

Educational Resource Packs for Clinical Ethics Committees

Pack one Ethics and the vulnerable patient

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Introduction to the ethics education resource pack

This resource pack is designed to be used by a clinical ethics committee or group (CEC) in discussion in a meeting. It aims to provide an effective and flexible method for self education of the CEC and to facilitate the group working together. Although members of the CEC are asked to do some reading prior to the meeting at which this resource pack is to be used, it is not designed for private study alone.

This resource pack provides an introduction to the ethical issues arising in the care and treatment of vulnerable patients. It is therefore most useful for ethics committees /groups that are starting to work together to discuss these issues.

What is included in the resource pack?

The resource pack comprises the following documentation:

- Suggested pre meeting reading (available online from Journal of Medical Ethics www.jme.bmjournals.com :

Mark Komrad, A defence of medical paternalism: maximising patient autonomy Journal of Medical Ethics 1983, 9, 38 -44

Shimon Glick, The morality of coercion, Journal of medical Ethics 2000; 26: 393 – 395

Introduction to moral theories and principles that inform ethical decision-making in healthcare

- Specific ethical issues relevant to the care and treatment of vulnerable patients
- Case study
- A structured approach to case consultation
- Issues to consider

How to use the resource pack

It will take about one hour to use this resource pack in a meeting of the CEC.

The idea is that the resource pack will provide tools to facilitate ethical discussion of the case study.

The **pre meeting reading** will provide background information on this topic. Two articles are included and a document entitled 'Introduction to Moral Theories and principles that inform ethical decision-making in healthcare'.

The chair or administrator should send a copy of all three documents to each member of the CEC who will attend the meeting, two weeks in advance. Members should read and familiarise themselves with the issues.

At the meeting the **case study** should be considered by the CEC. Using the resources provided to inform the discussion the committee should come to a decision on the most ethically appropriate course of action in this case. The CEC should consider:

- Whether any more information is needed
- What are the ethical issues
- The process of ethical discussion - use of ethical frameworks / counter arguments / case comparison

In considering the case study the CEC may find it helpful to refer to the following documents included in this pack:

- Specific ethical issues relevant to the care and treatment of vulnerable patients
- A structured approach to case consultation
- Issues to consider

These documents do not attempt to provide a definitive answer, nor do they provide a comprehensive list of every ethical issue arising. Rather this ethics education resource pack aims to develop and facilitate the skills of the CEC (and a CEC with experience in this area may simply wish to use the case study as a basis for discussion).

The process of decision making

As important as the consideration of ethical issues and the development of ethical argument is the **process** of discussion. In discussing ethical issues the CEC should adopt a process that is transparent and can be subject to critical appraisal. In this context it may wish to consider the following:

- The role of Chair in ensuring contribution of all views
- If the CEC can justify and test its views by use of counter-argument

Further information

In addition, this resource pack includes:

- Further reading
- Websites and contact groups
- Professional guidance

We hope you find this resource pack helpful as a tool in providing the ethics education to members of the CEC. Two other packs are available on Ethics & Genetics and Ethics & Resource Allocation. For copies of these packs and further information please contact:

The Ethox Centre
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Introduction to Moral Theories and Principles that inform ethical decision making in healthcare

Introduction

If a clinical ethics committee (CEC) is to provide support on ethical issues relating to clinical practice, and to facilitate discussion of the ethical dimension of clinical problems, members of a CEC will require an understanding of the moral theories and ethical frameworks that have informed the development of medical ethics.

In this section we provide a brief introduction to some of the key moral theories and ethical frameworks that have had an important influence on health care practice, particularly in Western medicine.

Ethical Theory

We may feel instinctively that a certain conclusion to a problem is 'fair' or 'unfair', but what criteria do we use to make such judgments? There are different ethical theories that can be applied to a problem to elucidate our thinking, but even so the results may not fit with our moral intuition.

There are several types of normative ethical theory including consequentialism, deontology - such as Kantianism - and virtue ethics. They can be applied in several **procedures** of ethical analysis, such as in analysis of cases (casuistry) and in different **settings** such as in a range of 'communitarian ethics': for example, a feminist approach or a social class based approach.

Moral or ethical theory may consider the application of rules or the consequences of actions.

Deontological theory - what one **MUST** do, based on duties and obligations

Teleological theory - the purpose or consequences of the moral acts

Consequentialist Theory

This is one sub class of teleological moral theory. According to consequentialist accounts of morality the moral value of an act, rule or policy is to be found in its consequences, not in intentions or motives. Utilitarianism is the most influential consequentialist theory. Jeremy Bentham in the late 18th century and John Stuart Mill in the 19th century formulated this way of thinking. Such 'hedonistic' utilitarians argue that the principle to judge our moral thinking is utility, that is, the maximisation of happiness, in the sense of pleasure and the minimisation of suffering, in the sense of pain. In any situation the morally right thing to do is the action that promotes the greatest happiness for the greatest number of people.

However pain and pleasure are not the only criteria that later utilitarians have used to evaluate the consequences of actions, rules or policies. Welfare-utilitarians consider the contribution to, or lessening of, human welfare. Preference-utilitarians seek to establish and satisfy human preferences.

Some key issues:

- Calculate net benefit

The net benefit or dis-benefit is found by balancing the happiness and unhappiness resulting from an act or policy. If one then seeks the greatest happiness of the greatest number that may be taken to justify overriding individual unhappiness in the interests of the happiness of the greatest number.

- Difficulty in calculating consequences

This theory requires that the consequences of acts or policies must be calculated. However in many situations one cannot predict consequences with any certainty and therefore consequentialism is probabilistic, one forecasts the consequences to the best of one's ability. Ethics committees using consequentialist criteria necessarily operate in an area of uncertainty.

- Act and rule utilitarianism

Bentham tended to deal with the consequences of **acts**. However, '**rule** utilitarianism' justifies certain rules on utilitarian grounds. For example, one might justify the general rule 'do not lie' on the utilitarian ground that lying produces more bad consequences than good consequences overall.

In considering what is the right course of action/treatment in any healthcare situation we tend initially to think about the consequences arising from the different options. For example, in deciding whether in particular circumstances a breach of the duty of confidence is justified, we think of the consequences- the harms of breaching the duty and the harms of not warning others of a risk to their health. However, it is often difficult to predict consequences with any certainty.

Deontological Theory

A criticism of consequentialist theory is that it is so concerned with **ends** that it may overlook the moral importance of **means** - the ways in which the ends or goals are achieved. Deontological theory uses rules rather than consequences to justify an action or policy. The best-known deontological theory is that of Immanuel Kant in the 18th century. 'Kantianism' is a modern term, referring to a Kant-like emphasis on duties and rules. Kant defended rules such as 'do not lie', 'keep promises', 'do not kill' on what he claimed were rational grounds. Rules should comply with the *categorical imperative*. The categorical imperative holds that:

- Moral rules should be universalisable i.e. applied to all rational, moral members of the community rather than to just some
- All persons should be treated never simply as means but also always as ends in themselves
- Members of the moral community should take a hand in making the laws as well as living by them

Many modern *Kantians*, as opposed to Kant himself, are not absolutist in their application of moral rules or laws, whilst nevertheless stressing the importance of generally living by moral rules or laws.

The theory is manifested in the idea of a duties owed to a patient – the duty of care and the duty not to harm.

Virtue ethics

Virtue ethics is the name given to a modern revival and revision of Aristotle's ethical thinking. Aristotle's ethics, while not generally thought of as consequentialist, is certainly teleological. For him, the telos, or purpose, of a human life is to live according to reason. This leads to 'happiness' in the sense of human flourishing. This flourishing is achieved by the habitual practice of moral and intellectual excellences, or 'virtues'. For Aristotle, the excellences are of two types. A moral virtue is an excellence of character, a 'mean' between two vices. One of Aristotle's virtues is courage, a mean between recklessness and cowardice, which are vices. Modern virtue ethics sets itself the task of discerning the virtues for our time. In a healthcare setting what virtues would we like doctors, nurses, etc. to possess - self-control, truthfulness, generosity, compassion, discernment, integrity?

Aristotle also identified a second type of excellences, intellectual virtues, which constitute a preference for truth over falsehood and for clarity over muddle, both in pure reason and in practical affairs. Both the moral and intellectual virtues are, for Aristotle, the expression of reason.

Virtue ethics can be seen in the way we feel is the 'right' way to behave towards patients and to colleagues. For example, a virtuous doctor / nurse would take time to explain treatment options to a patient and find out what he/she wants.

Casistry

Casistry, or case based reasoning, does not focus on rules and theories but rather on practical decision-making in particular cases based on precedent. So first the particular features of a case would be identified, and then a comparison would be made with other similar cases and prior experiences, attempting to determine not only the similarities but also the differences.

So if a clinical ethics committee were asked to consider whether it was ethical for a clinician to breach his / her duty of confidence, the committee would identify key factors, like the health risks to others if information was not disclosed. It would then make a comparison with other similar cases, identifying the relative risks of non-disclosure. Casistry should not be divorced from consequentialism, deontology, or virtue ethics but complement them.

A clinical ethics committee can build up useful experience by identifying key factors that informed a decision in one case and comparing and contrasting the application of these factors in a similar case. This may be particularly useful in a discussion of best interests of a patient. If it was in patient A's best interests to receive treatment, why and how does this differ from an assessment of patient B's best interests in the same circumstances?

The Four Principles

Beauchamp and Childress' Four Principles approach is one of the most widely used frameworks and offers a broad consideration of medical ethics issues generally, not just for use in a clinical setting.

The Four Principles provide a general guide and leave considerable room for judgement in specific cases.

Respect for autonomy: respecting the decision-making capacities of autonomous persons; enabling individuals to make reasoned informed choices.

Beneficence: balancing benefits of treatment against the risks and costs; the healthcare professional should act in a way that benefits the patient.

Non maleficence: avoiding causing harm; the healthcare professional should not harm the patient. Most treatment involves some harm, even if minimal, but the harm should not be disproportionate to the benefits of the treatment.

Justice: respect for justice takes several forms:

- Distribution of a fair share of benefits
- Legal justice - doing what the law says
- Rights based justice, which deals in the language, and perhaps the rhetoric, of claimed human rights, and hence goes beyond, though it includes, legal rights.

These principles are prima facie – that is, each to be followed unless it conflicts with one or more of the others - and non-hierarchical i.e. one is not ranked higher than another. In recent years however, respect for patient autonomy has assumed great significance in the context of patient choice, underpinned by the requirement to provide the patient with sufficient information to put him / her in a position to choose.

The 'Four Principles' are intended as an aid to balance judgement, not a substitute for it.

Taken from: Slowther A, Johnston C, Goodall J, Hope T (2004) A practical guide for clinical ethics support. The Ethox Centre. Section C: Ethical Frameworks.

Specific ethical considerations relevant to the care and treatment of vulnerable patients

Respect for Autonomy

The principle of respect for autonomy underpins the requirement for valid consent to treatment. This principle acknowledges the right of a person to determine how his or her life should be lived and to make choices that are consistent with his/her life's plan.

Autonomy is not all or nothing. Very few of us are able to make fully autonomous choices all the time. Some of us, in certain situations, will not have the ability to understand and evaluate the options in order to make a choice. The more complex the choice and the more impaired our ability to understand, the less we are likely to be able to make an autonomous decision.

This has implications for respecting autonomy in the context of health care, specifically in consent to treatment. First, health professionals have an obligation to endeavour to enhance autonomy and facilitate the likelihood of a patient being able to make an autonomous decision. Second, where a patient is unable to make an autonomous decision, it is the duty of the health professional to act in the patient's best interests. However, even in these situations, an effort should be made to discover any previous preferences of the patient, or current wishes, in order to respect his/her autonomy as far as possible.

Rationality, competence and autonomy

Does an autonomous decision have to be rational?

"In the ideal of autonomy day - to -day decisions should be rational, i.e. consistent with the person's life plans" (Hope, Savulescu and Hendrick, *Medical Ethics and Law*, the core curriculum, Churchill Livingstone 2003 p 34).

However this internal rationality may not be viewed as rational by an external view. A health professional may judge the rationality of a patient's decision by its consistency with the professional's view of what would be in the best interests of the patient. A decision that is seen as contrary to the patient's best interests may be interpreted as irrational by the health professional and therefore the patient may be seen, erroneously, as not competent to make an autonomous choice. It is the internal rather than the external rationality that is important here. A patient is not necessarily incompetent simply because he/she doesn't agree with the health professional about the suggested treatment. A good example of this is the case of a Jehovah's Witness who refuses a life saving blood transfusion. The decision appears irrational to the health care professional but is internally consistent with the beliefs of the patient.

Beneficence and Best Interests

The principle of beneficence highlights the moral importance of doing good to others. When a patient is unable to make an autonomous choice the health professional has a duty of beneficence. Beneficence is usually considered to rely on an objective view of what would be best for the patient whereas respect for autonomy identifies what the patient subjectively considers to be in his/her best interests.

The concept of 'best interests' is linked to well-being / beneficence but includes considerations wider than purely medical risks and benefits such as the religious and cultural interests of the patient. This implies a duty to discover if possible what the patient would have wanted or what is likely to be appropriate in the context of this patient's particular life. Thus respecting the patient as an individual person (or respecting his/her autonomy) is an intrinsic part of the process of determining best interests.

There is generally no conflict between beneficence and the principle of respect for autonomy - most patients would choose the course of treatment that is objectively considered to be in his/her best interests.

But there is a particular tension between the concepts of respect for autonomy and beneficence in the treatment of a vulnerable patient. The vulnerable patient may, because of the situation he /she is in, make treatment decisions that are arguably not in his/her best interests objectively speaking.

Where the view of a competent adult patient as to what is in his/her best interests conflicts with medical opinion - for example where a Jehovah's Witness patient refuses treatment using blood products, the principle of respect for patient autonomy overrides the principle of beneficence.

But what about the situation of a teenager who is apparently competent to make a decision about treatment, for example a pregnant 15 year old who seeks a termination without the knowledge of her parents? In such a situation the tension between respecting the patient's autonomous decision and acting in her best interests may be informed by consideration of relevant professional guidance and the legal issues.

There is much discussion in ethics literature about the interpretation of best interests. If a wide interpretation is given to "best interests" then the interests of those other than the patient may be taken into account in determining the interests of the patient, for example the best interests of the family unit, and there is a danger of moving away from the patient as a focus for legal / ethical decision-making.

This is taken from a more detailed discussion of ethical issues of consent and refusal of treatment to be found on the UK Clinical Ethics Network website:

Ethical Issues-Consent and Refusal of Treatment

<http://www.ethics-network.org.uk>

A structured approach to case consultation

This is one approach that can be helpful in analysing the ethical issues in a clinical case.

1. What are the relevant clinical and other facts (e.g. family dynamics, GP support availability)?
2. What would constitute an appropriate decision-making process?
 - Who is to be held responsible?
 - When does the decision have to be made?
 - Who should be involved?
 - What are the procedural rules e.g. confidentiality?
3. List the available options
4. What are the morally significant features of each option e.g.
 - What does the patient want to happen?
 - Is the patient competent?
 - If the patient is not competent, what is in his or her 'best interests'?
 - What are the foreseeable consequences of each option?
5. What does the law / guidance say about each of these options?
6. For each realistic option, identify the moral arguments in favour and against.
7. Choose an option based on your judgment of the relative merits of these arguments using the following tools.
 - Are there any key terms the meaning of which need to be agreed e.g. 'best interest', 'person'?
 - Are the arguments valid?
 - Consider the foreseeable consequences (local and more broad)
 - Do the options 'respect persons'?
 - What would be the implications of this decision applied as a general rule?
 - How does this case compare with other cases?
8. Identify the strongest counter-argument to the option you have chosen.
9. Can you rebut this argument? What are your reasons?
10. Make a decision
11. Review this decision in the light of what actually happens, and learn from it.

Taken from: A practical guide for clinical ethics support

Section C: Ethical Frameworks, a practical clinical ethics framework that may be useful for a clinical ethics committee to work through in discussion of a case.

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Case Study

Betty, a 76 year-old woman, suffers from recurrent intestinal obstruction following a bowel perforation and resection. She has been chronically unwell for a long time and has had recurrent chest infections and sepsis. She has been admitted to intensive care on at least four occasions in the past year. On each occasion, despite predictions to the contrary, she has recovered and has been well enough to return home.

She is admitted for a fifth time, again with a chest infection and sepsis. She is taken to intensive care for resuscitation prior to another laparotomy (operation to explore and unblock the bowel). Following resuscitation she refuses to have an intravenous line inserted and is therefore transferred to an ordinary ward for nursing care with instructions for the nursing staff that she is to be kept comfortable but is not for further active treatment.

Betty's daughter, who is a doctor, arrives at the hospital late one evening having flown in from her home in Australia. She is adamant that everything possible should be done for her mother. She asks for her mother to be returned to intensive care and provided with all appropriate treatment. Betty's son, who lives locally and has been her main carer over the last year, says that she has been through enough and does not want her to have any further active intervention.

What should the on call doctor do?

Case discussion - Issues to Consider

Questions for the committee to consider in the case of Betty

1. Is Betty competent to refuse medical treatment?
2. If so, has she made an informed decision – does she understand the implications of not having the treatment?
3. If she is not competent, what course of action is in her best interests?
4. To what extent is patient autonomy relevant in this situation?
5. To what extent should the views and wishes of Betty's daughter/ son be taken into account?

Discussion of the issues

Firstly establish the clinical facts – what is the prognosis without further active treatment?
Has contact been made with her GP?
Has her competence been assessed – if so by whom and how recently?
Has she made a written advance statement?

Betty is a vulnerable patient because of her long term chronic ill health. Her views about how she wants to be cared for are in conflict with the views of her daughter and she may feel vulnerable to potential influence on the treatment she receives.

Respect for Autonomy

If Betty is competent she has autonomy to make treatment decisions. If the principle of respect for autonomy is given the highest value then her refusal to consent to insertion of the intravenous line should be respected despite the fact that without active treatment she can only be kept comfortable and her condition will deteriorate. She has been admitted to intensive four times in the past year, so she has recent experience of the treatment she is now refusing and it could be said that she is making an informed refusal of treatment. Where a patient makes a decision about treatment that is not objectively in her best interests care should be taken that the patient has been informed about the treatment and the implications of refusing it. It would be useful to know if Betty objected to treatment on the previous occasions and if so what were her reasons.

It is important for an assessment to be made regarding Betty's capacity to refuse treatment. If Betty has been assessed to have capacity then her refusal must be respected - otherwise a battery may be committed. If she lacks capacity, then any treatment must be in her best interests.

Beneficence and Best Interests

A competent patient can refuse treatment even though objectively such refusal is not considered to be in her best interests – the patient is her own judge of what is in her best interests. However, even if Betty lacks capacity her views about the care she receives are important in determining her best interests. The clinician may feel that he is not acting beneficently towards his patient if he allows her to die for lack of

treatment. There is a tension between beneficence and non-maleficence in such a case.

The views of her son are also relevant in ascertaining Betty's past and present wishes regarding the type of treatment she is willing to accept. As his mother's main carer he has had the opportunity to discuss with her how she feels about the treatment she has received. In his view 'she has been through enough' but it should be established that this is what Betty would have wanted, not what her son wants for her. This seems to be commensurate with Betty's views - she is refusing to have an intravenous line inserted. It will be important to establish that she doesn't feel under any pressure to refuse treatment, perhaps because she feels her care is a burden on her son.

Although Betty's daughter requests that 'everything be done' for her mother, this may not be commensurate with what is in Betty's best interests objectively assessed. Also, as Betty is refusing treatment it cannot be said that the daughter is representing what her mother would have wanted.

The Mental Capacity Act 2005 makes provision for advance decisions and the appointment of proxies. It is likely to come into force in 2007. Until then common law principles will have effect. If Betty has previously stated her wishes when she was competent, then these should be respected. At common law a valid advance decision does not have to be evidenced in writing but where life is at stake "the evidence must be scrutinised with a special care. The continuing validity of the advance directive must be clearly established by convincing and inherently reliable evidence". (HE v A Hospital NHS Trust [2003] 2 FLR 408).

The law is changed by the Mental Capacity Act 2005. An advance decision refusing life sustaining treatment must be made in writing and witnessed. The Act enables a person when competent to appoint a proxy to take healthcare decisions for that person when he/she loses capacity. This can be done through a Lasting Power of Attorney, a formal document that must be lodged with the Court of Protection.

Legal Issues

Adults

An adult is a person 18 years and over.

There is a presumption of capacity for adults.

Capacity is treatment specific - it depends on the treatment to be performed. A higher level of capacity is required if the treatment is risky/has potential serious side effects.

Capacity can fluctuate.

In Scotland the Adults with Incapacity (Scotland) Act 2000 provides that competent individuals over 16 can appoint someone to make decisions about medical treatment on their behalf if they become unable to do so.

The new Mental Capacity Act 2005 sets out a framework in England and Wales for persons aged 16 years and over who lack capacity. The Act sets out a statutory test for those who lack capacity.

A person lacks capacity if he/she cannot:

- * understand information relevant to the decision,
- * retain that information,
- * use or weigh up that information as part of the decision-making process
- * communicate a decision (by any means)

The Act provides that any decision made on behalf of a person who lacks capacity must be taken in his best interests. The Act sets out a checklist that a decision maker should consider in assessing the best interests of a person who lacks capacity. Account should be taken, as far as is reasonably ascertainable, of the person's past and present wishes and feelings, the beliefs and values that would be likely to influence his decision and other factors that he would be likely to consider if he were able to do so.

The Act codifies the common law position on advance statements. These are referred to in the Act as advance decisions. An advance decision can be made by a person who has capacity when aged 18 years and over. The advance decision has the effect of *refusing* specified treatment. It must be both *valid* and *applicable*. If the advance decision applies to life sustaining treatment it must be written and witnessed and state that it is to apply to a treatment, even if 'life is at risk'.

The Act enables the appointment of a proxy under a Lasting Power of Attorney. The proxy will be able to take healthcare decisions for the person appointing him. Certain formalities must be complied with and the document must be lodged with the Public Guardian.

It is thought that the provisions of the Act will come into effect in 2007. For information on the way the Act will work it is useful to look at the draft Code of Practice and the Explanatory Notes: <http://www.dca.gov.uk/menincap/legis.htm>

Children

In law, children are those who are under 18 years of age.

Children under 16 years old

A child under 16 years old is considered incompetent unless he/she is found 'Gillick competent'.

In the case of **Gillick v West Norfolk and Wisbech AHA [1986] AC 112** it was stated that if a minor has sufficient intelligence and understanding to enable him / her to understand the treatment and implications of treatment then he / she is 'Gillick competent'.

A Gillick competent child can consent to treatment.

Children aged 16 and 17

Patients aged 16 and 17 years old are considered competent to consent to treatment although this may be rebutted on evidence.

Babies, young children and teenagers who are not competent

In law someone else must consent on their behalf. This can be a proxy or the court. A proxy is usually a parent or another person with parental responsibility.

Those taking decisions on behalf of the minor must act in the child's best interests and if this is not the case then the decision can be overridden by the court.

If there is a difference of opinion between the parent (s) and the clinician regarding best interests the matter can be referred to the Official Solicitor who is likely to make an application to the court.

Refusal of treatment

A competent adult patient may refuse treatment, even if this results in his /her death.

A refusal of treatment by a minor may be overridden by a parent or the court even if the minor is competent where such a refusal would be likely to result in his/her death or permanent disability. Then the wishes of the minor may be overridden to preserve his / her long-term interests.

When Consent may not be needed - s63 Mental Health Act 1983

A patient who has been sectioned under the Mental Health Act may be treated without the requirement for consent. This is only applicable for treatment for the mental illness.

See further:

<http://www.ethics-network.org.uk/Ethics/econsent.htm#tests>
<http://www.doh.gov.uk/mentalhea>

Professional Guidance

Department of Health

The Department of Health has produced the following guidance re consent

- A guide for adults
- A guide for children and young people
- A guide for people with learning disabilities
- A guide for parents
- A guide for relatives and carers

<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Consent/ConsentGeneralInformation/fs/en>

Reference Guide to Consent for Examination or Treatment, March 2001
www.doh.gov.uk/consent

Chief Nursing Officer bulletin

Integrating care for vulnerable patients
October 2004
<http://www.dh.gov.uk/>

BMA

Consent tool kit

Second edition – February 2003
<http://www.bma.org.uk/ap.nsf/Content/consenttk2>

Card 7 - children and young people
Card 6 - Adults who lack capacity
Card 8 - Determining “best interests”

Parental responsibility

<http://www.bma.org.uk/ap.nsf/Content/Parental>
Guidance from the Ethics Department
February 2004

GMC

Seeking patients' consent: the ethical considerations

November 1998
<http://www.gmc-uk.org/standards/default.htm>

Royal College of Psychiatrists

Vulnerable patients, vulnerable doctors: New Council Report on good practice in doctors' clinical relationships
September 2002

Reading

Pre meeting reading

Introduction to Moral Theories and Principles that inform ethical decision making in healthcare (taken from Slowther A, Johnston C, Goodall J, Hope T (2004) A practical guide for clinical ethics support. The Ethox Centre)

The morality of coercion, Shimon Glick, *J Med Ethics* 2000; 26: 393-395

(Available electronically: <http://jme.bmjournals.com/current.shtml>, search Author: 'Glick')

Key texts

A defence of medical paternalism: maximising patients' autonomy, Mark Komrad, *J Med Ethics*, 1983, 9, 38 – 44

Mason and McCall Smith. *Law and Medical Ethics*, J.K. Mason, R.A. McCall Smith, G.T. Laurie, (Butterworths) 2002

Consent, rights & choices in health care for children & young people
BMA, 2000

This book from the British Medical Association offers comprehensive practical guidance on the ethical and legal issues which arise in the health care of patients under 18 years of age

Further reading

Paternalism and partial autonomy, Onora O'Neill, *J Med Ethics* 1984; 10: 173-8

Some limits of informed consent, O O'Neill, *J Med Ethics* 2003; 29: 4-7

The courts' role in decisions about medical treatment, Laurence Oates, Official Solicitor, *BMJ* 2000;321:1282-1284

Competency and use of the Mental Health Act – a matrix to aid decision-making, Jacinta Tan and Martin Elphick, *Psychiatric Bulletin* (2002) 26, 104-106

Incapacity to give informed consent owing to mental disorder, C W Van Staden, C Kruger, *J Med Ethics*;2003; 29: 41-43

Clinical issues on consent: some philosophical concerns, R Worthington, *J Med Ethics*; 2002; 28: 377-380