

The Ethics of Sharing: How Do Social Workers Decide What to Record in Shared Health Records?

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Social workers form part of many healthcare teams. The roles of social workers in health care can involve in-depth conversations with clients, along with home visits. These encounters can reveal a variety of sensitive information, not all of which may be known, or accessible to, other members of the healthcare team. Most modern healthcare systems employ shared care records, which are populated by, and accessible to, multiple members of the healthcare team. Shared care records are valued for their capacity to enhance inter-professional communication and, thus, improve patient care. But this very capacity may increase the underlying tension for health records between privacy and efficient and effective care. Ethical tensions can arise for health social workers between comprehensive documentation to ensure provision of appropriate and beneficial care, and protecting client privacy by limiting access to privileged information obtained in the context of a social work encounter.

This qualitative empirical ethics study investigated health social workers' experiences of tensions between protecting client privacy and maintaining complete records, and how they thought the tension should be resolved. Eleven social workers from a range of health settings across New Zealand's North Island were interviewed. We adopted a pragmatist approach to ethical theory, in which everyday experiences and modes of reasoning are valid foundations for theory. Participant testimony provided the basis for developing an account of the principles that should govern decisions about recording sensitive information in shared care records. Three overarching principles were identified: necessity, accuracy, and neutrality. Participants' reports of moral concerns about some decisions regarding recording indicate that ethical tensions can occur. The identified principles offer a starting point for managing such tensions.

Keywords: health social work; records; record keeping; privacy; confidentiality; empirical ethics; qualitative research

Introduction

Good record-keeping is a professional requirement for social workers. Social work Codes of Ethics and Practice Standards typically encompass record-keeping (ANZASW 2007; AASW 2010; BASW 2012; CASW 2005a; NASW 2008). Confidentiality features strongly as a “cornerstone of professional social work relationships” (CASW 2005a, 7), supporting client trust and facilitating needed disclosures. It protects privacy interests and the rights protecting them (UN 2015: Right 12). But confidentiality is not the only ethical consideration that records raise. Information-sharing within and between teams can be critical to ensuring good outcomes for clients. Increasingly, information-sharing is facilitated through electronic record systems, accessible to multiple members of a care team. Recording also raises fundamental issues about respect and depiction of clients and their lives. In recording personal details about clients, social workers create an official account of proceedings that can have consequences for the client’s care, and depict a person, their situation and events in a way that may be exposing, affronting or painful. The development and expansion of electronic record systems provides a reason to reconsider the long-standing question of how practitioners should balance the potentially competing considerations of client privacy, confidentiality and enhanced service provision. As the audience for records expands, so the need to reflect upon judgements about depiction increases.

This paper presents an account of three ethical principles that should guide recording practice. It is the product of ethical analysis developed from the insights of social workers employed in health care teams in New Zealand, using a pragmatist empirical ethics methodology. This approach combines normative ethical reasoning with empirical investigation to produce a philosophically rigorous account grounded

in practical experience. It is intended to be useful to practitioners considering the ethical aspects of their recording practice; professional associations and organisations writing or revising codes of ethics or guidelines, and organisations engaged in recording system development. The data that informs it – derived from interviews with social workers – also provides a springboard for social workers to consider their own experiences with and concerns about recording. The principles that we argue for are: necessity, accuracy, and neutrality. We show how they are underwritten by the values of utility and fairness and, drawing upon participant testimony, explore their implications for recording practice.

The ethics of recording

Both the challenges and opportunities associated with the shift towards increasing record-sharing have received attention in literatures spanning multiple disciplines and perspectives (Greenhalgh et al. 2009; Häyrynen, Saranto, and Nykänen 2008; Huuskonen and Vakkari 2015; Knowles 2009; Langan 2009; Maiorana et al. 2012; Powell, Fitton, and Fitton 2006; Tai and McLellan 2012; Tuepker et al. 2015) and focused on a range of professional settings (primary care (Tierney et al. 2015); public health (Suzuki & Matsuda 2015); drug treatment and testing (Barton and Quinn 2002); hospital emergency departments (Hunt and Arend 2002); sexual health (Brook et al. 2014; Hyde et al. 2016); adolescent care (Bayer, Santelli, and Klitzman 2015) and mental health (Salomon et al. 2010; J. Richardson and McDonald 2016; Liew 2012)). Some discussions concern patient or client perspectives and expectations about records (Carman and Britten 1995; Menkes et al. 2008; Powell, Fitton, and Fitton 2006; M. Richardson 2003; Sankar et al. 2003; Teixeira et al. 2011; Whetten-Goldstein, Nguyen, and Sugarman 2001; Whiddett et al. 2006). Others address client

access to their own electronic records, which we do not discuss here (Schwartz et al. 2015; Zickmund et al. 2007). Researchers have examined the attitudes of providers and organisations (Dossa and Welch 2015; Fry et al. 2014; Maiorana et al. 2012; Salomon et al. 2010; Tuepker et al. 2015). Additionally, there is a substantial body of work investigating implementation considerations of electronic records systems, such as their economic profile (Sidorov 2006); uptake and implementation success factors (Handy, Hunter, and Whiddett 2001); impact on recording (Pullen and Loudon 2006); how users of records attend to information and how much they miss (Brown et al. 2014; Sakata et al. 2016); cost; patient control, equality of access and legitimate use (Spriggs et al. 2012). There is an informatics literature examining security issues, privacy protection and preventing illegitimate access (Appari and Johnson 2010; Bindahman and Zakaria 2011; Mizani and Baykal 2007).

Several tensions are consistently highlighted: a tension between clientⁱ expectations about who can access their records, and the reality of access; an interprofessional tension arising out of varying needs and expectations of recording; and a tension between the professional duty to protect confidentiality of the client-provider relationship and to share information within the health care team to enable quality care.

The tension between maintaining confidentiality and making information available to support best care

There is widespread agreement that accurate recording and interprofessional information-sharing can enhance care in health and social services (Laming 2003; Prince 1996). Informational continuity is seen as a means of partially addressing limitations in relational continuity, and ensuring efficient and effective care across

multiple providers (Cumming et al. 2007; Flynn et al. 2003; Häyriinen, Saranto, and Nykänen 2008; Whiddett et al. 2006). In healthcare, maintaining a single client record able to be accessed and populated by multiple professionals, sometimes from different professions or organisations, is seen as an efficient means of ensuring seamless care, particularly in dispersed teams with limited personal interaction (Cumming et al. 2007). Client benefit and harm minimisation constitute the strongest grounds for facilitating interprofessional access to records. The risks of limited interprofessional information sharing have been demonstrated in health and social work. The perils of failure to share information have been painfully documented in child protection inquiries (Department of Health and Social Security 1974; Laming 2003). Similarly, Walley et al. (2009) found that 30% of all 84 participants recruited from a methadone maintenance program did not have their opioid dependence diagnosis in their medical record, placing them at increased risk of drug interactions .

However, concerns also exist about increased information-sharing. The role that recording and sharing practices and policies play in the enlargement of state power and surveillance has been noted (Parton 2004, 2006, 2008); along with doubts about whether the value derivable from wide access overrides its potential to distort social worker-client relationships (Munro 2007a, 2007b, 2010). Others caution against inflated hopes for systemic bureaucratic solutions to complex social and professional issues (Hood, Gillespie, and Davies 2016; Marinetto 2011).

These tensions are present in codes of ethics and practice standards. They set an expectation for accurate recording (e.g. AASW 2010, 29; ANZASW 2007, 11; NASW 2008, 11) and interprofessional collaboration, including information-sharing, whilst emphasising the importance of maintaining confidentiality (BASW 2012). The mechanisms by which this tension is to be managed are honest conversations with

clients (about what is recorded, for what purposes, and for whom to access); consent, and conformity with legal requirements. Explanations about access to records should occur at the beginning of a relationship, and where necessary after that. Consent to these arrangements and to any further disclosures should be sought and obtained (AASW 2010, 27; ANZASW 2007, 11; NASW 2008, 6). Codes and practice standards tend to allow for unconsented disclosures where permitted or required by law, or where necessary to prevent harm to identifiable persons (AASW 2010, 29; ANZASW 2007, 11; BASW 2012, 14; CASW 2005a, 7; NASW 2008, 11).

These standards provide a framework that acknowledges the tensions at play. The standards preserve discretion for social workers to respond to the demands of a given situation. They establish client awareness and consent as crucial justifiers of recording and sharing arrangements. How social workers employ discretion and negotiate with clients is an interesting and under-explored question.

The tensions between client expectations and preferences, and practice

Client engagement with social workers typically involves a flow of information about the client to the social worker. As Prince (1996, 12) vividly observed, records are strongly associated with the practice of social work: “Notwithstanding a trend towards laptop computers, large files of case notes inevitably accompany a social worker and appear to represent an occupational badge akin to the medical bag or barrister’s silk”.

Most clients expect that social workers maintain a set of notes relating to them, and may observe recording. What might be less clear is who has access to them, and what information is recorded therein. Some clients know that there is a wider audience to their records than they would wish. Hyde et al. (2016) conveyed the

discomfort of their participants, young persons recently in state care, about their sexual health information being routinely shared with multiple professionals, including social workers, counsellors, nurses and psychologists (2016). They had little choice about this, but some made efforts to circumvent it. When clients know their information may be shared against their will, they may avoid accessing services or withhold important information.

Greenhalgh et al's (2008)' study of patient attitudes to the newly introduced Summary Care Record (SCR) in three English localities reported confusion and some misperceptions about access to health records. Most participants could see advantages to records being accessible to professionals involved in their care, but also identified disadvantages. Their overall willingness to have a SCR was, not unexpectedly, heavily influenced by their perception of their need and their previous experiences with, and trust in, health services. Carman and Britten's study of the views of patients about who does, and should, have access to general practice records also revealed a disjunct between patient expectations about recording and access, and practice (1995).

Some studies indicate clients believe that their wishes for confidentiality will not be respected in practice (Prince 1996; Whetten-Goldstein, Nguyen, and Sugarman 2001), despite the emphasis in practice standards and codes of ethics upon ensuring client clarity on these matters (AASW 2010, 29; ANZASW 2007, 11; BASW 2012, 14; CASW 2005a, 7; NASW 2008, 11). Even if recording and access arrangements are described clearly, it is possible that such matters will not be uppermost for clients during their interactions with social workers, and some will be unable to withdraw from services should they object to them. Such possibilities affirm the importance of social workers' judgements about what they record, and how.

Interprofessional tensions

Another theme in the literature relates to the interprofessionalism of records, particularly in health settings. Professions use personal health records for different reasons, in fulfilment of different roles, informed by different professional norms. Different professional groups attend to different sections of a client's records, consistent with the focus of their practice – such as a pharmacist concentrating on lists of medications (Sakata et al. 2016). Tensions can arise about who needs what information and in whom authority to determine access resides (Knowles 2009; Liew 2012). Divergent professional norms and cultures, ‘inter-tribal’ distrust and territorial anxieties can produce caution about interprofessional record-sharing (Hall 2005; Hudson 2005; Hunt and Arend 2002; S. Richardson and Asthana 2006). Recording is an important medium for enacting professional identity (Oglensky and Davidson 2009; Prince 1996) and instantiating professional values (McDonald et al. 2015). Perceptions about what should be recorded, and their purpose, vary between professions. Organisational policies and systems enabling inter-professional access to records can thus be expected to generate unease. Might one’s records be misinterpreted or misused by others unschooled in the norms informing them? Might clients feel betrayed by sharing across professional boundaries? Such concerns are present in the literature, but how they impact upon social workers’ perceptions of the ethics and their practice of recording is not fully understood.

Research approach and questions

This study investigated what concerns, if any, health social workers had about recording in shared health records. The overall aims were to illuminate the ethical

tensions that health social workers experience in relation to shared records, and to identify ethical principles that should inform recording practice and system design. We sought to do this through a combination of data-gathering via interviews with social workers in a range of health care settings, and pragmatic ethical analysis. This paper presents the findings relating to recording practice.

Ethics approval

The study received approval from the University of Auckland Human Participants Ethics Committee (approval number, **016556**).

Method

The study adopted a methodology combining ethical reasoning with empirical data collection. The approach was influenced by the philosophical tradition of pragmatism. John Dewey's pragmatist perspective identifies the application of wisdom to real world problems as the purpose of philosophy. The relationship between theory and practice is not unidirectional however; ethics cannot be determined independent of practice (Hildebrand 2013). Dewey advocated for a method of scientific inquiry, gathering evidence about the world to shed light on questions posed for a particular purpose (Dewey [1938] 2009). Inquiry does not come to a fixed point of truth, but merely a resting place (Putnam 2010). Dewey's pragmatist perspective formed a foundation for how empirical data and ethical reflection could be combined in this study.

A review of philosophical and practice-oriented literatures on privacy and record-keeping provided a starting point for reflection on the kinds of ethical issues raised by shared records. This informed the construction of the interview schedule,

which focused on four main areas: organisational arrangements and practices regarding recording; how decisions about what to record and to omit should be made; the status of clinical opinions or impressions; and professional understandings of client understandings, requests, attitudes and preferences regarding recording. The interview schedule was semi-structured, aiming to engage participants in discussion of their moral judgements and reasoning. The schedule was pre-tested with a professional working in a health-care setting to ensure clarity and relevance.

Health social workers were recruited from across New Zealand's North Island. District Health Boards (DHBs), the bodies responsible for funding and providing health care in New Zealand, were identified as the key employers of social workers within health settings, for both hospitals and communities. Eight DHB social work teams were approached to advertise the research to their staff. They were selected to ensure a mix of rural and urban settings and population profiles. A range of institutional requirements for approval to support research pertained within the DHBs. Five DHBs advertised the research to their teams, yielding 10 participants. Additionally, we contacted a general practice known (unusually in New Zealand) to employ social workers, one of whom participated. The participating organisations service rural, urban and semi-urban areas, and a range of populations, including Māori (indigenous people), Pākehā (NZ Europeans), Pasifika, refugee populations and other immigrant groups. The invitation to participate was distributed to social work teams by email. A follow-up email was sent after two weeks. All social workers who responded to the invitation were offered an interview.

This recruiting strategy yielded a convenience sample of 11 participants who were interviewed between March and June, 2016. Four had roles associated with mental health; two worked with older persons; two in oncology; two had general

hospital-based roles, and one worked in primary care. One worked with children and their families; the rest worked with adults. One participant was male and the rest female; there was a range of ages from roughly late twenties to early sixties; their social work careers spanned from eighteen months to fifteen-plus years.

Interviews were held at a location convenient to participants; most took place at the participant's workplace during work hours. Participants were offered a \$30 supermarket voucher in recognition of their time. Interview recordings were transcribed by one of the researchers. Transcripts were analysed iteratively, which influenced the discussion in subsequent interviews (Liamputtong 2009). The thematic approach was both inductive, developed from the data, and deductive, developed in response to pre-set questions (Braun and Clarke 2006). The first author conducted the coding, which was discussed in collaborative meetings with the other two authors.

Participants were sent a copy of their transcript, organised into broad themes, to allow them to check their intended meaning had been understood and to check for potentially identifying details. No participants asked to change their transcript. Two asked to obscure identifying details of clients, and one offered additional comments (about confidentiality discussions at the outset of the relationship). Participants were also provided with a draft of the final report submitted to the funder, and asked to provide feedback if they wished; one participant requested minor grammatical corrections and several others provided supportive comments.

Ethical analysis of the data was conducted to determine whether any ethical principles could be identified and developed. The first step was to determine whether any principles underwrote participant reasoning about recording in shared records, and if so, to identify them. Participant testimony was analysed through reference to arguments developed in philosophical treatments of privacy to identify what

principles might be at play (Nissenbaum 2009; Rachels 1975; Reiman 1976). Then ethical analysis was applied to the principles yielded through this process to explicate, test and explore their supporting claims and implications. The object was to test the validity of the identified principles beyond the specifics of our participants' practice and experience. Ethical analytic techniques included exploring counterfactuals; identifying and evaluating counterarguments, and testing for problems of consistency and coherence.

Results

Organisational factors

The interview began with questions about what notes were taken and who could see them. This opened the discussion in a non-threatening way enabling participants to relate practical information about the function of records for them, and applicable organisational policies of their team. It also revealed important features of participants' recording practice, including information about what records were kept and who could access them. All participants reported maintaining notes in more than one system, as required by their organisation. Generally this included both a hard copy system and an electronic records system, although two participants used only electronic records, and two only hard copy. Each was available to a variety of different people in their team and their organisation, access that was granted according to clinical involvement with a patient in line with organisational policy. These policies included an electronic alert system that records who views a client's file, a system that participants were aware of and took seriously. Some mentioned that their organisation had a specific audit process to ensure correct recording practice. Participants tended to have a good idea of the policies that related to what records

they could access, but there were some inconsistencies among participants (from the same organisations) about the nature of overarching arrangements about access. This particularly related to whether information collected by mental health services would be available on the general health record – participants from mental health services reported that this was kept separate, but accounts of exactly who could access it varied. One mental health participant said that emergency departments could not access her notes, or even her name or the involvement of her mental health service in a client's care; another mental health participant mentioned that this information definitely was available to emergency. Participants employed outside mental health services were asked about their access to mental health notes and two noted that they could see mental health assessments for their clients, but that more information might exist than what was available to them. The written documents that social workers created included initial assessment documents, progress notes (both inpatient and community), referrals, letters to other health professionals such as general practitioners (GPs), and risk management plans. Several participants also reported the use of email as a record.

Participant accounts indicated that a number of documents made up the 'record', that the level of access varied, and that access had not drastically changed with the partial introduction of the electronic record. Some documents were more likely to be read by others, such as referrals; others rarely so, such as progress notes. Sometimes social work notes were held separately, but could be requested and accessed by other practitioners, although whether they were was another matter. Participant 6 laughed when relating that her notes were not often requested; this was echoed by another participant, 9, who expressed frustration that her notes were not read by members of her team.

These participants expressed more support for than concern about inter-professional accessibility of records. Only one participant reported keeping a record separate to that which could be accessed by the other health practitioners in her organisation – it was available only to herself and her co-social worker. She had inherited this recording system from her predecessor, and considered that it made sense to continue using it, rather than deciding to put it in place herself. Practice management were aware of its existence, but the participant was not sure of its legal implications as this had not so far been tested, no clients having yet requested their full record. She used it for keeping details, such as budgets, that might clutter the health record. Working in primary care, she would also use it to record emotional details that she considered irrelevant to the general record:

(SW01) ‘Like I say, that is why I separate out the notes that I put in [record system name] and the additional information, is that sometimes I do think information should be held back, or not. But generally that’s because I don’t think it’s relevant, rather than because of an ethical concern. [...] That is the primary purpose of that record, is it’s a health record. So if someone’s health is being impacted by something, then that is relevant information.’

This was the only example of a consciously separate record – although Participant 11’s notes would be difficult to access, because they were kept in hard copy in her locked office, or on her person. All participants had choices about the way they shared information with their colleagues. All had regular team meetings, the opportunity to catch up in person outside these or talk on the phone – the record was not their only way of passing on information. They were aware that including information in the record could confer a special status upon it which might have

serious implications for clients, and considered it a professional obligation to take those implications seriously when determining what to record and share, and how. One participant illustrated this in the context of notification of possible harm to children:

(SW03) 'If we have a concern about a child being harmed, we notify [child protection agency], but we don't keep it on the file, we keep it separate. [...] Because it's not, it might not be proof. [...] But it covers us, we want to say that we did something, but we don't necessarily want it to be on the file and put a black mark against them, when it might just be an allegation.'

Participants did not view sharing information within a health care team as a contravention of confidentiality, and supported the practice for the purposes of providing health care. They spoke of the concept of 'team confidentiality' or confidentiality within the organisation, and all reported discussing this concept at the outset of the clinical relationship. Team confidentiality did have limits, however. Participants reported taking more care when sharing information outside their immediate team, even with other health providers such as GPs. They would explicitly seek client permission before this was done (and reported that permission was sometimes, but not always, forthcoming).

Participants demonstrated a working understanding of privacy regulation, and several participants based in DHBs knew that their access of records would be audited and that inappropriate accessing carried serious consequences. Formal mechanisms were not perceived as ensuring complete security of records, however. Participant 7 spoke of family requests for records containing sensitive information about a deceased client; Participant 2 mentioned the difficulty of a referral letter likely to be seen by a client's mother; while Participant 5 spoke of her concern about recording

information about parents in their children's files, where even if it was blanked out should the record be requested, it would look 'really dodgy'. In these examples, compliance with regulations and practice guidelines may not prevent problematic dissemination of private information. These participants were aware that records could be accessed in multiple, sometimes unforeseeable ways, by various parties, and reported that this influenced their recording practices.

Withholding details

Participants were asked how they decided what to record and to omit from shared care records. In particular, we explored the concept of sensitive information, and whether different recording practices apply to it.

Participants expressed the view that the sensitivity of information varies and that sensitive information requires careful, and possibly different, handling within the record. All participants explained that they would withhold details to minimise the record's sensitive content, and to respect their clients in the record, so long as omissions did not compromise their care. Possible omissions included: details of past trauma (Participant 5, Participant 8); a client's detailed expression of their emotional state (Participant 1), the history of a physical ailment (Participant 11), minor welfare fraud (absent a possibility of harm – Participant 2, 4), family conflict and discussion of finances (Participant 7). Participant 7 referred to this as the 'dirty laundry'. For mental health clients, in particular, details of their trauma history could feel like a 'list of their misdeeds' (Participant 8). Summarising rather than comprehensively detailing such information could preserve its usefulness whilst minimising a client's exposure. Participant 7 explained the strategy thus:

(SW07) 'But you can put things about people that inform the situation without being too detailed. Like I will say, where there's a conflictual family, "There appears to be pre-existing conflicts in the family." Full stop, leave it there. So the next person will go, "Oh, OK, the family don't get on." But you haven't said what's gone on, unless it's actually relevant to what you need to be doing.'

Homes visits were reported to expose especially detailed, sensitive information. Participants who conducted home visits stated that recording should preserve the privacy of the exchange to some extent:

(SW05) 'And we hear, we often think, it's almost like we're somebody's auntie coming in. That's what it feels like. [...] When I was writing it up, I actually just wrote, instead of writing all the detail, I wrote "Dad told me about his extensive history of trauma." Because I didn't want to put all that stuff in there to expose him, to anybody else's view.'

Participants reported being uncertain about how some information, or ways of recording it, could be interpreted by future readers. They were aware that some interpretations could lead to deleterious impacts on the client's future care, particularly if it fostered unfavourable attitudes towards clients:

(SW06) '[...] [the] concern could be that they bring it up with the patient, or... it changes their judgement of that patient. Which, in theory of course, should not impact anybody's professional care, but we're human as well. I guess it's about not wanting to, I don't know, impact on the overall picture too much.'

In particular, information of dubious relevance or dubious accuracy was identified as provoking uncertainty about how, or whether, to record. The prospect of

mis- or over-interpretation by other clinicians could tell in favour of omission, on the grounds that it was 'not needed'.

Sparing reporting was seen as justified not only by concern for client privacy; but also to ensure that notes were useful to other clinicians and would be read by them. In Participant 6's words: 'No one wants to read an essay'. The need for brevity was seen as aligning with privacy interests:

(SW06) "I'm not going to tell you hardly any details, I'm just going to tell you one, two, three, and maybe this example just to illustrate this point." [...] Thanks to time, lots of privacy stuff is just kept nice and private.'

Along with reasons to minimise the recording of sensitive information, participants also identified a compelling reason to record it: possible impact on the client's health or healthcare. For instance, alcohol or substance abuse was reported as always being recorded, due to its relevance to health and healthcare (Participant 2, Participant 4, Participant 6). Equally, detailed emotional information would need to be included if there was a risk of self-harm or suicide (Participant 1, 8, 10). Participants were very clear about recording such information if it was deemed to have consequences for healthcare decisions, or present a clinical risk or safety issue. Participant 4 explained why she handled information about tax and welfare payments differently to information about substance abuse, for instance:

(SW04) 'I wouldn't leave information out to do with risk or a person's presentation, but I might leave out information that they're double dipping, or they're working for IRD under the table, if it's not really relevant to...[but] we nearly always would [record information about substance abuse] in mental health. Because it's so much a part of a person's health and wellbeing, and a lot of people come through our service when there's drug abuse.'

Recording impressions and opinions

Participants were asked about whether, and how, they recorded their own opinions or impressions, and those of others. This line of questioning explored *what counts as information* in the healthcare setting.

All participants clearly stated that they considered it appropriate to record their impression of a situation. Recording this information was in line with their goal of communicating the features of the situation that were relevant to health. Rarely were social workers privy to feedback on the usefulness of their records, but Participant 1 did report that a doctor she knew:

(SW01) ‘[...] says that that assessment bit or that impression bit is often the main thing that he will read, rather than anything about what the social worker’s done or what they’ve talked about, but it’s that assessment, ‘this is the summary of the situation’ that he will read.’

Including a recorded impression or opinion did not necessarily compromise the accuracy of the record, because information was frequently unreliable. Clients may err; misremember; deliberately supply misleading information; or their perspective may skew their testimony. Recounting the details given by a client about her ex-husband, which she views as likely to be ‘embroidered’, Participant 5 declared, with a laugh, that: ‘I’ve given up on the word “truth”’. Ultimately, much of the information social workers come across is ambiguous or unverifiable, yet it needs to be included. Participants considered it important to reflect this uncertain epistemic status.

While participants expressed a willingness to report their impressions, they emphasised the importance of distinguishing them as such. Participant 3, in particular,

reflected on the legal status of social workers' records, and to the importance of distinguishing between fact and opinion, and between reports and hard evidence:

(SW03) 'And we've always got to write in that cautious way, because say if it goes to court, or they ask for their records, we say "This guy's hitting his wife." "Who said that?" you know. Is it hearsay, is it she saying, and we can report, "The wife said she was being hit by the husband." We can't say it necessarily as a fact.'

The quality of information was also seen as important for how future carers would interpret and use it. References to 'epistemic accuracy' were important to ensure that a record's meaning was not misunderstood, with the attendant adverse consequences of that:

(SW09) 'And I suppose that just comes with the social work experience, where we are dealing with people who are vulnerable. We don't want to add to that vulnerability unnecessarily by, if I can use the word, 'casual' recording in notes, which might send a team off on a totally wrong direction.'

Participants reported taking care about recording, for fear that an opinion or guess could become an allegation:

(SW03) 'But you've also got to be careful, like, if I say, "This person has an alcohol issue," just because they came into hospital and they were drunk, and that might have been a one off, you could say something and then it could become fact, and someone else reads it, "oh, alcohol issue, alcohol issue," and suddenly the whispers become the reality. So, always, you've got to be a bit careful. "This person looked grubby," and they might have just slipped over in

the way in, or whatever, or been in the garden and had the slip, and they're all dirty and stuff, they're unkempt.'

Use of neutral language was identified as necessary to minimise risk to clients, but also to express respect:

(SW09) 'I always review notes [...]. And I have read clinical notes that have been recorded in a way that makes me cringe, because of implied judgements. I can't control how other colleagues choose to record, what I can make sure is that what I record is accurate and reflects. And if it is an opinion, it's stated as an opinion and not a fact.'

Participants noted the frequency of, and their aversion to, judgemental recording. Using judgemental language could encourage or permit outward prejudice against the client, bias that was ultimately unprofessional, unfair, and could compromise care.

(SW08) 'Like I once had a file and at the very front of the file, there was a page written by a care manager who said, "This person is really manipulative, and be very careful when working with this person." And I grew to really be quite fond of that client, and I think I might have even taken that note off the front of the file, because I just thought that really colours somebody's perception of the client, and it was pejorative, the way that it was written, so I just thought it was irrelevant.'

One rule of thumb participants identified was that records should be written in such a way that the client could read them. This could be a struggle if social workers suspected duplicitous behaviour on the part of their clients, but they would aim to keep their records as neutral as possible.

(SW02) ‘So, I always am really clear about writing, doing statements of what she’s said to me, and what she’s reported to me, and really doing in the way that’s not having an opinion from me about... not skewing what’s she’s saying so it’s pejorative sort of judgements ... And trying to be really respectful, within that, even though I might feel really annoyed and angry with her at times [laughter].’

Participants regarded client access to notes as having a positive impact on recording. They expressed that the information ultimately belonged to the client, who had a right to see it, and that they should be respected.

Perceived client attitudes

Participants were asked to discuss their perceptions of client attitudes towards their records, and their impact upon client disclosures. The aim was not to understand clients’ viewpoints, but the contribution clients’ perceived attitudes make to practice.

In general, participants related that clients were not that concerned about the recording of their information, or its distribution among the healthcare team. All participants described discussing recording and information-sharing at the beginning of the clinical relationship, setting the expectations in terms of ‘team’ confidentiality. The aim was that clients would not be surprised by how their information was used. Participant 1 displayed some concern that clients would not remember the initial conversation, but hoped that her frequent mentions of leaving notes for other team members would reinforce it.

Clients were reported as approving of the distribution of relevant information about them among the healthcare team, and in fact could be annoyed if this did not happen. Client willingness to have information shared could extend to sensitive

information. As Participant 4 related – clients can see several different clinicians before allocation to a final team, and do not always want to repeat their story. Sharing information can be hard work for clients, particularly if they are unwell:

(SW03) ‘So, if, say, you went into hospital and needed a lot of help at home, [service name] would come in, do an assessment for you. Takes four hours. And I think, who can handle that? You might be sick, you’d be, even, anyone, if someone came and interviewed you for four hours...[...] You don’t want it to be a burden, a real challenge to them.’

Clients would rarely ask for things not to be shared amongst the team – and participants reported unwillingness to acquiesce to such requests if the information was important to health or suggested the risk of harm to the client, for example, intention to commit suicide.

(SW04) ‘I mean, I’ve been around a while, so I’m kind of used to saying to people, “Well, that’s not how it’s going to work.” I had a lady tell me on the phone yesterday, “I’ve made this plan, and I don’t really want to tell you about it” [...] And I said, well, I’m going to talk about that with your doctor, [...] negotiate from there. Negotiate.’

Participants reported client requests to access their records as rare. Several discussed their records with clients as they wrote them – though Participant 8 mentioned there was not much time to do so, because clients tended to arrive with many other issues to discuss. Participants overwhelmingly expressed that generally clients were willing to disclose information, even sensitive information, and sometimes, more than was needed:

(SW05) 'I'm astounded what people tell me, some days. But I think it's the nature of the people that we work with, because they have these extremely challenging children.'

Participants experienced clients as generally pleased to be receiving help and to be listened to. Exceptions were noted by some participants, including older people who were wary of being forced to give up their independence and move into care (Participant 6).

Participants aimed to maintain good relationships with their clients, which extended to minimising disagreements about recording – but this was not always possible. Participant 4 describes how she was surprised by how a client reacted to an email that she had shared.

(SW04) 'And then you get a little bit stuck as well, when the person you're working with says, "Yeah, you can tell her anything," and she doesn't like some things that you tell her. [...] So, from the person's perspective, it wasn't that I talked to her support worker, the problem for her was how I wrote things, that she didn't decline any services, that she just told someone that she was sort of still thinking about it, and that she was... [...] From my perspective, just in case you were wondering, I would have been really happy to sit down face to face and tell this person all of this stuff anyway. It wasn't that side of it. [...] I think that I wrote it in a kind enough and not too overly professional way. But... And there were things going on in the background of that case as well. That was the catalyst.'

Discussion

We identified three principles from participant accounts that regulate their ethical recording practice, and which our analysis suggests apply to recording more

generally. These are: necessity, accuracy and neutrality. These principles reflect our participants' awareness of the role that records play in the formation of professional judgements about clients. Judgements can have a material impact on clients, and thus require a sound evidence base. Utility is an underlying ethical consideration, and one which is served by these principles. Good records supply the right information, and enough of it, to ensure that sought benefits are realised as fully as possible, and disbenefits or harms minimised. But utility was not the only operative underlying ethical concern. Considerations of fairness also apply.

Records should inform professional judgements, but only justly so. They should not unfairly discriminate, prejudice, or wrongly label, clients. In short, they should treat a client fairly by demonstrating respect for them. Considerations of utility and fairness inform the ethical framework within which social work is practiced, because they connect with the justificatory purpose of the profession and thus inform role obligations (Hardimon 1994).

The principles that we identified guided participants in achieving this end: information should be recorded if it is *necessary* and in such a way that it is *epistemically accurate* and *neutral*. These principles ensure that the record serves its purpose by: providing useful information for care providers; embodying respect for the client and fairly serving their interests. The principles also serve to minimise the risk to clients that recording presents. But working out what each principle requires in practice is not always easy; it requires wisdom, which is likely to be cultivated by team cultures that recognise these principles and consciously attune their practice to them.

Necessity

Participants frequently discussed the concept of ‘relevance to health’ as a determining factor for recording decisions. Shared care records are generated to support the provision of health care, and this purpose governs content. Records do this by providing a common receptacle for information that a healthcare team needs to provide safe and effective care. As the record is particularly a *health* record, what is needed is related to the client’s health. The record has a limited bandwidth, and what should appear in it are the most useful, health-relevant, details.

Our participants reported encountering a wide spectrum of possible information to record, and referring to the concept of necessity as a touchstone or filtering principle. If a piece of information or statement is not necessary to the purposes of healthcare, then it ought not to be included in the record. If it is necessary, then it ought to be included.

Of course, identifying whether a given piece of information is necessary for the purposes of healthcare requires judgement. The skill of distinguishing the relevant features of a client’s situation is developed through experience and training (McDonald et al. 2015).

Whilst recording judgements rest with the relevant professional, their purview extends beyond his or her needs, interests and expectations to encompass those of the client and the broader team. The purpose that necessity is defined in relation to is the purpose that connects clients with social workers and the healthcare team. It is the purpose that characterises the professional interaction as a whole.

Clients engage with a healthcare team in order to advance their health-related interests. They understand the role of the professionals that they encounter as connected to that purpose. They share information with them, and consent to information being obtained from other sources, in order to advance that purpose. The

shared purpose is what motivates and justifies professional interactions, and it sets client expectations about what will be recorded, and how so, and with whom it will be shared. Sound professional judgements about necessity for a shared purpose will correctly identify and, insofar as possible, align with the client's understanding of their purpose for sharing and allowing access to their private information. Ideally, information recorded by a social worker should be necessary to reflect the purpose that they share with their client.

Client belief that recording is governed by the principle of necessity for a shared purpose is one possible explanation of the reported low levels of client concern about their records (Teixeira et al. 2011; Whiddett et al. 2006). From our participants' perspectives, clients generally trust them to record information in a way that advances their interests. Of course, infrequency of client questions about records or requests for access and correction may reflect limited options, other priorities, lack of awareness of entitlement to access and influence records, and fear of repercussions, rather than trust. There are limits to what can be inferred in terms of actual levels of trust from social workers reporting low rates of requests or objections about recording. But where trust pertains, it is likely to incorporate trust that social workers will adhere to the principle of necessity for a given purpose in their recording practice.

All social workers in this study identified their service as voluntary for their clients, but this is not the case in all social work settings. The degree to which engaging with a social worker is a choice for some clients in healthcare settings, such as those with long term mental health issues, can be debated. Where engagement with social workers is not voluntary, the prospect of a truly shared purpose existing between client and social worker, such that recording decisions can be based upon it, becomes dimmer. The principle of necessity for a shared purpose receives its fullest

instantiation in the context of a voluntary interaction characterised by strong mutual understanding. But the principle remains relevant to compulsory interactions and those in which no shared purpose exists. In such cases, social workers can refer to the purposes that their engagement with the client is intended to serve; they can explain those purposes and ensure that their recording practice remains within its confines. In such cases, even if the purposes are not mutually endorsed, they can at least be mutually understood. This facilitates informed client decision-making about what information to provide to social workers. Consistent team approaches will also facilitate informed decision making by clients, alongside trust.

Accuracy

The principle of accuracy is endorsed in social work guidelines. For instance, principle 11 of the British Association of Social Workers code of ethics (2012, 14) states that social workers should keep “clear and accurate records”. Our participants also identified accuracy as an important recording principle, but its application may differ in the social work context from that of other professional contexts.

In some professional contexts, accuracy is largely a matter of ensuring factual correctness. For instance, it is important that the dosages and names of drugs that have been administered, the times of administration, and the reading of vital signs are all correctly recorded in hospital notes. Mistakes can lead to serious adverse outcomes in terms of patient health.

Facts also form part of the social work record. However, the greater challenge in the social work context is recording the contestable, less demonstrable information, observations and assessments that support the team’s understanding of the client’s situation. The nature of the role means that social workers are especially likely to

encounter the challenges that accuracy poses to the recording of opinions, impressions and unverifiable statements.

Our participants emphasised the epistemic elements of accuracy in good recording practice. The provenance and status of a statement included in the record should be made explicit, alongside the statement itself. This extends to the professional judgements reached by social workers themselves. Opinions and impressions should be labelled as such, as should reports of events and facts. This is a requirement of a number of codes and practice standards (AASW 2010, 29; BASW 2012, 14; CASW 2005b, 9.) The principle of accuracy also requires careful use of language to control the bounds of possible interpretation

The principle of accuracy tracks the utility of the record and minimises risks to clients. It also ensures fair representation, of the client and others. The principle of accuracy is demanding: it requires social workers to assiduously attend to their own judgements, noting their status as such. It requires careful reflection upon interactions with clients and their families, what they meant, what evidence supports statements made, and to sift through a discussion, sorting belief from reason. . As our participant testimony indicated, attending to the judgements of other professionals when reading records can be a useful way of becoming attuned to the power of language to convey judgements.

Neutrality

Fair representation is only partly achieved through accuracy. It also requires the social worker to refrain from employing language that embodies character evaluations. This is the principle of neutrality.

Our participants emphasised the importance of words and labels, and an attention to unbiased language that avoids inherent judgement about the worth or dignity of a client. Respecting clients encompasses depiction in records, respect and protection of human dignity is a core role obligation for social work (Banks and Gallagher 2009; International Federation of Social Workers 2017). Maintaining respect through adopting a neutral stance was important for participants for a number of reasons. Firstly, respect for clients was seen as a strict professional role obligation, required in order to sustain the viability of a therapeutic relationship. The social work role is one of assistance and support; engaging with social workers requires trust. In order to trust social workers, clients need to believe that social workers are concerned with and appropriately motivated by their interests. A social worker who has reached an unfavourable assessment of a client is less likely to be motivated and concerned in the appropriate way, and is thus less deserving of the client's trust. Pejorative judgements, if discovered, are likely to be resented by clients and to damage the trust required to sustain therapeutic success. Secondly, neutrality contributes to ensuring that clients receive impartial healthcare, an important aspect of the value of justice which involves a commitment to the fair allocation of goods among people (Banks and Gallagher 2009).

It is not always easy to interpret the demands of neutrality in practice. It can be difficult to separate factual from evaluative statements. This is illustrated in one participant's reference to a statement made by another social worker about a client being manipulative. From the participant's perspective, this was a violation of the principle of neutrality. It is important to recognise the legitimacy of the experiences of social workers as they try to balance their professional obligations with their humanity and attendant tendencies to evaluate others through their actions, statements, and

inferred intents. The recorder may have felt manipulated, and in fact have may have been manipulated, by this client. But, given their inextricable positionality within a professional-client relationship, they are not well positioned to fairly evaluate the client's character traits. The principle of neutrality does not require that the actions or events that led the recorder to feel manipulated are not recorded. Rather, it requires that the events and actions are recorded in a way that refrains from labelling, and does not close off other assessments or prejudice other practitioners against the client.

Limitations

The empirical data that formed the basis of this analysis were drawn from a small, non-representative sample of social workers. Their testimony cannot speak for others, but the pragmatic empirical ethics methodology of the study reduces the impact that this has on the findings. Our participants' testimony supplied a starting point and a touchstone for analysis of the ethical issues in recording. Moving between their testimony and philosophical and practice literature, and our own ethical analysis, has enabled the identification of three principles that we believe transcend our participants' practice and experience. However, with a larger participant group, we may have been able to identify more principles, and reach more specific and nuanced conclusions about what each principle requires in different settings or with different client groups. In particular, only one participant currently provided services to children in families. This limited our ability to draw out implications of the principles for this important and difficult area of social work.

Conclusions

Our participants were unified in their recognition of the principles of necessity, accuracy and neutrality, and could describe how they informed their recording practice. These principles, the values of utility and fairness (with an emphasis upon respect) and our participants' testimony, cast an interesting light on the three zones of tension outlined above. Our participants navigated the tension between maintaining confidentiality and making information available to support best care through observing the principles of necessity. Information necessary to care provision must be recorded; the rest is omitted. The tension between client expectations and preferences, and practice is controlled through adhering to the principles of necessity and neutrality, but also through establishing shared expectations through open conversations at the outset, and throughout, the relationship. Interprofessional tensions were managed through accurate, neutral recording that minimise opportunities for misunderstanding, and for some, through separate maintenance of records that do not meet the standards of necessity to healthcare. These principles are likely to accord those of other health professionals, providing a point of commonality in a site potentially fraught by interprofessional tensions.

We have explicated each principle's role in the ethical framework of social work recording. Nevertheless, uncertainty persists. Exactly what constitutes a neutral expression? What information is necessary for appropriate care and who determines what is necessary? Does documentation of an impression satisfy the demands of epistemic accuracy? Identifying principles does not in itself provide an answer to a practical ethical question, but it does give a place from which to start reasoning. As shared records assume greater prominence in health and social care systems, it is important to recognise the ethical frameworks within which recording occurs. Without a sense of this, trust in a system and a profession could be eroded.

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i A number of terms are used to refer to the person to whom the record relates. For simplicity's sake we use a single term, *client*, in keeping with the practice of our participants.