

## STATE OF THE ART AND SCIENCE

### International Access to Clinical Ethics Consultation via Telemedicine

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#### Introduction

Clinical ethics consultation (CEC) is a service provided by clinical ethicists (or sometimes, clinical ethics committees) to enhance patient care by identifying, analyzing, and resolving ethics dilemmas in clinical settings [1]. CEC has long been offered as part of health care services in the US [2, 3], but it is less common in other countries, perhaps because of a lack of trained personnel due to limitations in the number of clinical ethics fellowships [4-6]. A result of this relative lack of clinical ethics training is that, in some parts of the world, CEC is either not available or it is performed by unskilled personnel [3].

Collegiality and the duty of care are two important and linked ethical values in health care. Clinicians should call on the help of colleagues when cases are complex, and this includes seeking the help of clinical ethicists as needed [7]. An ethical duty of care requires that health care workers be skilled in their professions [8]; thus, sending unskilled ethicists to perform CEC is problematic. According to the American Medical Association, "A [clinical ethics] consultation service should be careful not to take on more than it can handle" [9]. This suggests that practicing outside the scope of one's skill set should be avoided in favor of seeking skilled ethicist colleagues [9]. Everywhere ethical dilemmas arise in medicine, competent ethics consultation should be used.

Clinical ethics dilemmas are not limited to large academic medical centers, where clinical ethicists typically reside. Community hospitals face ethical dilemmas [10], as do rural hospitals [11]. Additionally, clinical ethics dilemmas occur in a wide variety of specialties, including neurology [12], organ donation and transplantation [13], pediatrics [14], and intensive care medicine [15]. Some of these dilemmas need urgent resolution [16], and thus timely access to skilled CEC is valuable.

Interactive telemedicine for remote, real-time communication that uses telephone, email, and videoconferencing technologies [17] might also be a way to provide CEC directly to patients as well as organizations (e.g., hospital departments and committees), in the same country or in other countries. As I discuss below, low-cost tools are available that make remote consultation feasible.

Telephonic CEC is valuable in the setting of transplant ethics consults, particularly for the [screening of living organ donor candidates](#). Many potential living donors do not live near the organ transplant center [18] (e.g., out of state, out of country), and telephonic screenings can reduce costs (e.g., travel, accommodation, food) for the donor candidate and add efficiency to the screening process. While these candidates might be clinically suitable in terms of blood type compatibility, and while they might have undergone a telephonic screening by the social worker beforehand, the clinical ethics consultant can screen for ethical and psychosocial measures of suitability telephonically. Based on my experience, examples of exclusions assessed during telemedicine CEC screening are lack of motivation or ambivalence about donating, coercion, lack of an altruistic motive for donation, moral distress about donating, inability to provide informed consent for donation, and conflict of interest (e.g., desire for compensation or personal gain or a large power differential between potential donor and recipient, such as an employee-employer relationship). After the CEC, the ethicist can make additional referrals to other specialists as needed, such as psychiatry or pastoral care.

### **The Australian CEC Telemedicine Experience**

Australia is known for its large size and unusual dispersion of population; specifically, the geographic distribution is such that most residents live in the coastal perimeter (due to moderate temperatures), with far fewer residents living inland or in rural areas [19]. The first use of telemedicine in Australia was reported in 1929, when the pedal radio was used by the Royal Flying Doctor Service in Queensland to allow doctors to communicate with nurses about patient care in the outback [20]. Possibly due to telemedicine now being widely available, less than 3 percent of the Australian population travels more than one hour to see a general practitioner [21].

With the arrival of a fellowship-trained clinical ethicist, Bond University's medical school initiated a CEC service (in-person and remote) in 2012. Because of its direct link to several local teaching hospitals, the CEC service was poised to offer both inpatient and outpatient consults. And because of the ethicist's specialty in transplant ethics, the service provides this specialty consultation nationwide as well as internationally using telemedicine technology (phone, email, videoconferencing) [22].

Since January 2013, a CEC registry has formally recorded consultations [23]. As of December 2015, this CEC service had performed 46 telemedicine consults, mostly on the topic of transplant and donation ethics (91.3 percent). Most telemedicine consults (82.6 percent) were performed for international clients in various countries, including the USA, Canada, and Switzerland. Technology use for international clients was as follows: 52.6 percent (20 of 38) of consults were by email, 42.1 percent (16 of 38) by telephone, and 5.3 percent (2 of 38) by videoconferencing. Direct patient contact/interview was involved in 57.9 percent (22 of 38) of international telemedicine CECs. All patients who were directly contacted/interviewed were outpatients and all were offered the opportunity of

videoconferencing via Skype or FaceTime, but 72.7 percent opted for telephone consultation (because of, e.g., lack of access to these technologies and concerns about data usage for a 45-60 minute consultation), the cost of which is borne by the caller (clinical ethicist). Telephonic interpreters have been used for Spanish- and Arabic-speaking patients. Consults not involving direct patient contact were focused on matters pertaining to research ethics, organizational ethics, or a deceased patient.

### Lessons Learned

Planning for and structuring of international CEC are required to ensure safety and efficacy (see table 1).

**Table 1.** Avoiding logistical problems in telemedicine clinical ethics consultation

Potential problem	Solution tool
Multiple time zones	Electronic world clock meeting planner
Language barrier	Translator arranged prior to consultation
Lack of costly formal videoconference system	Skype, Skype for Business, FaceTime
Need for access to medical records for review and to create consultation notes	Remote chart access or copy transmitted via encrypted email

*Time zone differences.* When international CEC is performed, both participating locations must be aware of the time zone difference, especially when the International Date Line is crossed. For example, a consult planned for 8:00 a.m. Friday in Brisbane will occur at 2:00 p.m. Thursday in Los Angeles—but only during Daylight Savings Time (which Los Angeles observes, but Brisbane does not). The use of an electronic world clock meeting planner [24] can be very helpful to ensure all parties show up at the same time.

*Language barrier.* Foreign languages can be a challenge in international CEC. Some hospitals have on-site translators, while others use phone interpreter services. Both are suitable for international CEC, but these services must be reserved in advance. It is helpful if the hospital or clinic arranges these translator services for the ethicist. Family members should not be used as translators due to the emotional challenges of ethics consultation, the risks of lack of objectivity, and their lack of experience with the health care context [25].

*Prohibitive cost of videoconferencing systems.* Videoconferencing systems can cost \$20,000-\$30,000 [26], an expensive price tag for many rural or small facilities. This high cost would also make it difficult for private practice ethicists and even bioethics centers to have their own systems [26]. A much simpler and more cost-effective video communication system is online videoconferencing software. Skype [27] is available in two formats: Skype (free) and Skype for Business (requires a monthly fee). Both formats allow users to communicate with each other via text, audio, and video, and both use

suitable encryption technology; however, only Skype for Business is compatible with the Health Insurance Portability and Accountability Act (HIPAA) [28, 29]. (In fact, Skype for Business is bundled with MDLIVE telemedicine and telepsychology services [30].) FaceTime, for Apple devices, is a free, HIPAA-compliant videoconferencing platform that is used by the United States Department of Veterans Affairs [30, 31].

Of course, in other countries compliance with HIPAA is not required. For example, the Australian College of Rural & Remote Medicine argues that the personal version of Skype is suitable for telemedicine use for nonurgent consults lasting less than one hour (to ensure call quality) and emergency consults, but not for texting patients or file sharing [32]. Telemedicine consults using the personal version of Skype are also permitted by the Australian Department of Health and Ageing and Australian Medicare (public health service) [32]. This policy is reasonable, as it might not be feasible for all patients, hospitals, and ethicists to have expensive videoconferencing systems or Skype for Business accounts.

*Need for access to medical documents.* The performance of telemedicine CEC requires review of the patient's medical record, and there are two ways of accomplishing this. The facilities that request the consultation can arrange for direct electronic access to health records through remote login procedures, although training might be required to navigate the electronic health system. Another option is for the requesting facility to send portable document format (.pdf) files through encrypted email. The facility can provide a secure email account that allows direct entry into their regulation-compliant system. These technologies can also be used for depositing the CEC report into the patient's medical record [33]. Private practice clinical ethicists can also use free, HIPAA-compliant email servers for communication with patients and organizations [34].

## Conclusion

Telemedicine allows the remote presence of trained and experienced clinical ethicists directly in inpatient and outpatient settings across the world. Interpreters can bridge the gap in settings of foreign language, and low-cost telemedicine technology can be used in resource-poor areas. No longer shall the availability of CEC be limited to academic medical centers.

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