

# UK CLINICAL ETHICS NETWORK NEWSLETTER

Issue 16: Spring 2006



## Welcome to the Spring 2006 Issue of the UK Clinical Ethics Network Newsletter

Welcome to the first issue of 2006 of the UK Clinical Ethics Network newsletter. This year looks set to be one of some changes for the network. We hope to have established the network as a registered charity by the time of our annual conference and AGM on May 11<sup>th</sup>. The conference will be held in Norwich and a copy of the programme is included with this newsletter. Don't forget to book if you haven't already done so. . Since our last Newsletter we have recruited two new members to the Network Committee, Mr Colin Greenhalgh, chair of the Cambridge University Teaching Hospitals NHS Foundation Trust Clinical Ethics Forum, and Dr Martin Vernon, Chair of South Manchester Clinical Ethics Committee. Both Colin and Martin bring a great deal of experience from their work with local CECs.

As you know Jane Goodall left Ethox in September 2005 to embark on a teaching career. She is currently enjoying her training enormously and still finds time to respond to cries for help when we get stuck with the website! Anne Slowther has now been appointed Senior lecturer in Clinical Ethics at the University of Warwick Medical School but she continues to work in Ethox one day a week to support the Network. She has been supported in this by the Ethox Foundation who have provided bridging funding for this work to continue for a further six months. We are actively seeking secure funding for the Network Support Programme but for the time being we are providing a skeleton service. So if responses to your queries take a little longer than they used to we apologise and ask for your patience.

We have had several round robin requests over the past six months and these are summarised on page. One that prompted particular interest and flagged up a lack of policy on the issue was a query about self discharge of patients who lacked competence to make a decision about their health care. This concern relates in part to the Bournemouth ruling which is summarised and commented on by Stephen Louw and Julian Hughes on page.

There has been an increasing interest in the Network and in clinical ethics from Primary Care Trusts over the past year, so it is timely that this issue has a commentary on the experience of a PCT clinical ethics committee by Ethna Cooke, Chair of Dartford, Gravesham & Swanley PCT.

We hope you enjoy the Newsletter. Please feel free to make suggestions for future issues (or volunteer to contribute a piece!) We look forward to seeing many of you in Norwich in May.

Anne Slowther

Editor: Anne Slowther,

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# UK CLINICAL ETHICS NETWORK ANNUAL GENERAL MEETING

THURSDAY 11<sup>TH</sup> MAY 2006

## NORWICH CITY FOOTBALL GROUND

This year the network AGM will be held immediately before lunch on the day of the Annual Conference. We hope this will enable many more of you to attend the AGM as you will already be attending the conference.

All Network members are invited to attend.

The agenda includes:

- Constitution and funding issues
- Competencies for clinical ethics committee members
- Liaison with GMC regarding guidelines for HV testing
- Developing links with national organisations
- International Network contacts

The pre-conference dinner is on Wednesday 10<sup>th</sup> May at 8.p.m.and will be held at Tatlers Restaurant in Tombland, Norwich, which is next the Norwich Cathedral. The cost is £25 and anyone wishing to attend should let Gaynor Hannon know before the 20<sup>th</sup> April. She can be contacted at:

Dept. of anaesthesia, James Paget Hospital, Lowestoft road, Gorleston, Norfolk, NR31 6LA  
**Telephone 01493 452475**  
**Email [gaynor.hannon@jpaget.nhs.uk](mailto:gaynor.hannon@jpaget.nhs.uk)**



## CLINICAL ETHICS IN PRIMARY CARE: THE EXPERIENCE OF A PCT CLINICAL ETHICS COMMITTEE

Here in North West Kent, the need for a committee came from the Professional Executive Committee of the PCT. The aim was to create a climate where clinical ethical issues could be openly discussed. This includes policy advice, looking at areas of concern, providing support for individuals and advising on individual cases. It reports to the clinical governance committee.

It enables discussion between people who can bring a wide range of clinical, professional and life experience to the debate. Membership includes a GP, nurse, public health consultant, member of the Patient and Public Involvement Forum, and a non-executive chairperson. A senior member of the Inter-faith Council brings a multi-faith dimension and also represents the concerns of ethnic minority communities. We have an academic ethicist through our higher education links and members from social services and the acute trust.

Others attend depending on the topic and the PCT communications team has also been actively involved.

It quickly became apparent that there were many ethical issues in primary care and, for the most part, they didn't fit neatly into existing policy areas. Most of the issues raised came from nurses and allied professionals rather than GPs. Examples included:

Artificial feeding – the rights and wrongs of PEG feeding were a concern of continuing care nurses, whose patients might exist in a twilight world for years, because a PEG had been inserted at the outset without considering the longer-term. The senior dietician from the acute hospital talked to the CEC about jointly-developed decision pathways and this prompted other questions - consistency when patients move between different care settings; provision for religious or other dietary preferences.

Teenage sexual health strategy – Would you ask a fourteen year-old to pose as a “mystery shopper” to find out if pharmacies and clinics were user-friendly to teenagers? The teenage pregnancy lead nurse asked the CEC for its views. This led on to ongoing debate on wider issues such as emergency contraception available in schools or via text request.

Another frequent concern to community staff is their duty of care to the non-compliant patient. How far to respect autonomy as in the case of an elderly diabetic in general practice? More difficult still are the non-attenders in community paediatrics, children whose parents don't keep physiotherapy or home visit appointments.

Issues raised by the public included chaperones for personal examinations in doctors' surgeries; use of drugs containing animal products; facilities for safe, non-therapeutic male circumcision and availability of high-cost drugs. Commissioning decisions are increasingly high-profile and two members of the committee sit on the patient appeal panel where individual treatment requests have not been approved.

Public involvement is important to us – we aim to encourage open public debate – this depends on our ability to make the subject relevant, interesting and jargon-free. The public is entitled to understand how clinical decisions are made and to take an active role in health-care planning.

Over three years it has become clear that a CEC can be strategic. The topics raised challenge the PCT and its stated priorities and values. None of the issues stands alone – there are always connections with other patient groups, other partner organisations, other staff groups and always resource implications. In the long term, it is about helping the PCT to be open and accountable and to ensure equity for individuals and communities.

Ethna Cooke  
Chair, Dartford, Gravesham & Swanley PCT  
[Ethna.Cooke@btinternet.com](mailto:Ethna.Cooke@btinternet.com)



## BOURNEWOOD: A RICH GROUND FOR ETHICAL DEBATE

It has traditionally been the practice in the UK to 'admit patients informally' for in-hospital (or nursing care) if they lacked legal capacity and did not appear to object to the admission. By so doing, medical and psychiatric health professionals avoided the stigma of a formal 'sectioning' process under the Mental Health Act of 1983. And, incidentally, saved a lot of time and expense.

This practice has been fundamentally challenged by the Bournemouth case. Following an appeals process through the English Courts, including the Law Lords, the case was heard by the European Court of Human Rights and the practice of informally admitting cases in the UK was judged as in breach of the principles of Human Rights. The European Court decision seems *prima facie* entirely justified at least on the grounds that patients who are institutionalised without their consent require the protection of the law.

### **The facts of the case**

A severely autistic man ("L") had been a resident in Bournemouth Hospital for more than 30 years and was given a trial discharge to paid carers. He became severely agitated whilst visiting a day centre and was given a sedative. He was then re-assessed in Bournemouth Hospital and admitted to a psychiatric behavioural unit. The psychiatrist did not 'section' the patient under the Mental Health Act of 1983 since the patient made no attempt to leave the hospital. He was thus regarded as a 'voluntary' detention, even though he clearly lacked legal capacity. In law, this detention was regarded as 'in his best interests' under the common law doctrine of 'necessity'. His paid carers wished to clarify the legal position and took the matter to Court on the allegation of unlawful detention. The hospital Board evidently supported the psychiatrist's position.

### **The legal findings**

The case was first heard before a Judge in **High Court** in July 1997; the Judge rejected the claim for 'damages due to false imprisonment', on the grounds that (a) he did not make any effort to leave the hospital and thus could not be said to have been detained and (b) that his treatment in hospital had been in his best interests.

An appeal hearing in December 1997 reversed this decision. The **Appeal Court** concluded that L *had* been detained, since the psychiatrists would have prevented L from leaving(1). The Court further held that only a capable person may be detained informally (i.e. not sectioned under the Act) and then only if they consent to admission.

The case went to the **House of Lords**, who disagreed with the Appeal Court's finding(2). The Law Lords found that the Mental Health Act (1983) did allow admission without consent, provided that the patient does not dissent and the treatment was lawful under the common law doctrine of 'necessity'. The Lords finding included consideration of the implication that if the Appeal Court's view prevailed and all such cases were to be formally 'sectioned', some 48 000 currently informally detained patients per year would require formal sectioning. The Lords considered that this 'would in the result be a more than substantive impact on the available resources'. A number of bodies, including the Royal College of Psychiatrists and the executive director of the Alzheimer's Society, had expressed concern about the resource implications of the Appeal Court's decision. On the other hand, it was recognised that if patients like L were formally sectioned under the Mental Health Act, 'they would reap the benefit of the safeguards written into the Act for the protection of patients compulsorily detained'. Lord Goff of Chieveley referred to the Percy Commission (The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957 [1957] Cmnd. 169.) who considered 'compulsion and detention quite unnecessary for ... probably the great majority, of the patients at present cared for in mental deficiency hospitals' and stated that

'we strongly recommend that the principle of treatment without certification should be extended to them'. Percy argued that 'many parents...feel that they lose their rights as parents...when their child ...becomes subject to detention'. The Percy Commission further suggested that the law should be altered such that compulsory detention is not necessarily invoked in all instances where patients cannot positively express their desire for treatment, 'replacing this by an offer of care, without deprivation of liberty, to all who need it and are not unwilling to receive it'. Lord Goff indicated that the history of the relevant section of the Act (1983) 'did not depart from, or modify, the recommendations of the Percy Commission' and thus council's argument that the act be restricted to voluntary patients was 'wholly untenable'.

The matter was then taken to the **European Court of Human Rights (ECHR)**, whose findings were published on 5 October 2004(3). The ECHR found in favour of the patient. Much of the legal argument centred around the question, 'What does it mean to be detained?'. The ECHR found that although L never attempted to leave hospital, nor expressed the wish to leave, the fact that the psychiatrists had said they would have prevented him from leaving meant that the intention was to detain him. Also, L was 'under continuous supervision and control and was not free to leave'. In terms of Article 5 of the European Convention on Human Rights (the right to liberty), L had therefore been illegally detained.

The ECHR found that if the patient had been confined to hospital in terms of the common law doctrine of 'necessity', such confinement would be in breach of Article 5, since this could be seen as subject to 'arbitrary' decisions. The ECHR criticised 'the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted' and listed several attributes of the common law that did not comply with Article 5.

### **Ethical considerations**

Briefly, the following are some of the key ethical issues arising out of the Bournemouth hearings.

1. Respect for the autonomy of persons includes a duty on the part of clinicians to avoid restricting a patient's physical liberty. In practice many patients are deprived of their liberty when they are placed under near-constant supervision and other subtle or overt institutional means to maintain institutional control over patients. A broader notion of autonomy (beyond the usual discussions relating to consent for investigations and treatment) should enter the frame of medical ethical discourse.
2. One might accept that patients lacking capacity in hospitals and nursing homes are being detained for purposes that are 'in their best interests', i.e. for treatment of to protect their health and welfare. However, unless they are detained ('sectioned') under the Mental Health Act, they are deprived of the protection of the law. Lord Goff argues that professional ethics (the duty of care) is sufficient to counterbalance the absence of protection in law. An overview of the merits of each approach may be helpful.
3. The Percy Commission pointed to the sense of loss suffered by parents when their child is admitted to hospital with consequent automatic sectioning under the Act and felt that they 'lose all their rights as parents'. Thus, formal sectioning may have the effect of marginalizing relatives and putting a strain on or disrupting important relationships that may be fundamental to the patient's sense of identity. Whereas multidisciplinary team decisions would currently include relatives or carers (and where appropriate the patient), engendering a direct and shared decision-making process, this dynamic consultation process may be weakened by the presence of agents of the Act who may not necessarily appreciate the nuances of the patient's prior wishes. In practice the agents of the Act may defer decision-making to a body or senior official who is remote from the particularities of the case.
4. In terms of the ethical principle of distributive justice, the opportunity costs to the health and social services of formally sectioning an additional 48 000 cases a year

should be considered. The National Institute for Clinical Excellence uses £30 000 per QALY as the cut-off criterion for approving treatments in the UK. The question arises whether the cost-benefit ratio of wholesale 'sectioning' of these cases will be affordable.

### **The case as an example of casuistic reasoning**

Casuistry is a form of reasoning in moral philosophy which is, in the first instance, case-based. Aristotle is said to have argued that ethics could not be based on abstract, universal principles that are known with certainty, but that ethics dealt with a multitude of specific concrete situations.

Unlike other forms of reasoning which argue from the level of moral theories and principles to the individual case, casuistry takes the view that such abstract considerations are generally too broad to be of value in the individual case(4,5). Casuistry relies on well-established cases in a lexicon of 'paradigmatic' or landmark cases and essentially seeks to compare the current case with a previous, similar, landmark case. Inasmuch as the current case closely matches the paradigmatic case, the conclusions pertaining to the paradigmatic case then apply to the current case. Analysis of the current case requires detailed consideration, a process termed 'immersion'— including the ethos and facilities of the clinical environment, the circumstances of the patient and carers, the options open to health professionals etc. Moral theories and principles are considered as informative to the process, rather than determinative. The process of 'interpretation' requires *phronesis* (Aristotle's term), i.e. applied, practical wisdom and is guided by rules or axioms. In terms of the casuistic school, conclusions are always 'presumptive', i.e. they are not deemed to be universal (true for circumstances, times and places); indeed casuistry views morality as an evolving process. Casuistry has a rich pedigree in law – it is the basis of jurisprudence in all countries with a tradition of case law.

The Bournemouth case all the key aspects of casuistry. Firstly, the fact that successive courts granted leave to appeal indicates that they regarded their decisions as *presumptive*. Secondly, each court shows clear evidence of *immersion* into the particularities of the case: Lord Goff, for example recites the exact details of the circumstances of the L's admission to hospital and what the doctors and social workers thought at the time (according to their affidavits). Thirdly, the English Courts refer to statute and legal principles and these inform their reasoning; but essentially the case is considered within the limits of its own circumstances. Thus, a landmark case is created (there not having been a prior, similar case before English courts).

The challenge for medical ethics is to construct a lexicon of paradigmatic cases, as is extant in case law.

*Footnote:* Interestingly, the European Court of Human Rights follows a different legal tradition - it argues from the theory and principles of the European Human Rights Convention down to the specifics of the case of L. The European court seems to find the notion of English common law perplexing, criticising it in terms of its failure to satisfy certain demands implicit in Article 5 of the Human Rights convention. It seems oblivious (or careless) of the far-reaching implications of its findings – there is no serious attempt to determine (as was the case in the English courts) the number of cases that will henceforth have to be formally sectioned in Europe (this must run into hundreds of thousands) and the opportunity costs of this strict requirement on the health and welfare services in Europe.

### **Where do we stand, practically?**

Currently there is a feeling of disquiet among British psychiatrists about the implications of the European Court judgement. It is felt that the resource costs of formally 'sectioning' all cases who are currently admitted informally would place demands on psychiatrists that would effectively paralyse the services. Psychiatrists justify their inaction by regarding 'L' as an unusually poorly handled case, and hold that existing professional standards - particularly in the multi-disciplinary context - afford a sufficient safeguard for informally admitted patients.

## Stephen J Louw

Chair, Clinical Ethics Advisory Group, Newcastle upon Tyne

Dr Julian C Hughes, Old Age Psychiatry, Northumbria Healthcare NHS Trust and the Institute of Ageing And Health, Newcastle University

## References

1. Regina v. Bournemouth Community and Mental Health N.H.S. Trust, *ex parte "L"* [1998] 2 WLR 764.
2. Lords of Appeal: Opinions for judgment in the cause *In Re L (by his next friend GE) (Respondent)* on 25 June 1998. [www.publications.parliament.uk](http://www.publications.parliament.uk) - Judgments of the House of Lords.
3. European Court: *HL v United Kingdom*, Application no 45508/99, decision of 5 October 2004.
4. Jonsen AR & Stephen Toulmin S. The abuse of casuistry: A history of Moral Reasoning. Univer Calif Press, London 1988.
5. Louw SJ & Hughes JC. Moral reasoning--the unrealized place of casuistry in medical ethics. *Int Psychogeriatr.* 2005 Jun;17(2):149-54



## NETWORK ROUND ROBINS

Since the last newsletter the Network has received six round robin enquiries on issues including:

- Disclosure of non paternity in genetic testing.
- HIV testing in unconscious patients.
- Electronic flagging of advance directives.
- Self discharge of non competent patients.
- CEC involvement in Trust policy for responding to avian flu pandemic.
- Withholding or withdrawing treatment policies following Burke.

Currently we are not reporting on case specific queries in the newsletter due to issues of confidentiality. The issue of electronic flagging of advance directives generated a rich discussion, which is summarised below.

### **Tagging of patients electronic records to alert staff to advance directives**

Some responders expressed concern that maintaining an up to date record of a patient's advance directive that was accessible to all members of the health care team across acute and community services was not practical. It was suggested that the most appropriate method for dealing with this was for the patient to have responsibility for alerting staff, possibly by wearing a Medic-Alert bracelet identifying the presence of an advance directive and its location. The fact that an advance directive did not need to be in writing unless it involves a refusal of life sustaining treatment was also seen as a problem for recording. One responder also pointed out that advance directives could be revoked orally, contributing to a fluid situation regarding recording of current wishes of the patient. The difficulties of relying on flagged records in an emergency situation, or in the community when notes may not be available to the treating health professional were cited as reasons for not flagging records, or at least not relying on flagging as the main method of identification of advance directives.

A key concern appeared to be whether tagging the records indicated a responsibility for ensuring that the advance directive was updated and that a tagged record would be seen as an enduring record of the

current status of any advance directive. This may be impossible to achieve in a secondary care situation where patients are not seen on a regular basis. One responder suggested that a more appropriate place for tagging would be primary care records. Tagging of primary care records would then mean that either the GP should note the presence of an advance directive on referring the patient to hospital, or if the patient was admitted directly in an emergency, the hospital doctor should make enquiries of the GP as to the presence of an advance directive as a matter of routine practice.

Some respondents called attention to the forthcoming electronic patient care record, which will have a central spine for recording data accessible to all relevant health professionals. This could provide a solution to the accessibility of information about advance directives in the patient record as the record should be accessible from any location. However, as one responder pointed out, this assumption may be somewhat naïve in view of the previous record of government IT initiatives!

### **Commentary on responses (Anne Slowther)**

The interesting and thoughtful comments from CECs to this query illustrate the difficulties of dealing with advance directives, and the need to have a clear system that is understood by patients and health care professionals, particularly in view of the implementation of the Mental Capacity Act in 2007, which sets out the legal status of advance directives. It would appear that there are several different scenarios in which the presence of an advance directive could be recorded, and it may be helpful to consider these individually in developing a strategy.

1. One scenario is the comprehensive monitoring system. In this scenario all patient records should be flagged as to the presence or absence of an advance directive. This could be a requirement for GPs to record this data in the patient record in the same way as they record smoking status for example. It would be possible to include a system for reviewing its status at intervals, although there is no legal requirement for a patient to 'renew' his advance directive once it has been made. In the absence of a national patient record this system would only work if GPs informed hospitals of the presence of an advance directive on admitting patients, and if hospital doctors checked with the patient's GP if a patient was admitted as an emergency. Patients would need to take responsibility for ensuring that they informed the relevant person if they wished to change or revoke their directive. A comprehensive monitoring system, particularly in the absence of a central patient record, may not be practical, or even desirable. One responder commented that if Parliament had wanted us to provide a comprehensive monitoring system for advance directives they would have said so in the Statute.
2. A second scenario is the situation where an individual has made clear to her clinician that she has an advance directive in the context of an ongoing health care relationship. It would be part of the clinician's duty of care to that patient to respect her wishes regarding refusal of certain forms of treatment, and to take reasonable steps to ensure that her wishes were respected. Thus, if a patient informed her GP of her advance directive, it would be reasonable for the GP to flag the records and to check with the patient at reasonable intervals that her wishes had not changed. Similarly if a patient was under the care of a hospital clinical team for an ongoing problem that involved multiple emergency admissions, and that patient had informed the team of a valid advance directive, it would again seem appropriate that the records be flagged with regard to the patient's wishes. In contrast to the universal system described above, flagging of ADs in patient records would be on an individual case basis within the context of an ongoing clinician/patient therapeutic relationship. It would not cover all ADs ever written so to some extent would get around the problem of the length of time since the AD had been written and issues of revocation. But it would recognise the importance to some patients of being able to determine what treatment they receive at a time when they are unable to communicate their wishes directly.
3. A further scenario would be that anyone who wished to make an advance directive should be required to wear a Medic-Alert bracelet indicating the presence of an AD and ensuring that it could be easily located. For some patients, for example those who do not attend their GP or hospital regularly, and/or who do not have relatives who may know about the AD, this may be the safest option. However, insisting that this is a requirement for recognition of an advance



directive may be too inflexible and may not be necessary in some cases. If Parliament had wanted all patients to wear Medic-Alert bracelets to indicate they had an advance directive they would presumably have also said this in the Statute.

Advance directives raise many complex issues for health professionals, most of which are unlikely to be simplified by the implementation of the Mental Capacity Act in 2007. As those CECs who have been involved in developing institutional policy in this area will know only too well, it is an extremely difficult task to ensure that the interests of patients are best served in what are often uncertain and emergency situations. A policy for dealing with advance directives may need to be flexible to accommodate different scenarios. In any event it will need to be clearly understood by health professionals and patients alike.

The Mental Capacity Act 2005 sets out the legal status of Advance Directives in sections 24-26 <http://www.opsi.gov.uk/acts/acts2005/50009--b.htm#24>

The Freeman Hospital Clinical Ethics Advisory Group has developed a policy on Advance Directives which is available on the Network website. <http://www.ethics-network.org.uk/Committee/functions/functions.htm>



## ISSUES OF INTEREST

### **Launch of the Clinical Ethics Journal**

The Royal Society of Medicine has launched the first issue of the Clinical Ethics Journal. Edited by Bobbie Farsides and Sue Eckstein, the new journal aims to provide cross-disciplinary debate, 'with a particular focus on how ethics are, and should be, applied in clinical practice'. Regular features of the Journal include a virtual ethics committee in which the committee is asked to discuss cases and policy with a commentary on the discussion by Dr Heather Draper, and a 'Five Minute Focus' in which Dr Anne Slowther provides a brief synopsis of common ethical difficulties for the busy clinician. The first issue is available FREE online at <http://www.ingentaconnect.com/content/rsm/ce>

### **Withdrawal of ventilation on child with spinal muscular atrophy not in his best interests**

Doctors caring for an 18 month old boy with a severe progressive neurological disorder sought a declaration from the High Court that continued ventilation was not in his best interests on the grounds that his condition was intolerable. His parents disagreed and said that he was able to enjoy their love and attention. Mr Justice Holman found that the child (known only as MB) still had a quality of life that was worth preserving. "I positively consider that as his life does still have benefits, and is his life, it should be enabled to continue." <http://www.timesonline.co.uk/article/0,,200-2088035,00.html>

### **High Court ruling on confidentiality for pregnant teenagers**

Sue Axon sought a declaration from the court that a doctor was not under a duty of confidentiality to teenagers under sixteen in respect of contraception, sexually transmitted diseases and abortion and that the Department of Health's document 'Best Practice Guidance for Doctors and other Health Professionals on the provision of Advice and Treatment to Young People under 16 on Contraception, Sexual and Reproductive Health' ("the 2004 Guidance") was unlawful. Mr Justice Silber dismissed the application, concluding that the medical professional is entitled to provide medical advice and treatment on sexual

matters without the parent's knowledge or consent provided that the child is Gillick competent and cannot be persuaded to inform their parents, and that provide treatment without informing their parents would be in the child's best interests. The full judgement can be found at <http://www.bailii.org/ew/cases/EWHC/Admin/2006/37.html>  
A commentary on the case can be found in the commentaries section of the Network website <http://www.ethics-network.org.uk/comment/Fosteraxon.htm>






## USEFUL WEBSITES

- 📄 UK Clinical Ethics Network <http://www.ethics-network.org.uk>
- 📄 Journal of Medical Ethics: <http://jme.bmjournals.com/>
- 📄 Journal of Medical Ethics pre-published papers:  
<http://jme.bmjournals.com/misc/ecurrent.shtml>
- 📄 British Medical Journal: <http://bmj.com/>
- 📄 British Medical Association: <http://www.bma.org.uk>
- 📄 General Medical Council: <http://www.gmc-uk.org/>
- 📄 Cardiff Centre for Ethics, Law and Society: <http://www.ccels.cardiff.ac.uk/>



## DATES FOR YOUR DIARY

-  **UK Clinical Ethics Network Annual General Meeting**  
**Thursday 11<sup>th</sup> May 2006**  
Open to Network members. To be held during the annual conference at Norwich City Football Ground.
  
-  **UK Clinical Ethics Network Annual Conference**  
**Friday 11<sup>th</sup> May 2006**  
Themed around Ethics and the vulnerable, this conference will be hosted by the James Paget Health Care NHS Trust Clinical Ethics Group. Full details of the programme and a registration form are available on the Network website or from [Maggie.wright@jpaget.nhs.uk](mailto:Maggie.wright@jpaget.nhs.uk).
  
-  For details of other courses go to the Courses and Conferences page on the website. If you would like to advertise an event with us please contact [admin@ethic-network.org.uk](mailto:admin@ethic-network.org.uk)



## CONTACT DETAILS

Listed below are the names of the CEC grouped by geographical area in the UK. All the details are now available online.

If you do not have access to the website, and would like the contact details of any clinical ethics committee, please contact the Network.

### **Scotland**

Dundee Medical Forum  
Grampian NHS Board

### **North East**

Newcastle Upon Tyne NHS Trust  
Northgate and Prudhoe NHS Trust

### **North West**

Calderstones NHS Trust  
Lancashire Teaching Hospitals NHS Trust  
Pennine Acute Clinical Ethics Committee  
Royal Manchester Children's Hospital  
Wythenshawe Hospital  
Cheshire and Wirral Partnership NHS Trust  
Wirral Hospital NHS Trust

### **Yorkshire and Humberside**

Doncaster Royal Infirmary  
Hull and East Yorkshire Hospitals NHS Trust  
Leeds Teaching Hospitals  
Mid Yorkshire Hospitals NHS Trust

South Tees Hospitals NHS Trust

**Northern Ireland**

Royal Hospitals Belfast  
Altnagelvin H&SS Trust

**Wales**

Cardiff and Vale NHS Trust  
North East Wales NHS Trust

**West Midlands**

Birmingham Children's Hospital  
Birmingham Heartlands and Solihull NHS Trust  
Birmingham Women's Health Care NHS Trust  
Mid Staffs General Hospitals NHS Trust  
Shelton Hospitals  
University Hospitals Coventry and Warwickshire NHS Trust

**East Midlands**

Derbyshire Mental Health Services NHS Trust  
Highbury Hospital  
Nottingham City and University Hospitals  
Sheffield Childrens Hospital NHS Trust  
Sheffield Teaching Hospitals Trust  
Sherwood Forest Hospitals NHS Trust  
St Andrews Hospital  
Southern Derbyshire Acute Hospitals NHS Trust  
University Hospitals of Leicester NHS Trust

**Eastern**

Addenbrooke's Hospital  
East Anglian Ambulance NHS Trust  
King's Lynn and Wisbech Hospitals NHS Trust  
James Paget Healthcare NHS Trust  
Norfolk and Norwich University Hospital  
Princess Alexandra Hospital NHS Trust  
Peterborough Hospitals NHS Trust  
Queen Elizabeth II Hospital  
Southend Acute Hospital Trust  
St Johns Hospital

**London**

Barts and the London NHS Trust  
Central and North West London Mental Health NHS Trust  
Cromwell Hospital  
Great Ormond Street Hospital for Children NHS Trust  
Homerton University Hospital NHS Trust  
King Edward VII Hospital  
Kingston Hospital NHS Trust  
Northwick Park Hospital  
Queen Elizabeth Hospital NHS Trust  
Royal College of Anaesthetists  
Royal College of General Practitioners  
Royal College of Nurses  
Royal College of Obstetrics and Gynaecology

Royal College of Ophthalmologists  
Royal College of Paediatrics and Child Health  
Royal College of Pathologists  
Royal College of Physicians  
Royal College of Psychiatrists  
Royal College of Surgeons of England  
Royal Free Hospital  
St Christophers Hospice  
St Georges Hospital  
St Marys Hospital  
The London Clinic  
UCLH NHS Trust

**South East**

Brighton and Sussex University Hospitals NHS Trust  
Dartford, Gravesham and Swanley PCT  
Hastings and Rother NHS Trust  
Helen and Douglas House Oxford  
Oxford Radcliffe Hospitals NHS Trust  
West Kent NHS and Social Care Trust

**South**

British Association of Paediatric Surgeons  
High Wycombe General Hospital  
Poole Hospital NHS Trust  
Portsmouth Hospitals NHS Trust  
Royal Berkshire Hospital  
Salisbury Health Care NHS Trust  
Southampton University Hospitals Trust  
UK Genethics Club

**South West**

Plymouth Primary Care Trust  
Royal Devon and Exeter Hospital  
Royal United Hospital NHS Trust  
Taunton and Somerset Hospital



## UK CLINICAL ETHICS NETWORK NEWSLETTER

**Issue 16, Spring 2006**

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