INTERNATIONAL CONFERENCE ON CLINICAL ETHICS CONSULTATION, 21-23 June 2018: https://iccec2018.org/

A PHILOSOPHY STUDENT IN A CLINICAL ETHICS COMMITTEE

WITHDRAWING CLINICALLY-ASSISTED NUTRITION AND HYDRATION FROM MINIMALLY CONSCIOUS AND VEGETATIVE PATIENTS: TO COURT OR NOT TO COURT?

ETHICS IN THE NEWS, ROUND ROBINS, MEMBERSHIP BENEFITS AND MORE...
Welcome to the spring newsletter. We are now preparing for the ICCEC conference in Oxford on June 21st – 23rd. UKCEN are participating in this important event which is the International Conference in Clinical Ethics Consultation. It is the first time that the conference has been held in the UK and it is a very great honour that we are participating. We will be hosting a symposium and also sponsoring the “Inside the Ethics committee” event which will be held on the first evening of the conference.

There are bursaries available and reduced registration places to assist UKCEN members to attend please see the website for details. Registration for the conference is via the ICCEC website: [https://iccec2018.org/registration/](https://iccec2018.org/registration/). You will be redirected to the Institute of Medical Ethics website to complete the process. Please ensure you declare your association with UKCEN in order to access your discount.

We are always interested to hear from UKCEN members who would be interested in becoming a trustee of the organisation, please give this some consideration or think of colleagues within your committee who may be interested.

Please look out for our “Round Robins” as these give you the opportunity to feedback on ethical issues which have been identified by a committee, seeking views on potential outcome, seeing whether colleagues have encountered similar dilemmas and of course you can raise issues of your own. The outcome of these circulars are then summarised and circulated. They are additionally available on the private members section of the UKCEN website.

Due to our contribution to the national conference this year we will not be holding a training workshop at the time of the event. Hence we hope to hold some local events later in the year. Please keep an eye on the website for further details. Our plans to hold the 2019 conference in Cambridge are now well underway and we will update you all with dates and venue in the forthcoming few months.

This will be my final newsletter as chair, so I will say goodbye but hope to see as many of you as possible at ICCEC.

Best wishes,

Karen Le Ball, Chair UKCEN
There’s lots of interesting reading for you in this issue. Richard Huxtable writes on a potential shift in the decision-making processes for artificial nutrition and hydration for people with the most severe types of brain injury—a shift away from the Courts. We have detailed and informative notes from some recent Round Robins—on ethical decision-making tools, the implications for Clinical Ethics Committees of Trust mergers, and compassionate use of innovative treatments. A final year Philosophy Student, Amy Grabe, writes about being exposed to clinical ethics in practice. Amy reflects that there is much public misunderstanding of ethical decision-making, and this often comes to a head in troubling cases, as we have recently seen with Alfie Evans. So how can we mitigate these misunderstandings?

One solution is through more inclusive and sensitive discussion. Of course this can take place in Clinical Ethics Committees, where hopefully there will be lay members. Richard Huxtable’s piece suggests that as the courts become less involved in feeding decisions for people in, for example, vegetative states, Clinical Ethics Committees should have more of a role. This suggestion is mirrored in an editorial in the BMJ by Wilkinson and Savulescu on Alfie Evans’ and similar cases (https://doi.org/10.1136/bmj.k1891). But these are closed deliberations, so more general, informed discussion has to take place in the public sphere. The 14th Annual International Conference on Clinical Ethics Consultation Conference (ICCEC), announced below, will no doubt trigger some of these.

Increasingly, the public are informing themselves through social media, but it’s not clear to me, at least, how dependable these discussions are. By the look of things there’s very healthy social media activity at @ICCEC2018, so the aim now should be to broaden out related discussions more widely to the public.

Andrew Stanners

Amy reflects that there is much public misunderstanding of ethical decision-making, and this often comes to a head in troubling cases, as we have recently seen with Alfie Evans.
Last September, I began working on my placement dissertation having decided to pursue my interests in medical ethics further. Fortunately, I was put in contact with a clinician with an interest in medical ethics, who has supported my placement in many different ways, ensuring that I got a full insight into the role of medical ethics in practice.

My placement has taken place at Pinderfields Hospital in Wakefield, where I have accompanied a Consultant on his ward rounds, including discussing each individual patient, the ethical components to their care and the most effective way of responding to these concerns. I have also accompanied the nutrition team, visiting a range of patients with complex needs, often discussing the instatement or removal of artificial nutrition and the impact that this will have. Not only that, I have become part of the Mid Yorkshire Hospitals Healthcare Ethics Committee discussing the most complex cases.

As a philosophy student working alongside medical professionals, I feel as though I have been able to offer a unique viewpoint into some of the cases we have discussed. Whilst I wasn’t able to make decisions, I felt as though I could offer insightful contributions based on my skills I have learnt as a philosopher. My ability to think critically and analytically as well as my problem solving skills learnt throughout my undergraduate degree enabled me to look at the ethical issues from a completely different point of view. Due to a lack of medical training, I felt that I was unobscured by less important, technical aspects of each case; I was merely looking at the ethical concerns of each decision. One key thing I learnt, was that the patient’s best interests and quality of life, determined by them where possible, is at the forefront of all decisions made by medical professionals; something that is considered at each step of their decision making process concerning treatment.

After my experiences at Pinderfields, I came to the conclusion that there really isn’t a lot of public knowledge regarding the role of Clinical Ethics Committees in hospitals. It seems that many people are only made aware of their existence and purpose when controversial cases appear in the media. By this time, people have come to their own conclusion that there really isn’t a lot of public knowledge regarding the role of Clinical Ethics Committees in hospitals. It seems that many people are only made aware of their existence and purpose when controversial cases appear in the media. By this time, people have come to their own

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conclusions, often full of misconceptions. It is very clear, after having an insight into the decisions that are made, that medical professionals only want to act in the best interests of the patient, but this is something that I believe needs to be communicated more clearly. It appears as if the general public need to be informed more about the role of Clinical Ethics Committees, and healthcare ethics as a whole, in order to improve their understanding of the decision making processes that take place when deciding how to treat a particular patient.

My placement at Pinderfields Hospital has been incredibly insightful. Not only have I learnt about medical ethics in a clinical setting, I have also been able to apply my skills as a philosophy student in a very sensitive environment.Whilst philosophy cannot provide technical solutions, it does help to ensure that the patient’s care is carefully planned in order to align with their best interests and maximise their quality of life. From my experiences, I think that it is crucial to the development of medical ethics to continue to raise awareness of its role, especially at a more accessible level, for instance within hospitals. This way, patients may be able to discuss and engage with members of the committees and gain a real understanding into the process, rather than gathering information from the media.

Amy Grabe
Final Year Student in Philosophy, University of Leeds

Editor’s note: Amy became an honorary member of staff, signed a confidentiality agreement and obtained all necessary permissions.
The English courts first decided that clinically-assisted nutrition and hydration (CANH) could be withdrawn from a patient in the persistent vegetative state in the landmark ruling in Bland in 1993. Then, as now, the test was whether treatment was in the best interests of the patient. Although this focus remains, the legal and clinical landscapes have changed considerably since 1993: the Mental Capacity Act 2005 has altered some of the reasoning to be applied in such cases, and the methods of clinical assessment, and even the language used, has evolved. However, aside from the focus on best interests, there is one other aspect of the Bland ruling that has not shifted, at least until now. Mindful of the various complex dimensions of the decision they were making, the court in Bland essentially signalled that future similar cases should be resolved in court, rather than at the patient’s bedside. This requirement now looks set to change. Since 1993, the courts have decided the fates of many patients in the vegetative state, and they have routinely decided that treatment is not in the best interests of such patients. Following the 2005 Act, the requirement to seek a judicial decision about the withdrawal of CANH was extended to include minimally conscious patients. The first (explicit) ruling
Withdrawing clinically-assisted nutrition and hydration from minimally conscious and vegetative patients: To court or not to court?

Two rulings in 2017 suggest that the approach has now changed and that recourse to the courts is not required in every case. In Re M, the judge indicated that there may be no need to bring such cases to court, if the clinical team and patient’s family are in agreement that treatment is not in the patient’s best interests. This was recently reinforced in the decision in Re Y.

It is too early to tell what the ramifications of these rulings might be, although it is conceivable that CECs might increasingly be consulted about these best interests decisions, now that judicial determination is no longer obligatory. However, we should wait and see, especially as leave to appeal to the Supreme Court – the highest court in the land – has been granted. As such, we await further confirmation about the legal position.

Richard Huxtable

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We like to draw members’ attention to some national and international events which have an ethical context. We hope you continue to find this interesting.

Lately there have been 3 very dramatic end of life issues which have arisen with severely disabled children. This has had wide media scrutiny and also huge impact on social media.

We have chosen to explore this theme further, that is, the role of the media in sharing information, maintaining confidentiality and more in our symposium at ICCEC on the first day (June 21st).

There has also been an interesting case from Australia from the other end of life. A man has travelled to Switzerland for voluntary euthanasia based on age itself—he was 104—rather than in the context of terminal illness. He had campaigned for a relevant change in the law in Australia.

Isaiah Haastrup’s parents, from south-east London, said treatments exist that could help their son

The parents of a brain-damaged baby lost their bid to appeal against a decision to stop his life-support treatment.

Read more: http://www.bbc.co.uk/news/uk-england-london-43169755

Family losses the right to intervene in the treatment of their child


We have chosen to explore this theme further, that is, the role of the media in sharing information, maintaining confidentiality and more in our symposium, ‘Clinic, Court or Committee: In the Best Interests of the Critically Ill Child?’ at ICCEC on the first day (June 21st).

Who was Alife Evans and what was the row over his treatment?

[Links to BBC News articles regarding Alife Evans]

David Goodall, Australian Scientist aged 104 to end his own life

Read more: [BBC News](http://www.bbc.co.uk/news/world-australia-43957874)

Noel Conway right to die case returns to court

[Link to BBC News article on Noel Conway case]

Guernsey could be first place in British Isles to allow assisted dying

The implications of this could be extensive. If this vote goes ahead then could we see UK residents flying to Guernsey to receive euthanasia in a Swiss clinic like situation?

Find out more: [The Guardian](https://www.theguardian.com/society/2018/mar/21/guernsey-parliament-to-vote-on-proposals-to-allow-assisted-dying)

Visit our Facebook and Twitter pages for more ethics in the news...
Membership benefits include Online Video & Round Robin Library Resource

**Why be a member of UKCEN?**

- **Discounted rates at ICCEC2018** (please refer to the ICCEC website for T&Cs).
- **The opportunity to apply for an educational grant of up to £500 to support your committees’ educational activities.**
- **Access to our private members only forum.**
- **Access to online conference talks and a round robin library.**

Members can access commissioned videos of conference talks and round robins all in one place at: www.ukcen.net

This resource now includes all recorded UKCEN conference talks and round robin summaries.

Access to the Members’ Area on the UKCEN website is required. This access is strictly a privilege of membership.

**How to Access:**

- Visit www.ukcen.net
- Click on ‘Members’ (top right hand corner).
- If you already have a password enter your username and password.
- If you do not have a password or have forgotten it please enter the email address that we send emails to and click ‘Forgot your password’. Enter your email address when prompted.
- You will be emailed instructions for setting/resetting your password.
- If you still encounter problems or are sent back to the home page on entering your new password it may be that your subscription has not been paid.
- All current members should use your email address and password for the purpose of accessing this resource.
- When members leave please remember to update your password!

**New membership rate: from 1st April 2018 just £220.00/year**
We receive a number of round robin requests each year. Below we provide an edited summary of recent requests about frameworks, merging committees and innovative treatments. Thank you to all the CECs who respond to our requests. The responses are always illuminating and helpful to the submitting committee as well as a learning tool for other CECs. If your CEC would like to request a round robin please contact Louise Hutton.

Request One - Ethical Frameworks

A committee is interested in learning what frameworks (if any) other committees use for structuring their discussions on cases referred to the committee. This committee uses the Dilemma method but there are other models, some of which are on the UKCEN website. We would be interested in hearing from committees on:

- whether the committee uses a specified framework and if so which one?
- if you use a framework what is your experience with it (works well, needs adapting etc.)?
- if the committee does not use a formal framework how does the committee structure a case discussion e.g. informally agreed structure, different depending on case or context?

Round robin response

We received ten responses to this query. Some committees sent an example of the framework they used. Thank you to those committees for sharing these.

Three committees said that they did not use a formal structured framework for the ethical discussion in the meeting. One committee uses email to seek the views of each committee member on a case referral and one member of the committee takes responsibility for collating all responses and providing a summary. The summary includes perspectives that include legal ethical and clinical from different members with different backgrounds and expertise. The two other committees who do not currently use a framework both expressed interest in having some form of structured approach that could be used to improve consistency of process across discussion of cases. One committee has formally reflected on their approach to their (mainly retrospective) case discussions and identified 5 key themes: timeliness of decision-making, holistic care, contextual openness, values diversity, and consensual understanding. This has been published in the journal Clinical Ethics. Elements of an engaged clinical ethics: a qualitative analysis of hospice clinical ethics committee discussions" Clinical Ethics, 2012; 7: 175-182).

Two committees use the Dilemma method which is an approach developed by VU University Amsterdam within the context of their Moral Deliberation programme. Both have revised the original approach to fit within their own
context and one committee commented that their approach is a combination of the Dilemma method and the Idea framework although they do not formally use a structured framework during case discussion. The other committee noted that they had had several discussions about the use of the framework over the years leading to revisions. One committee had used the Ethox Framework but had recently moved to using the Ethics Grid which they find more ‘user friendly’ for a newly formed committee. Two other committees use a combination of the Ethox Framework and the Idea model.

Benefits of using a framework reported by the committees who used them included helping to focus the discussion on ethical rather than clinical issues in the case, mitigating the risk of not considering all perspectives and thus having a biased discussion, providing a guide for less experienced members of the committee, and giving structure to the thoughts of the committee. One committee noted that they had had feedback from referrers since using a framework that the outcomes of their discussion are well balanced and the process for decision-making clearly understood. The committee reflected that prior to adopting the use of a framework their discussions were based more on individual member’s own moral perspective and alternative points of view were not easily identified. However some committees also noted that using a framework had challenges, particularly in getting all members of the committee to follow the framework approach. Some committee members prefer more fluid discussion and this is a risk that too rigid a structure could inhibit the sharing of views.

One committee has a structured record for case consultations which includes a summary of the case (anonymised) the relevant ethical issues, and the outcome as well as a record of whether the patient has given consent, who was involved and the format of the consultation. This acts as the formal record and response to the referrer.

Examples of the frameworks mentioned and the versions used by the responding committees are included online in the private members section of the UKCEN website.

Request Two - Merging committees

With the current changes in the NHS several NHS Trusts are merging. For Trusts with a clinical ethics committee this can present challenges for the committee (merging two committees with different objectives or ethos, persuading a Trust without a committee that the newly merged Trust should embrace the existing committee). We would be interested in hearing from committees who have experienced this situation about the challenges they faced and how they responded to them.

Round robin response

With regard to the question on how to deal with merging committees and merging Trusts, all responders noted that this was a timely matter for consideration given the current nature of the NHS.

Most had no experience of such a merger but anticipated it could be an issue for them in the future. Two committees had experience of merging Trusts.
One committee is in a Trust that has several widely dispersed sites. New sites included by mergers had no existing committees and initially were happy to refer cases to the original main site committee. However they have noticed a drop off in referrals from external sites over a period of years indicating that this geographical distance may lead to lack of engagement with the ethics committee.

The difficulty of recruiting members from other sites in the Trust was also noted.

A second committee has a more positive experience of merging committees in two distinct Trusts which were geographically close and shared some staff and services. One Trust had a well-established committee with clear governance structures and terms of reference and having one committee across both was seen as providing an opportunity to share similar experiences and learn from colleagues in the other Trust.

A joint committee was established with the approval of both Trust’s medical directors and Board. Equal representation from each Trust as far as is possible is aspired to and the chair switches between a member from each Trust every 3 years. The arrangement is seen as a partnership of equal standing. It was clarified that whilst some members were employed by one Trust or the other, for the purposes of the committee all members were ‘neutral’. The joint committee has been in place for 7 years and report that they ‘have gained a wealth of experience by working together and sharing the ‘resource’ of people and their expertise’.

Request Three - Innovative Treatments

We have received an enquiry from a CEC in relation to how CECs address requests for an ethical opinion regarding the use of novel treatments outside of a research project that may be being offered by a drug company on a ‘compassionate use’ basis. The ethics committee had recently received a request regarding the use of Nusinersen in a terminally ill child with spinal muscular atrophy type 1 but who fell outside of the inclusion criteria based on the available evidence. No national guidance on the use of Nusinersen exists and its use has not been appraised by any national body e.g. NICE. This committee noted that they have had other similar requests for advice in the past and would be interested in the views and experiences of other committees on this difficult issue.
Round Robin

Round robin response

Thank you to all CECs who responded to this round robin request. We had a larger than usual number of responses which is encouraging. I have summarised the collected responses to each query below.

We received eight responses to this request. None of the responding committees had experience of considering similar requests, or were familiar with the drug. One committee had investigated the cost of Nusinersen and found that treatment cost in the first year was US$750,000 and US$375,000 a year thereafter. All responders recognised the difficulty of such decisions when a child has a life threatening condition and there is little standard treatment available. There was agreement that the key ethical considerations included the balancing of benefits and burdens of treatment for the child, respecting parental wishes where possible and ensuring that they were given all relevant information, the potential consequences for other patients including a fair allocation of health care resources, and the need to address any conflict of interest of drug company and clinicians.

Balancing burdens and benefits. SMA is a severe life limiting condition and the more severe forms of the disease are inevitably fatal. A clinical trial reporting in the New England Journal of Medicine in 2017 included 80 infants. Infants treated with the drug showed a 50% improvement in achieving developmental milestones compared to the control group and a 47% reduction in risk of death or ventilator requirement. The study was stopped at 6 month because the researcher considered the benefits substantially outweighed the harms. The drug is thought to be more effective if given early which means starting treatment in very young infants, (in the UK children have to be less than 7 months to be eligible for treatment. However there are no long term studies so it is not known whether benefit is maintained over time or whether there are any long term side effects. No significant short term side effects were noted in the trial. The treatment is however invasive as the drug can only be given via lumbar puncture and this needs to be repeated. In the first year, there are 4 injections in the first 2 months, and a further 2 injections in the remaining
10 months. From the second year, onwards it is anticipated children will require 3 lumbar punctures each year. All our responding committees thought that it would be necessary to do a careful evaluation of the benefits and burdens of treatment for the particular child. One responder pointed out that the currently published benefits and burdens applied to a specific group of children and as a particular child moved away from the specified criteria for inclusion in the programme the relative benefits and burdens may change, or become less clear.

Respecting parental autonomy. Responders emphasised that it was important to explore the views of the parents. The assumption is that they would want this drug for their child given that it appears to offer some hope of increased life expectancy and improved function. However respecting their autonomy would require ensuring that they understood the risks of treatment as well as the benefit including the likelihood of benefit for children who fall outside the inclusion criteria for current treatment. Enthusiastic clinicians who want to help their patients, or family members who have read about new drugs, may place explicit or implicit pressure on parents to choose treatments.

Potential consequences for other patients. Responders identified two elements to this consideration. Firstly the precedent that approving a treatment outside the current inclusion criteria would be likely to prompt other parents of children with SMA to seek similar approvals, and while each case may be considered individually fairness would require that similar cases should also be able to obtain approval. This is linked to the other consideration of fair use of resources across the health care system. This treatment is extremely expensive and allocation of Trust, CCG or wider NHS resources to fund it will have implications for funding of other treatments for other patients. In addition to the cost of the drug the additional NHS costs of providing the treatment (repeated lumbar puncture and associated care) also need to be taken into account. However if ventilator requirements are significantly reduced this could also have a cost saving effect. Balancing the needs of different patients, the benefits of specific treatments, and the overall cost to all patients is a
perennial challenge for ethical decision making in patient care.

A final point raised by responders was that of conflict of interest of drug companies and clinicians in advocating for funding for new treatments for severely ill patients. Drug companies will want their drug to be used by as many people as possible and clinicians may be involved in research or development of innovative therapies which could influence their support for a particular treatment. Exploring these issues will be important in considering the request.

Two responding committees used an ethical framework to consider the case, one used the IDEA framework (Identify the facts, Determine the relevant ethical values/principles, Explore the options, and Act on your decision. The other used their own CEC framework based on a merging of the IDEA framework and the Ethox framework.

The consensus of the responding committees was that if on assessment the benefits of treatment clearly outweighed the burdens for this child on the available evidence and the parents were aware of all relevant information and were in agreement then they would support its use. Further information on the reason for the inclusion criteria currently used and why this child did not meet them was thought to be an important consideration in assessing the balance of benefit/burden.

One committee would support the approval on the understanding that the drug company would fund the treatment for as long as the child showed benefit from it (the current arrangement for children who meet the criteria is that the drug company covers the cost of the drug and the NHS covers the associated NHS costs).

Further information about Nusinersin and the current funding arrangements in the UK is available at [http://www.smasupportuk.org.uk/nusinersen](http://www.smasupportuk.org.uk/nusinersen)
Dates for your Diary

25 May 2018
Frailty and urgent care – Hospital Wide Comprehensive Geriatric Assessment, British Geriatric Society
Leeds
Further details: http://bit.ly/FrailyUrgentCare18

13 June 2018
Loneliness in Older People and it’s Impact on Health
London
Further details: http://bit.ly/Lone18

21 - 23 June 2018
14th Annual International Conference on Clinical Ethics Consultation Conference
Oxford
Further details visit: http://iccec2018.org/

25 June 2018
Workshop on Consent in Healthcare
Oakwell Centre, Dewsbury District Hospital
Further details from a.j.stanners@leeds.ac.uk

10 - 14 September 2018
Intensive Course on Medical Ethics
Imperial College, London
Find out more visit: www.imperial.ac.uk/cpd/medeth

For further details and registration for all these events visit: http://www.ukcen.net/main/courses_conferences
If you have any events that you would like UKCEN to advertise please email: info@ukcen.net
We continue to strive to raise the profile of the Network in various arenas, helping new committees setting up, speaking at various events and participating in a table top workshop for the Health Services Journal. As part of this initiative we have allocated trustees to support each sector of the UK. Your nominated trustee will be available to support local committees, organising educational events, offering advice on committee function and profile within your organisation and anything else you need.

Please refer to the list below for your designated trustee and also on the website.

Scotland and Northern Ireland
Regional Sector Trustee: Karen Le Ball
Belfast Health and Social Care Trust
Clinical Ethics Committee
Grampian NHS Board
Royal Hospital for Sick Children

North West
Regional Sector Trustee: John Bridson
Alder Hey Children’s NHS Foundation Trust CEC
Royal Liverpool & Broadgreen University Hospitals NHS Trust
Clinical Ethics Committee

Yorkshire and Humberside
Regional Sector Trustee: Andrew Stanners
Leeds Teaching Hospitals NHS Trust Clinical Ethics Committee
Mid Yorkshire Hospitals NHS Trust Healthcare Ethics Group
Sheffield Children’s Hospital NHS Trust
York Hospitals NHS Foundation Trust Clinical Ethics Group

Wales
Regional Sector Trustee: Premila Fade
Abertawe Bro Morgannwg University Local Health Board
Betsi Cadwaladr University Local Health Board
Cardiff and Vale University Health Board
Cwm Taf University Health Board
Clinical Ethics Committee
Regional Sectors / Clinical Ethics Committees

**West Midlands**
Regional Sector Trustee: Rex Polson
Birmingham Children’s Hospital Ethics Advisory Group
Coventry Clinical Ethics Forum, University Hospitals Coventry & Warwickshire NHS Trust
Heart of England NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust

**Eastern**
Regional Sector Trustee: Kiran Jani
East & North Hertfordshire NHS Trust
James Paget University Hospital NHS Foundation Trust
Norfolk and Norwich University Hospital
Norfolk Community Health & Care NHS Trust CEG
Princess Alexandra NHS Trust Harlow
Queen Elizabeth II Hospital Joint Clinical Ethics Committee

**South East London**
Regional Sector Trustees: Premila Fade
Central and North West London NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Trust
Guy’s and St Thomas’ Foundation Trust Clinical Ethics Advisory Group
Imperial College Healthcare Clinical Ethics Committee
King Edward VII’s Hospital
Royal Free Hospital
Royal Hospital for Neurodisability
St Georges Hospital
West Herts Hospital NHS Trust Eastern Region CEC
Whittington NHS Trust Clinical Ethics Group

**East Midlands & Easter Region**
Regional Sector Trustee: Kiran Jani
Derby City Hospitals
Luton and Dunstable University Hospital NHS Foundation Trust CEC
Nottingham University Hospitals Ethics of Clinical Practice Committee
Sherwood Forest Hospitals NHS Foundation Trust
United Lincolnshire Hospitals Trust Clinical Ethics Committee
University Hospital of North Midlands Clinical Ethics Advisory Forum
University Hospitals of Leicester NHS Trust
Regional Sectors / Clinical Ethics Committees

South East
Regional Sector Trustee: Sara Mason
Helen & Douglas House Oxford
Oxford Health NHS Foundation Trust
Princess Alice Hospice
Royal Surrey County Hospital NHS FT Clinical Ethics Forum

North East
Regional Sector Trustees: Raj Mohindra
City Hospitals Sunderland NHS FT Medical (Clinical) Ethics Group
Newcastle Hospitals Clinical Ethics Advisory Group
Northumbria Healthcare Clinical Ethics Advisory Group

South
Regional Sector Trustee: Anne Marie Slowther
Guernsey Health & Social Services Department Ethics Committee
Poole Hospital NHS Foundation Trust
Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust
Southampton University Hospitals Trust
Southern Health NHS Foundation Trust CEG

South West
Regional Sector Trustee: Richard Huxtable
Bristol Acute Trust Clinical Advisory Group
Gloucestershire Hospitals
Plymouth Health Community Clinical Ethics Group
Royal Devon & Exeter Hospital Clinical Ethics Reference Group Committee
Bath Clinical Ethics Advisory Group
Taunton & Somerset Foundation Hospital
Yeovil District Hospital Clinical Ethics Committee

For Full contact details visit:
http://www.ukcen.net/index.php/committees/member_list