29$, 28.2%); conflict with patient care plan ($N=28$, 27.2%); non beneficial care ($N=26$, 25.2%); moral distress ($N=25$, 24.3%); and patient capacity to make medical decisions ($N=20$, 19.4%). The causes for ethics consultation are summarized in Table 2. When examining consultations in North Dakota, which has a surrogate hierarchy law, and Minnesota/Wisconsin, which both lack such a law, 3 of 12 North Dakota consultations cited patient representation as cause for consultation, while 31 of 91 Minnesota consultations cited the same cause. Notably, patient cases with the ethical issue listed as 'conflict with care plan' did not delineate whether the conflict was between the patient and care team, between patient and family members, amongst family members, between family and the care team, or between members of the care team.

Table 2 Surveyed causes for ethics committee consultation. Percentages add to greater than 100% because more than one reason for CEC could be identified

Ethical Question	*All consults (n = 103)*	
	n	**%**
End-of-life decisions	35	34.0
Nonbeneficial care	26	25.2
Question of appropriate decision maker	29	28.2
Patient capacity for medical decisions	20	19.4
Lack of guardianship	3	2.9
Unrepresented patient	11	10.7
Patient representative making non-ideal decision	1	1.0
Conflict with care plan	28	27.2
Moral distress	25	24.3
Discharge concerns	9	8.7
Allocation of scarce resource	7	6.8
Religious directives	6	5.8
Organizational	3	2.9
Other	2	1.9

Across the healthcare system, general medicine or hospitalist departments requested the largest number of CECs, requesting 38 of 84 (45.2%) cases with recorded departments. The second most common department to request ethics consultation was critical care ($N=14$, 16.7%). Of the surgical subspecialties, Trauma Surgery requested the majority of CECs, composing 6 of the 10 surgical CECs. Table 3 shows consults by department.

Patient representation was documented in 77 (74.8%) cases, with a surrogate decision maker most commonly making decisions ($N=24$, 31.2%), followed by the patient themselves ($N=23$, 29.9%); the designated healthcare agent ($N=19$, 24.7%); and the patients guardian ($N=11$, 14.3%). In the 24 cases where a surrogate decision maker was making decisions, this entity was not one outlined in a living will, but rather someone designated to make

Table 3 Department requesting clinical ethics consult

Department	Consults with recorded department (*n* = 84)	
	n	%
General Medicine / Hospitalist	38	45.2
Critical Care	14	16.7
Trauma Surgery	6	7.1
Psychiatry	5	6.0
OB/GYN	5	6.0
Emergency	3	3.6
General Surgery	2	2.4
Oncology	2	2.4
Neonatology	2	2.4
Palliative Care	2	2.4
Pediatrics	1	1.2
Nephrology	1	1.2
Cardiology	1	1.2
Cardiac Surgery	1	1.2
Orthopedic Surgery	1	1.2

Table 4 Entity responsible for patient decision making

Entity	All consults (*n* = 103)	
	n	%
Surrogate decision maker	24	23.3
Health care agent	19	18.5
Guardian	11	10.7
Patient themselves	23	22.3
Not documented	26	25.2

decisions in the patient's best interest at time of consultation. These surrogate decision maker cases include six cases that took place in North Dakota, where a next-of-kin surrogate decision maker was designated per state legislature. Statistics on patient decision making entities are summarized in Table 4. Of the 83 unique patients with accessible medical records, it was determined that 21.7% (*N*=18) of patients had an advance directive on file at the time of the consult. Among those 18 patients with established advance directives, the median time between establishment of advance directive and time of consultation was 2440 days (6.7 years). Five patients (27.8%) had an advance directive established within two years of consultation; four patients (22.2%) with advance directives between two to five years; four patients (22.2%) with advance directives between five to ten years; and five patients (27.8%) with advance directives older than ten years. In five cases, patients had an advance directive change following CEC. Most patients had code status documented at time of ethics consultation, with code status recorded in 77 (92.8%) of 83 available cases.

Of the 83 CEC cases with accessible medical records, standalone notes specific to the CEC, or 'ethics-specific' notes were documented in 37 (44.6%) patient medical records. Ethics-specific notes were most commonly documented by a member of the ethics team; this occurred in 35 of 37 cases (94.6%). The remaining two ethics-specific notes were documented by the attending physician. Across accessible cases, it was common for the attending physician to mention the ethics consult in their charting, occurring in 52 (62.7%) cases.

Consultation recommendations were most often guided by previous cases (*N*=38, 36.9%); institutional policy (*N*=26, 25.2%); professional code (*N*=17, 16.5%); legal issues (*N*=13, 12.6%); published literature (*N*=10, 9.7%); or ethical and religious directives (*N*=6, 5.8%). It was common (*N*=27, 26.2%) for ethics recommendations to use multiple sources of reference in documentation. Nineteen of 83 patient cases with accessible medical records had advance directives, but advance directives were only cited as a source for determining recommendation in 2 cases (1.9%). Of the CECs with recorded results, 54 were deemed an ethics issue and recommendation was given upon immediate consultation from the on-call ethics team. Cases that were not deemed resolved upon initial consultation were escalated to the ethics committees, resolved by the care team, or advice was given to better assess the patient and ethical question.

Discussion

This paper provides a descriptive analysis encompassing two years of CECs in a regional health system across three states and multiple specialties, addressing new questions of consultation indications for a regional hospital with a mostly volunteer ethics committee. This research categorizes and describes data contained from initial ethics consult to resolution of each case, using the information to describe trends and guide quality improvement for this system and others like it. The following findings will be discussed with a focus on types of consult, consulting departments, decision making entities, and quality improvement recommendations for development of CEC policy.

Types of ethics consultations

Unsurprisingly, most of our cases involved patients who were admitted as inpatients in general medicine wards. Those who received consultations were admitted for a median time of 21 days, receiving the consultation a median time of eight-and-a-half days into their stay, and discharging a median seven days following consultation. The median time from admission to consultation among this patient population was roughly four days earlier than reviews containing patients of similar median hospitalization time [7, 8]. This data did not permit analysis of the timeline from ethics consultation request to recommendation, a measure used in some reviews to gauge ethics response [8]. As there is no standardized documentation

for ethics consultations, this is not uncommon. Due to the on-call nature of these ethics committees, and documented resolution following initial call, it is concluded that the majority of this healthcare system's CECs reached resolution immediately following initial consultation. It is most typical that cases are resolved when the ethicist (or team of ethicists) can provide a professionally supported recommendation. Resolution is reached when the consulting ethicist deems the CEC has reached a satisfactory outcome. As the complexity of ethics cases do not often permit specific metrics of quality, it is best left to the consulting ethicist to determine whether outcomes are satisfactory. Consult-to-resolution timeframe is not the case in many healthcare systems, where ethics consults often take 1–3 days to reach a resolution [7, 8]. The smaller size and robust committee numbers play a part in this, but the organizational commitment to having a team member on call at all times is something that could be implemented at larger systems as well. Volunteer members who are willing and able to be on call 24/7 implies that in systems with paid ethicists, the standard could and should be immediate or near-immediate consultations rather than only weekdays during working hours.

Consultation departments

While general medicine requested the largest share of CECs; departments caring for imminently dying patients, such as critical care, trauma surgery, and emergency, also accounted for a large portion of patients. Considering the critical nature of the ethics questions these departments face, on-call ethics teams are an essential tool. In this healthcare system, 19 of 21 recorded cases from these departments met immediate resolution following initial consultation. This further suggests the earlier stated need for immediate consultation. It is important to note that many of these cases are on a strict timetable, and thus earlier ethics resolution may have the ability to improve patient care. In comparison to similar research at larger urban hospitals with more academic committees, the breakdown by department looks to be largely the same. This suggests that there may not be a large difference in comfortability making consultations based on formulation of ethics committees. Whether a provider identifies more with a committee made up largely of peers may not play as large a part as other factors, such as knowledge about the role of their ethics committee or previous experience requesting consultation. Further research investigating attitudes about ethics consultation by department may be useful. Investigating differences in consult indications across different specialties as well as differences in consultation requests based on committee composition may add new possibilities for quality improvement in the future. To that end, the current ethics consultation request form does not include the field of "requester name", this would be of great benefit to analyze CEC use trends and care team-patient dynamics. Like other studies, it is common for attending physicians to submit ethics requests, but it is unclear if other members of the care team or family members submitted CEC requests in this data set [8].

Decision-making entities

Considering only 19 of the total 77 patients with recorded decision makers had a designated health care agent, it was not surprising the second most common broader category of ethics consultation request were those involving the question of patient representation. These CECs involved cases in which there was difficulty assessing a patient's capacity to represent themself or difficulty determining a patient representative. Patient representation in this population is unique in that Minnesota and Wisconsin do not have a hierarchy in determining patient surrogate decision makers. State statute does not name the order of patient decision makers in the case where one has not been named. This may have implications on the generalizability of these results in the states where there is a hierarchy of decision makers as written in state statute. While only twelve patient cases occurred in North Dakota, a state with surrogate decision-making hierarchy, differences in consultation cause were observed in our data. In Minnesota and Wisconsin, roughly one-third (31 of 91) of all consultations cited patient representation (unrepresented patient or determining appropriate decision maker) as cause for consultation, while only one-quarter (3 of 12) of North Dakota consultations cited the same cause. Observing larger patient populations for similar trends would allow better comparison of states with or without surrogate decision-making hierarchy, and further delineate the utility of ethics consultations in approaching patient representation.

Like many other healthcare systems, end-of-life decisions were the most prevalent reason for ethics consultation [8, 9]. Of the 73 admitted patients, 24 patients, nearly one-third, were documented deceased during the stay in which the consult occurred. Understandably, very few cases involving end-of-life care were those in which the patient could make their own decisions; patients represented themselves in only three of these 35 cases. Further, only four of 35 end-of-life CEC patients had advance directives filed at time of consultation. Overall, 18 of 83 patient cases with accessible medical records had advance directives. While the lack of documented advance directives may be explained considering that patients with advance directives may be less likely to require ethics consultations; the low number of these documents and overall number of consultations highlights the importance of promoting conversations regarding advance care planning with patients. The lack

of articulated advance directives place immense pressure on care teams while deciding care when patients' healthcare wishes are not known. Unfortunately it is these cases where care team members must decide what they think is best for the patient, cognizant of the fact that they may be going against the patient's wishes unknowingly. This further illustrates the utility of a responsive on-call ethics team in aiding care team members in ethical decision making.

Ethics policy formulation

With existing healthcare policy used as a source in 25.2% ($n=26$) of all CECs, review of such policies by ethics committees becomes critical in making sure that they are current and correct in following the mission of the healthcare system. Since many ethics teams have meetings monthly or quarterly, it would be reasonable for team members to have at least a yearly holistic review of the existing policy. When policy is created, endorsement from the Essentia Clinical Practice Committee is obtained, followed by approval from every hospital's executive medical staff committee. The policy may be written once, and then reviewed triennially with minimal change to the actual policy. In the case of a major change to the ethics committee membership or policy, such as a large merger or new law, it would likely be necessary to have a more robust review or total revision of existing ethics policies. Enacting change in ethics policy is often a very involved process, but regular reviews, rather than sporadic large changes and rewrites will make the process go more smoothly, with the added benefit of having a more updated policy to work with.

Documentation of ethics consultations

Chart notation specific to an ethics consult is one of the most robust and easiest ways to make sure that CECs are documented for review, and so that departments, patients, and their families are aware that a consult has been made. As of April, 2021, federal ruling of the 21st Century Cures Act mandates that healthcare providers offer patients access to their medical records online, without delay or charge, called "open notes" [10, 11]. Given this transparency between providers and patients in the era of 'open notes' where patients have the right to read all personal medical records, there are questions about which notes should be included in records accessible by patients. Although there is ability for providers to hide a chart note in cases where it could cause a patient imminent distress or harm, there is still likely some hesitancy to document consult information, especially in cases with conflicting care plans or safety concerns [11, 12].

It is important to note the third most common cause (28 of 103 cases) for consultation was "conflict with care plan". Documentation often made it unclear whether this conflict was between the patient and care team, between patient and family members, amongst family members, between family and the care team, or between members of the care team. Characterizing this conflict in the initial ethics consultation may be useful in delineating whether the consultation should be documented in the patient medical record. For example, documentation of conflicts between patients and the care team in the medical record may be cause for distrust and damage the provider-patient relationship.

With 37 of 83 cases in this set containing documentation specific to the consults, there is still clear room for growth in ethics documentation. To ensure satisfaction for both providers and patients (or their respective entities) and given the potential for providers to hide notes that could compromise patient safety, a policy mandating ethics-specific documentation in the patient chart would be beneficial. This would enable an ethics department to keep track of time and experience consulting, allow for trend assessment analysis, and make a clear registry of cases for further research [13]. However, the wide range of complexity in ethics cases may pose difficulty in standardization of documentation methods. Childers et al. suggests incorporating narrative features in ethics consultation documentation; this is thought to not only increase autonomy of patients by allowing them to be "more informed and involved in their care", but also strengthen the care team's understanding of the patient's illness [12]. In supporting the patient's narrative of care, Mangino and Danis suggest involving patients whenever possible in the consultation, and when involvement is not possible, minimize negative reactions from patients by including a preface to notes [14]. Mangino and Danis suggest adding a three part preface in these notes, one that: "1) describes the nature and purpose of ethics consultations, 2) alerts patients that they might be unaware that an ethics consultation has been requested, and 3), provides information for contacting the ethics consultation service about any questions or concerts" [14].

In cases where it is determined that documentation may cause harm to a patient, it may be of benefit to approach withholding documentation considering the basic ethical framework of non-maleficence. In these cases, it may be justified to enact a level of therapeutic privilege regarding CEC disclosure to the patient or surrogate decision maker. This would need to be done on a case-by-case basis to allow someone to forgo documentation of a specific CEC. In these cases, it would be of recommendation to receive endorsement of the ethics committee or healthcare ethicist in withholding ethics documentation. As it is best practice for physicians to document cause for withholding information in the cases of therapeutic privilege, cases where ethics consultation

documentation is withheld from the medical record also call for stringent internal documentation. Of the total 103 consultations, three were also designated as organizational CECs. It may also be permissible to omit consultations from the patient record that do not involve the patient's care, for example, those specific to organizational policy. Ultimately, it is recommended to promote patient involvement in consultations, and document CECs in the medical record with the rare exception of those cases where documentation may cause harm to the patient, or those where the ethics consultation did not pertain to the patient's care.

Limitations

One of the major limitations of this study is the issue with logging the ethics consultations. Of the 99 unique patients, 20 patient medical records could not be retrieved due to lack of identifiable data; this is partially due to the fact that MRN numbers were not a required field on the ethics consultation form. This means chart review is not available and multiple pieces of data had to be left out of the study. There is currently no standard protocol for entry of consultation data, which led to issues categorizing data in some instances. Regardless, all findings from this two-year time period were logged and each case was used as part of some larger data set in this study.

Another one of the limitations is the relatively small number of consults done over the two-year period. Most other studies at larger hospital systems have larger numbers or longer time periods than what was used in this study (Tapper et al., 2010;Kaps & Kopf, 2020). This limits the power of the study, and therefore may limit the generalizability of it to other hospital systems of much larger or smaller size, or of those that have a significantly different demographic makeup (i.e. urban teaching hospitals).

Conclusion

Our study adds to the body of literature characterizing ethics consultations and their documentation; unique in demonstrating the use of 24-hour on-call ethics teams in Midwest regional hospital systems. CEC is used in these cases for a broad range of reasons, and from a broad range of departments, indicating a continual need across the system for ethics committees. Recommendations about timely policy review are given based on changes in committee makeup, religious ethical contentions and legal changes surrounding healthcare ethics. Our study also provides ideas for reconciliation around unique scenarios surrounding health systems. Further investigation into open notetaking and associated patient outcomes is necessary to guide ethics documentation as more data becomes available after the inception of the Cares Act.

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Author contributions
G.A. and J.H. collected data and drafted manuscript; D.F., S.J., C.M. contributed to the design of the study, and reviewed the manuscript.

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Data availability
The data sets analyzed during the current study are not publicly available due to confidentiality reasons but de-identified data sets may be requested from the corresponding authors (G.A., J.H.).

Declarations

Ethical approval
The Institutional Review Board of Essentia Health reviewed the protocol and determined it to be a quality improvement project, not human subjects research.

Consent for publication
Not applicable.

Clinical trial number
Not applicable.

Competing interests
The authors declare no competing interests.

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References

1. Kelly DF, Hoyt JW. ETHICS CONSULTATION. Crit Care Clin. 1996;12(1):49–70. https://doi.org/10.1016/S0749-0704(05)70214-1.
2. Sexson WR, Thigpen J. Organization and function of a hospital ethics committee. Clin Perinatol. 1996;23(3):429–36.
3. Danis M, Fox E, Tarzian A, Duke CC. Health care ethics programs in U.S. hospitals: results from a National Survey. BMC Med Ethics. 2021;22(1):107. https://doi.org/10.1186/s12910-021-00673-9.
4. Crico C, Sanchini V, Casali PG, Pravettoni G. Evaluating the effectiveness of clinical ethics committees: a systematic review. Med Health Care Philos. 2021;24(1):135–51. https://doi.org/10.1007/s11019-020-09986-9.
5. Hajibabaee F, Joolaee S, Cheraghi MA, Salari P, Rodney P. Hospital/clinical ethics committees' notion: an overview. J Med Ethics Hist Med. 2016;9:17.
6. Essentia Health Market Research Department. Essentia Health Facts and Figures. Published online June 30, 2023. Accessed August 15. 2024. https://www.essentiahealth.org/about/facts-figures/
7. Nowak A, Schildmann J, Nadolny S, et al. Clinical ethics case consultation in a university department of cardiology and intensive care: a descriptive evaluation of consultation protocols. BMC Med Ethics. 2021;22(1):99. https://doi.org/10.1186/s12910-021-00668-6.
8. Kaps B, Kopf G, Functions. Operations and Policy of a Volunteer Ethics Committee: a quantitative and qualitative analysis of Ethics consultations from 2013 to 2018. HEC Forum. 2022;34(1):55–71. https://doi.org/10.1007/s10730-020-09426-4.
9. Swetz KM, Crowley ME, Hook CC, Mueller PS. Report of 255 clinical Ethics consultations and Review of the literature. Mayo Clin Proc. 2007;82(6):686–91. https://doi.org/10.4065/82.6.686.
10. Bonamici S. H.R.34–21st Century Cures Act. Published online December 13, 2016. Accessed July 7, 2024. https://www.congress.gov/bill/114th-congress/house-bill/34
11. Delbanco T. Open Notes: Doctors and Patients Signing On.
12. Childers C, Marron J, Meyer EC, Abel GA. Clinical ethics consultation documentation in the era of open notes. BMC Med Ethics. 2023;24(1):27. https://doi.org/10.1186/s12910-023-00904-1.

13. Bramstedt KA, Jonsen AR, Andereck WS, McGaughey JW, Neidich AB. Optimising the documentation practices of an Ethics Consultation Service. J Med Ethics. 2009;35(1):47–50. https://doi.org/10.1136/jme.2008.024265.
14. Mangino D, Danis M. Sharing Ethics Consultation Notes with patients through Online portals. AMA J Ethics. 2020;22(9):E784–791. https://doi.org/10.1001/amajethics.2020.784.

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