Everyday Medical Ethics and Law

British Medical Association Ethics Department
Information about major developments since the publication of this book may be obtained from the BMA’s website or by contacting:

Medical Ethics Department
British Medical Association
BMA House
Tavistock Square
London WC1H 9JP
Tel: 020 7383 6286
Email: ethics@bma.org.uk
Website: bma.org.uk/ethics
Contents

Medical Ethics Committee xvii
List of case examples xix
Preface xxiii

1 A practical approach to ethics 1
   Does medical ethics help and how? 2
      Key terms and concepts 2
      Professionalism 4
      Duties and rights 5
      The public interest 5
   Medical law and healthcare law 6
      Statute and common law 6
      Human rights law 7
      Quasi (or soft) law 8
   Ethical decision making 9
   Approaching an ethical problem 10
      The BMA’s approach 11
         Recognise that a dilemma exists 11
         Dissect the problem 13
         Do you need more information? 13
         Identify and apply relevant legal or professional guidance 13
         Analyse the facts 14
         Can you justify the decision with sound arguments? 15
   A final word on problem solving 15
   References 16

2 The doctor–patient relationship 17
   Setting the scene 17
   Responsibilities for patients and the duty of care 18
      The duty of care 19
         Independent assessors 21
         Professionals with dual obligations 22
   Continuity of care and patients’ rights to change 22
   Delegation of tasks and referral of patients 23
## CONTENTS

### Patient autonomy and choice
- Managing patients’ expectations
  - Do patients have choices about who provides care?  
  - Rights of homeless people, detainees and asylum seekers  
  - Can patients insist on having the drugs they prefer?  
  - Do patients have the right to a second opinion?  
  - Patients’ rights to combine NHS and private care  
  - Patients’ rights to reject medical advice  
- What are the rights of patients who are violent or misuse services?
- Patients’ rights to complain

### Truth-telling and good communication
- Giving bad news
  - Telling patients about unfunded treatments  
  - Reporting mistakes and telling patients about them

### Keeping patients’ trust
- Managing conflicts of interest
  - Conflicts when commissioning services  
  - Payment for referrals or recommendations  
  - Accepting gifts and bequests
- Covert medication
- Recording consultations
- Covert recording and surveillance
- Chaperones and accompanying persons
  - Intimate examinations

### Recognising boundaries
- Managing personal relationships with patients
- When a friendship becomes inappropriate
- Intimate relationships
- Use of social media
- Health professionals acting as witnesses to legal documents
  - Advance decisions about medical treatment  
  - Acting as a legal advocate for a patient  
  - Firearms certificates
- Health professionals’ personal beliefs
  - Conscientious objection
- Breakdown of the doctor–patient relationship
- Limits or boundaries on advertising services

### Treating oneself, friends and family
- Self-diagnosis and treatment
- Treating family or close friends
- Staff who are also patients
Providing a safe service 54
Whistle-blowing 54
Emergency situations 55
Ensuring competence in daily practice 56
Locums, out-of-hours services and arranging medical cover 57
Vetting and barring 57
Students, shadowing and work experience 59
Writing references for colleagues 59
A last word on the doctor–patient relationship 60
References 60

3 Consent, choice and refusal: adults with capacity 65
Setting the scene 65
The importance of information 67
Offering information for contemporaneous and advance decisions 67
Translation and signing services 69
What type of information? 70
Information to make an advance decision 71
Information about participating in a research project 72
How much information? 72
The duty to warn about risks 73
Can information be withheld? 76
Can patients refuse information? 77
Refusal of treatment 78
Seeking consent 80
Who should seek the patient’s consent? 80
What type of consent or refusal is valid? 81
Implied decisions and explicit or express decisions 81
Written and verbal decisions 82
Voluntary and pressured decisions: Do patients mean what they say? 82
Undue influence 82
Cultural influences 85
The influence of incentives 85
Documenting the decision 86
Documenting consent 86
Documenting refusal 86
Documenting views about future medical treatment 87
Advance requests 88
Advance decisions refusing treatment: The law in England and Wales 89
Advance refusals in Scotland 91
Advance refusals in Northern Ireland 91
Implementing the decision 91
Does having consent mean the procedure must proceed? 91
A last word about patient consent and refusal 92
References 92

4 Treating adults who lack capacity 96
Setting the scene 96
The law concerning treatment and non-treatment of adults lacking capacity to consent 98
General legal principles across the UK 98
England and Wales 99
Scotland 99
Certificate of incapacity and the general authority to treat 99
Common law in Northern Ireland 100
Assessing patients’ capacity 101
What is mental capacity? 101
How is it assessed? 102
What factors indicate capacity? 102
What factors indicate impaired capacity? 103
Fluctuating capacity 104
Who should assess capacity and when? 105
Providing care and treatment for adults lacking mental capacity 106
Best interests and benefit for patients 106
Exceptions to best interests 107
Involving people close to the patient 107
Best interests and covert medication 108
The role of proxy decision makers 108
Power of attorney in England and Wales 108
The power to make health and welfare decisions 109
Disputes arising in relation to LPAs 110
Court-appointed deputies (England and Wales) 110
Independent mental capacity advocates (IMCAs) (England and Wales) 110
The role of IMCAs in decisions to withhold or withdraw serious medical treatment 111
The role of IMCAs in decisions about where patients should live 111
Contents

Attorneys and guardians in Scotland 111
Resolving disputes (Scotland) 113
Decisions needing special safeguards 113
Giving treatment with serious implications 113
Withholding treatment with serious implications 115
Taking legal advice and involving the courts 116
The Official Solicitor (England and Wales) 116
Withholding or withdrawing life-sustaining treatment 117
Clinically assisted nutrition and hydration 118
Safeguards for participation in research 120
Dementia research 120
Emergency research 121
Control, restraint and deprivation of liberty 121
Deprivation of Liberty Safeguards 124
England and Wales 124
Scotland 124
Northern Ireland 125
The difference between protection, restraint and deprivation of liberty 125
A last word on caring for adults who lack capacity 126
References 127

5 Treating children and young people 131
Setting the scene 131
Consent to examination and treatment 132
Competence to consent to or refuse treatment or examination 133
Consent or refusal on behalf of babies and young children 133
Parental responsibility 134
Best interests 134
Disagreements between people with parental responsibility 137
Refusal by people with parental responsibility 137
Involving older children in decisions 138
Unaccompanied minors 139
Confidentiality 139
Assessing competence in children and young people 140
Competence to consent 141
Competence to refuse 143
Consent and refusal by competent young people 143
Consent 143
Refusal 144
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research involving children and young people</td>
<td>147</td>
</tr>
<tr>
<td>Parental consent or refusal for children and babies</td>
<td>147</td>
</tr>
<tr>
<td>Assent from children who lack competence</td>
<td>148</td>
</tr>
<tr>
<td>Consent or refusal by competent children and young people</td>
<td>148</td>
</tr>
<tr>
<td>Emergency research involving children and babies</td>
<td>149</td>
</tr>
<tr>
<td>Availability of research and trial data</td>
<td>149</td>
</tr>
<tr>
<td>Consent and refusal in exceptional circumstances</td>
<td>149</td>
</tr>
<tr>
<td>Male infant circumcision</td>
<td>149</td>
</tr>
<tr>
<td>Serious difference of opinion between parents and health professionals</td>
<td>150</td>
</tr>
<tr>
<td>Paternity testing</td>
<td>151</td>
</tr>
<tr>
<td>Consent to testing</td>
<td>151</td>
</tr>
<tr>
<td>Refusal of testing</td>
<td>151</td>
</tr>
<tr>
<td>Testing and best interests</td>
<td>152</td>
</tr>
<tr>
<td>Advance decision making</td>
<td>152</td>
</tr>
<tr>
<td>Using restraint to provide treatment</td>
<td>152</td>
</tr>
<tr>
<td>Refusal of medical or psychiatric examination under the Children Act 1989</td>
<td>153</td>
</tr>
<tr>
<td>Child protection</td>
<td>153</td>
</tr>
<tr>
<td>Confidentiality and disclosure of information about abuse or neglect</td>
<td>157</td>
</tr>
<tr>
<td>Advisory services and involving the courts</td>
<td>159</td>
</tr>
<tr>
<td>A last word on treating children and young people</td>
<td>160</td>
</tr>
<tr>
<td>References</td>
<td>160</td>
</tr>
<tr>
<td>6 Patient confidentiality</td>
<td>165</td>
</tr>
<tr>
<td>Setting the scene</td>
<td>165</td>
</tr>
<tr>
<td>What is confidential?</td>
<td>167</td>
</tr>
<tr>
<td>Identifiable data</td>
<td>168</td>
</tr>
<tr>
<td>Anonymised data</td>
<td>168</td>
</tr>
<tr>
<td>Pseudonymised data</td>
<td>169</td>
</tr>
<tr>
<td>Keeping information secure</td>
<td>170</td>
</tr>
<tr>
<td>Informing patients about possible uses of their health information</td>
<td>171</td>
</tr>
<tr>
<td>The law on confidentiality and disclosure</td>
<td>172</td>
</tr>
<tr>
<td>The common law protecting confidentiality</td>
<td>172</td>
</tr>
<tr>
<td>Data Protection Act 1998</td>
<td>172</td>
</tr>
<tr>
<td>Health and Social Care Act 2012 (England)</td>
<td>173</td>
</tr>
<tr>
<td>The NHS Future Forum and the review of information governance</td>
<td>174</td>
</tr>
<tr>
<td>Statutory disclosures</td>
<td>174</td>
</tr>
</tbody>
</table>
Statutory restrictions on disclosure 175
Human Rights Act 1998 (UK-wide) 176
NHS Act 2006 (England and Wales) 177
  Comparable arrangements in Northern Ireland 178
  Comparable arrangements in Scotland 178
Computer Misuse Act 1990 (UK-wide) 178
Use of patient information for purposes directly related to care 178
  Consent by patients with capacity 178
    Sharing information with other health professionals 180
    Sharing information with relatives, parents and patients’ friends 181
    Sharing information for social care 181
    Leaving phone messages for patients and texting them 182
  When adults lack capacity 182
    Sharing information to invoke a Lasting Power of Attorney (LPA) 182
    Sharing information with other proxy decision makers 183
  Information sharing when children lack competence 183
Uses of patient information for purposes indirectly related to care 184
  Secondary uses of data 184
  Clinical audit 185
  Financial audit and other healthcare management purposes 185
  Commissioning agencies’ use of patient information 186
  Teaching 187
  Medical research 187
  Public health 188
Disclosures unrelated to health care 189
  Employment, insurance, immigration and social benefits 189
    Reports to insurers and employers 189
  Disclosure to government departments 190
    Disclosure to the driver and vehicle licensing agency (DVLA) 190
  Releasing health information to the media 190
Disclosures to identify and address poor health care 191
  Patient complaints 191
    Involving elected representatives 192
  Whistle-blowing about substandard care 192
  Disclosure to agencies monitoring standards 192
    Disclosure requested by regulatory bodies 193
Disclosures related to crime prevention, detection or prosecution 193
Disclosure to the police and investigatory agencies 193
  Gunshot and knife wounds 195
  Domestic violence 195
  Abuse of vulnerable adults and minors who lack capacity 196
Disclosure to courts and tribunals 196
Disclosure to solicitors 197
Disclosures in the public interest 198
The confidentiality owed to deceased patients 201
  Factors to consider before disclosure 201
  The needs of the bereaved 202
  The interests of justice 202
    Investigations by a coroner or procurator fiscal 203
Access to records in relation to claims 203
Freedom of Information Act 2000 203
A last word on confidentiality 204
References 204

7 Management of health records 211
  Setting the scene 211
Defining medical records 212
  Manual and electronic patient records 212
Images 213
  Visual and sound recordings 213
    Patients who lack capacity (including children) 214
Recording telephone calls 214
Making a health record 215
  What to include in the record 215
    Standardising hospital records 215
    Recording discussion with patients and noting their wishes 216
      Aggressive or threatening behaviour 216
What to exclude from the record 216
Records made and shared by several professionals 217
National summary records 218
Changing medical records or adding to them 218
  Disputes about accuracy 218
    Patient requests to omit or remove some information 218
    Altering or tampering 219
    Adding information later to the record 219
      Adding or removing information when the record is shared 220
Transsexual patients 220
Adopted patients 220
Tagging records 221
<table>
<thead>
<tr>
<th>Primary and secondary uses of records</th>
<th>221</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary uses of records</td>
<td>221</td>
</tr>
<tr>
<td>Secondary uses of records</td>
<td>221</td>
</tr>
<tr>
<td>Secondary uses of children’s records</td>
<td>222</td>
</tr>
<tr>
<td>Using material in publications or other media</td>
<td>222</td>
</tr>
<tr>
<td>Giving access to patient records and reports</td>
<td>223</td>
</tr>
<tr>
<td>Ownership of records</td>
<td>223</td>
</tr>
<tr>
<td>NHS records</td>
<td>223</td>
</tr>
<tr>
<td>Private records</td>
<td>224</td>
</tr>
<tr>
<td>Access by patients</td>
<td>224</td>
</tr>
<tr>
<td>Information which should not be disclosed</td>
<td>225</td>
</tr>
<tr>
<td>Access by solicitors</td>
<td>226</td>
</tr>
<tr>
<td>Access by people other than the subject</td>
<td>226</td>
</tr>
<tr>
<td>Access to the records of children and young people</td>
<td>227</td>
</tr>
<tr>
<td>Access to the records of incapacitated adults</td>
<td>228</td>
</tr>
<tr>
<td>Access to the records of deceased persons</td>
<td>228</td>
</tr>
<tr>
<td>Access to reports for insurance or employment</td>
<td>228</td>
</tr>
<tr>
<td>Security of data</td>
<td>229</td>
</tr>
<tr>
<td>The obligation to protect identifiable data</td>
<td>229</td>
</tr>
<tr>
<td>Records management policies</td>
<td>230</td>
</tr>
<tr>
<td>Transmission of information</td>
<td>231</td>
</tr>
<tr>
<td>By fax</td>
<td>231</td>
</tr>
<tr>
<td>NHSmail</td>
<td>231</td>
</tr>
<tr>
<td>Transfer of information within the NHS</td>
<td>231</td>
</tr>
<tr>
<td>Transfer of GP records</td>
<td>232</td>
</tr>
<tr>
<td>Sending information abroad</td>
<td>232</td>
</tr>
<tr>
<td>Retention and destruction of records</td>
<td>233</td>
</tr>
<tr>
<td>Accessing records after the duty of care has ended</td>
<td>233</td>
</tr>
<tr>
<td>Recommended retention times</td>
<td>233</td>
</tr>
<tr>
<td>Disposal of manual records</td>
<td>235</td>
</tr>
<tr>
<td>Storing and disposing of recordings</td>
<td>235</td>
</tr>
<tr>
<td>A last word about records management</td>
<td>235</td>
</tr>
<tr>
<td>References</td>
<td>236</td>
</tr>
</tbody>
</table>

8 Prescribing and administering medication   241

Setting the scene                            241
Talking to patients and obtaining consent     242
Giving information about a prescription       242
Concordance/medicines adherence               243
Taking account of patients’ values and religion | 244 |
Prescribing placebos                          244
Pressure from patients
   Patients’ requests for complementary and alternative medicines (CAMs) 246
   Requests for repeat prescriptions 247
   ‘Lifestyle drugs’ 249

Choosing the right product for the patient 250
   Responsibility for prescribing 250
   Clinical freedom 250
   Prescribing errors 251
   Pressure from employers 252

Complying with official guidance 253
   NICE (England and Wales) 253
   Comparable arrangements for technology evaluation in Scotland 254
   Arrangements for technology appraisals in Wales 254
   Arrangements for technology appraisals in Northern Ireland 255

Prescribing and monitoring resources 255
   ‘Topping up’ NHS treatment 256
   Generic prescribing 256
   Drug switching 257
   Off-label prescribing and unlicensed drugs 257
   Prescribing drugs off-label to save money 258
   Reporting adverse drug reactions and adverse incidents 259

Shared prescribing and continuity of care 259
   Prescribing shared between different doctors 260
   Prescribing shared between primary and secondary care 260
   Prescribing shared between the NHS and the private sector 261
   Patient group directions (PGDs) 261
   Prescribing shared between doctors and other health professionals 262
   Supplementary prescribing and independent non-medical prescribers 262
   Prescribing shared with practitioners of complementary therapies 263

Continuity of care 263
   Exchange of information between doctors in referrals and discharge summaries 263
   Prescribing for people at a distance – internet, email or telephone 264
   Prescribing for patients abroad 266
   Prescription-only medicines on the internet 266
Prescribing for different patient groups 267
Controlled drugs and prescribing for addicts 267
Prescribing strong opioids for pain in adult palliative care 269
Use of opioids and the principle of double effect 269
Prescribing for older people 270
Involving older people in concordance 270
Over-medication of older people 271
Prescribing for children 272
Prescribing for oneself, friends or family 272
Conflicts of interest 273
Financial interests in health-related products or services 273
Ownership of pharmacies 274
Dispensing doctors 274
Gifts and hospitality from pharmaceutical companies 274
Participation in market research 276
Administering medication 276
Following guidance and protocols 277
When medication needs special safeguards 277
Covert medication 278
Patients with capacity 278
Patients who lack mental capacity 279
A last word about prescribing and administering medicine 279
References 280

Index 287
Medical Ethics Committee

A publication from the BMA’s Medical Ethics Committee (MEC). The following people were members of the MEC for the 2011/12 session.

Dr Anthony Calland, Chairman – General practice (retired), Gwent

Dr JS Bamrah – Psychiatry, Manchester
Dr John Chisholm (deputy) – General practice, Bromley
Dr Mary Church – General practice, Glasgow
Professor Bobbie Farsides – Medical law and ethics, Brighton
Claire Foster – Medical ethics, London
Professor Ilora Finlay – Palliative medicine, Cardiff
Professor Robin Gill – Theology, Canterbury
Professor Raanan Gillon – General practice (retired) and medical ethics, London
Dr Zoe Greaves – Junior doctor, South Tees
Dr Evan Harris – Former MP and hospital doctor, Oxford
Professor Emily Jackson – Medical law and ethics, London
Dr Surendra Kumar – General practice, Widnes
Professor Graeme Laurie – Medical law, Edinburgh
Dr Lewis Morrison – General and geriatric medicine, Lothian
Dr Ainslie Newson – Biomedical ethics, Bristol
Professor Julian Savulescu – Practical ethics, Oxford
Dr Peter Tiplady (deputy) – Public health physician, Carlisle
Dr Frank Wells – Pharmaceutical physician (retired), Ipswich
Dr Jan Wise – Psychiatry, London

Ex-officio
Dr Hamish Meldrum, Chairman of BMA Council
Professor David Haslam, President of BMA
Dr Steve Hajioff, Chairman of BMA Representative Body
Dr Andrew Dearden, BMA Treasurer

Thanks are due to other BMA committees and staff for providing information and comments on draft chapters.
List of case examples

Throughout this book points are illustrated with the use of case examples. Some of these are cases that have been decided by the courts (these have the case name, in italics, in the title) while other case examples are based on enquiries to the BMA or on material published by other organisations, including some disciplinary cases heard by the General Medical Council.

Chapter 2: The doctor–patient relationship

Duty of Care: Barnett 19
Case example – continuing duty of care 20
Case example – managing expectations 24
Case example – failure to discuss 30

Reporting errors: Froggatt 33
Case example – accepting a bequest 37
Case examples – maintaining professional boundaries 41
Case example – personal relationships 43
Case example – personal beliefs 48
Case example – religious beliefs 48
Case example – deregistration on grounds of cost and disability 50
Case example – removal without warning 51
Case example – doctors working outside their sphere of expertise 56
Case example – out-of-hours cover 57
Case example – writing references 59

Chapter 3: Consent, choice and refusal: adults with capacity

Case example – exceeding consent during surgery 68
Case example – problems conveying information accurately 69
Case example – advance decision made on the basis of incomplete information 72

Duty to warn about risks: Sidaway 73
Duty to warn about risks: Pearce 74
Duty to warn about risks: Chester 75
Refusal of life-sustaining treatment: Re B 79
Case example – valid refusal of treatment following a suicide attempt 79
Refusal and undue influence: *Re T* 83
Case example – a pretence of refusal 83
Alleged influence from a health professional: *Mrs U* 84
Treatment without consent: *Patrick McGovern* 87
Failure to make a formal advance decision: *Re M* 88
Request for treatment: *Burke* 89
Documentation of advance refusal: *XB* 90

Chapter 4: Treating adults who lack capacity

Valid refusal of treatment by a mentally ill patient: *Re C* 102
Refusal of treatment due to phobia: *MB* 104
Case example – need for safeguards on powers of attorney 112
Giving experimental treatment: *Simms* 114
Bone marrow donation: *Re Y* 115
Withdrawal of artificial nutrition and hydration: *Bland* 118
Case example – powers of restraint 122
Deprivation of liberty: *Bournewood* 123

Chapter 5: Treating children and young people

Parents requesting treatment considered inappropriate: *Re C* 135
Courts insisting on continuing treatment for a young child: *MB* 135
The unpredictability of prognosis in some young children: *Charlotte Wyatt* 136
Parental refusal: *Re T* 137
Consent by people under 16: *Gillick* 141
Case example – requests for contraception by underage patients 142
Young person’s refusal of a heart transplant: *Re M* 143
The power to override a young person’s competent refusal: *Re W* 144
Overriding a young person’s refusal of a blood transfusion: *P* 145
Case example – Hannah Jones’s refusal of a heart transplant 146
A young person’s refusal of treatment in Scotland: *Houston* 146
Circumcision and a child’s best interests: *Re J* 150
Involving the court: *Glass* 150
Case example – judging who should act and when 154
Case example – Victoria Climbié 155
Case example – Baby P 155
Chapter 6: Confidentiality

The use of anonymised data: *Source Informatics* 169
Case examples – breaches of confidentiality 170
Case examples – failure to keep data secure 171
Case example – retention of information 173
Confidentiality and the Human Rights Act: *Campbell* 176
Case example – information fraudulently requested 179
Case example – inappropriate discussion 180
Clinical information and the media: *Ashworth* 191
Case example – police request for too much information 194
Patients’ rights to object to disclosure: *TB* 197
Case example – disclosure to the police 198
Disclosure in the public interest: *Egdell* 199
Case example – contacting the DVLA 200
Case example – patient with a serious communicable disease 201
Freedom of Information requests: *Bluck* 204

Chapter 7: Management of health records

Case example – whether unsubstantiated allegations should be recorded 217
Case example – tampering with records 219
Case example – publication of an identifiable case 223
Case example – disposing of private records 224
Case example – third-party information in medical records 225
Case example – separated parents applying for access to a child’s record 227
Case example – misplaced records 229
Case example – unauthorised access by staff 231
Case example – accessing records after the duty of care has ended 233

Chapter 8: Prescribing and administering medication

Case example – patients insisting on having antibiotics 245
Case example – media reports generating demand 246
Case example – failure to tell patients about lack of evidence 247
Case example – demand for inappropriate repeat prescriptions 248
Case example – request for past prescribing to continue 248
Case example – drugs to improve exam performance  250
Case example – failure to prescribe correctly  252
Case example – pressure from employers  252
Case example – Viagra  255
Case example – prescribing off-label on cost grounds  258
Case example – shared care  261
Case example – failings in internet prescribing  265
Case example – Annie Lindsell and double effect  269
Case example – the influence of financial investments  273
Case example – meeting with pharmaceutical company representatives  276
Case example – lack of protocols for administering medication  277
Case example – covert medication of people with capacity  278
Preface

The BMA is a doctors’ organisation which, among other activities, provides ethical and medico-legal advice. Other health professionals are increasingly exploring similar dilemmas to those facing doctors and BMA guidance has broadened out to reflect that. This book also summarises best practice standards, legal benchmarks and the advice published by a range of other authoritative organisations throughout the UK. This book may be useful for other health and social care professionals as well as for doctors, although naturally, they are our main audience.

Traditionally, medical ethics applied to the standards and principles that governed what doctors do but now often describes the obligations of all health professionals. Some people prefer a broader and, arguably, more inclusive term such as healthcare ethics, but we have stuck with the term medical. While recognising that good patient care consists of a range of skilled personnel working cooperatively, sharing the same basic values and with very similar ethical duties, our experience is primarily concerned with advising doctors. This book focuses on the daily ethical and medico-legal problems doctors face. We know what these are because, for several decades, the BMA has run an advisory service through which members can receive prompt advice on specific dilemmas. Very often, the recurring problems involve aspects of confidentiality and patient consent, such as whether an unmarried father can legally access his child’s medical records or who can consent to treatment for young people. Patterns of queries alter to reflect high-profile cases reported in the media and the very significant growth of case law (judge-made law) and statute. Now many of both the mundane and the more tricky questions are covered by law, which can differ significantly across the four nations of the UK. This is reflected in the following chapters.

Case examples are also included in the text. Some of these are cases which have gone through the courts and illustrate specific points of current good practice. Others are based on dilemmas doctors have raised with us. We have summarised and anonymised real cases, but some of the examples are amalgams of many very similar scenarios, rather than one specific case. The aim is to capture the very common niggling worries that should have easy answers but often do not.

Above all, our approach is practical rather than abstract or theoretical. As each chapter is based on the problems raised with us by BMA members, many of the fascinating topics of more abstract ethical debate, beloved of philosophers and examiners – such as the moral status of the embryo and whether
assisted dying should be perceived as a human right – are entirely absent from this volume. The BMA has, of course, explored all these issues in considerable depth. Readers who wish to see the full range of topics should consult the third edition of our detailed ethics handbook, Medical Ethics Today. A range of guidance notes are freely available to all health professionals and patients on the ethics section of the BMA’s website and members can also talk through specific dilemmas either by telephone, letter or email.
1: A practical approach to ethics

Picture this . . .

A senior police officer is asking for details of all patients on a certain drug. It could be in connection with a serious crime or an unidentified corpse, but the facts are vague. What do you think? Is patient confidentiality trumped by serious crime and, if so, how serious does the crime have to be? In another part of the building, an irate father is demanding to see his daughter’s record. Can he do that as a divorced dad without custody rights? Should the mother or the 12-year-old daughter herself be asked first? Another headache is that you are new to the area and keen to meet people. Surely there’s no problem in going to a local barbecue? You’ve already had a few flirty emails from one of the organisers who wants to be your Facebook friend and happens to be a patient. It seems quite innocent or is it? On top of that, a senior colleague wants to do some research involving a change of medication for your patients with early-stage dementia. It may do them some good, but doesn’t someone need to consent on their behalf or can they do that themselves? Also there’s a man who always stands far too close and keeps accidentally brushing against you. He’s booked in for a prostate examination and asked specifically for you to do it. Do doctors really still need chaperones? It sounds so Victorian and what if the patient objects? And you’re worried about the patient with the fractured ribs who makes a habit of falling downstairs but refuses to let you tell the police that or about the cigarette burns on her arms. She has young children who don’t look too good either. Shouldn’t you do something? The teenager waiting for stitches in his hand also gives an odd account of the accident. Aren’t you supposed to report all knife wounds even if, as he says, he was just showing off his chef’s chopping technique to his mum in the kitchen?

Common enough questions but the answer may not always seem immediately obvious. That is the point of this book. In the following chapters, we pull together some of the recurring queries that doctors raise. Many dilemmas appear relatively mundane, but some touch on life-changing decisions that need to involve the courts. In fact, all health professionals are likely to face situations in which they have to pause and consider. Their initial gut reaction is not always the right one and, if challenged, they need to be able to offer a reasonable justification for the decisions taken.
Does medical ethics help and how?

When professionals have to work through a problem and feel justified about the options they take or recommend, they need some consistent benchmarks. Traditionally, codes of ethics helped by setting out a framework of duties and principles. Modern medical ethics still provides the framework but also needs to take account of professional regulation, law and quasi law. Frustratingly, ready-made answers are seldom available. Careful analysis and reasoning about the particular circumstances is usually needed, so that superficially similar cases may prompt different responses. This is because an ethical decision is not just about providing the best clinical outcome for the patient but may also include accommodating that person’s own wishes and values. It involves a search for coherent solutions in situations where different people’s interests or priorities conflict. It is often as concerned with the process through which a decision is reached as with the decision itself.

Most of the issues covered in this book are not new. In many cases, the law or well-established pathways and protocols point the way forward but as health care is constantly evolving, new challenges also arise. Ethical debate and the law may then lag behind practice for a while. Often new problems can be usefully addressed by reference to parallel scenarios for which best practice has already been defined but sometimes, a solution which works well in one instance cannot be applied to another, although it appears similar. As each patient is an individual with hopes and expectations that can differ from the norm, radically different solutions may be needed. Health professionals need the skill to analyse the particular problem they face in its own context. This chapter briefly sketches out the BMA approach to medical ethics, with some practical steps on how to approach an ethical dilemma.

Key terms and concepts

Throughout history, doctors have been seen to have special obligations. Sometimes labelled Hippocratic, similar moral obligations were expected of doctors in diverse cultures. As other caring professions attained recognition, they reiterated the same core virtues. One of the problems, as we discuss later, is how we currently interpret traditional concepts, such as the duty to benefit patients and avoid harm (see below). Qualities doctors and other health professionals are now expected to possess include integrity, compassion and altruism as well as the pursuit of continuous improvement, excellence and effective multidisciplinary working.
Key concepts in medical ethics

Common ethical terms are generally self-evident but may require some interpretation when applied to specific cases. All of the terms listed below are explored further, with examples, in later chapters.

**Self-determination or autonomy** – The ability to think, decide and act for oneself is summed up in the concept of self-determination or personal autonomy. When patients have the mental capacity to make choices, their decisions should be respected as long as they do not adversely affect the rights or welfare of others. Adults with capacity who understand the options are entitled to accept or refuse them without explaining why. They can make choices that seem very harmful for them (as long as those things are lawful), but they cannot choose things that harm other people.

**Mental capacity** – In order to exercise their autonomy, people need to have the mental capacity to understand and weigh up the options so that they can make a choice. All adults are assumed to have this, unless there is evidence to the contrary and, in practice, most people (unless unconscious) are capable of making some decisions. Adults’ decisions can still be valid when they appear unconventional, irrational or unjustified, but health professionals may need to check that patients have the mental capacity to exercise their autonomy, when such choices have major life-changing implications.

**Honesty and integrity** – Health professionals are required to be honest and to act with integrity. This means more than simply telling the truth. Their actions should never be intended to deceive and there should be transparency about how decisions are reached. One of the major challenges in this context is giving patients bad news about their prognosis, when the temptation may be to imply more hope than is justified. Good communication skills are essential. A failure to communicate effectively can undermine trust and invalidate patient consent if information the patient needs and wants to know is left unsaid.

**Confidentiality** – All patients are entitled to confidentiality, but their right is not absolute, especially if other people are at serious risk of harm as a result. Cases arise where an overriding public interest justifies disclosure, even against the patient’s wishes. Although this is one of the oldest values reiterated in ethical codes, it is increasingly difficult to define its scope and limitations in practical terms, not least because notions of public interest change.

**Fairness and equity** – The individual patient is the main focus, but health professionals also have to consider the big picture and whether accommodating one person’s wishes harms or deprives someone else unfairly. General practitioners, for example, may be confronted with situations in which the needs or interests of different patients conflict and some doctors, such as public health doctors, are necessarily concerned with groups rather than individuals. The values of fairness and equity are closely linked with the practicalities needed to prioritise and ration the use of scarce communal resources, often summarised in the term distributive justice. There are various ways of approaching justice besides the obvious one about equality (Continued)
(trying to treat all similar cases the same), including the *sufficiency* view (what matters most is that everyone has essential care – although views can vary on what counts as *essential* – and beyond this, inequalities are less important). Fairness under the law is another aspect which is considered further below. Fairness to patients is also a consideration when conflicts of interest arise and doctors’ professional judgement risks being influenced by factors such as the prospect of personal gain.

**Harm and benefit** – Notions of maximising benefit and minimising harm are among the trickiest aspects of modern medical ethics, although the ancient ‘Hippocratic’ commitment to benefit patients and to do so with minimal harm remains central to medical ethics and, indeed, to other healthcare professional codes. Keeping people alive and functioning was traditionally understood to encapsulate the obligation to avoid *harm* and promote *benefit* but, although the terminology has not changed, the interpretations have. Actions are harmful if the person experiencing them believes them to be so or has clearly rejected them. An example would be the use of invasive technology to try and prolong the life of someone who has refused it. Although they can be slippery, notions of harm and benefit continue to feature strongly in any problem-solving methodology and increasingly preoccupy the courts. There is no clear and universal definition and interpretation of the terms depends in different contexts on a number of variables, including individuals’ preferences as well as legal and professional benchmarks.

**Professionalism**

Professionalism is closely linked to modern ethical precepts and reflects traditional core values. Defined as a set of values, behaviours and relationships that underpins the trust that the public places in health professionals, it focuses on health professionals’ partnerships with patients and with each other. Some commentators express concerns about the way market models in health care might affect how we define professionalism. For example, although NHS doctors always had an ethical obligation to consider resources, their own income was generally not linked to their clinical decisions. Increasingly, the use of more commercially orientated tools, including incentives, has led to concerns about how potential conflicts of interest should be managed. (Conflicts of interest are discussed in Chapter 2.) More generally, concerns have been expressed that a broader cultural shift towards a consumer-led model of health care could undermine the core values associated with medicine. Key challenges include finding and maintaining ways in which core values, such as compassion, beneficence and a strong obligation to promote the interests of patients, can still underpin and guide practice in a commercially orientated and consumer-led health environment.