

# Clinical ethics and law

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## Introduction

This chapter begins by reviewing some of the recent trends in clinical ethics education and their relationship to standard ethical analysis methods. Some newer areas of content are then briefly examined and set in the context of this book. The chapter concludes with some suggestions as to the furtherance of study in the clinical law and ethics domain, offering a number of institutions and courses of study that can be undertaken.

## Background

To a certain extent this chapter stands out from the others in this book, as it concerns a particular area of potential educational interest, rather than the theory and practice of education in general. There are several reasons for this. First, the study of medical ethics or what we might better call clinical ethics, subsumes all areas of patient care. It is axiomatic that every interaction between a patient and a clinician, even if not face-to-face, has some ethical or legal content.

For the most part that content has traditionally been analysed in terms of dilemmas: moral dilemmas that find medical expression.<sup>1</sup> It is not difficult to identify some of these dilemmas from any area of clinical practice.

- Should this very low birth weight infant, born at 23 weeks' gestation, be treated aggressively?
- Should a clinician discuss a patient's history and management with her relatives and friends?
- Should a doctor acquiesce to a patient's request for a treatment of limited value?
- Should the National Institute of Clinical Excellence (NICE) fund assisted reproduction interventions for all?

Answers to these sorts of questions do not come easily. It seems almost trite to

declare, but a number of frameworks for ethical analysis are available to at least attempt resolutions. Perhaps the most popular is the principles framework of Beauchamp and Childress,<sup>2</sup> which can be ruthlessly summarised as follows:

- autonomy: respect individuals' own choices
- beneficence: do good
- non-maleficence: do no harm
- justice: treat equitably.

This framework has been honed over the years<sup>3,4</sup> to the extent that it is the most-quoted ethical analysis for clinical purposes, perhaps even applied overmuch.

Second, the undergraduate approach to clinical ethics education is in transition and advancing fast. In 1998, a seminal paper was published, drawing together departments of medical law and ethics across the UK.<sup>5</sup> A formal syllabus on the subject for medical schools emerged and teaching in this area has expanded enormously. The 12 core themes described by this consensus group were as follows:

- informed consent and refusal of treatment
- clinical relationships: trust, truthfulness and communications
- confidentiality
- medical research
- human reproduction
- the new genetics
- children
- mental disorders and disabilities
- life and death, dying and killing
- vulnerabilities created by the duties of doctors and students
- resource allocation
- rights.

Each of these themes is developed further in the document. The whole represents a core syllabus for the subject and a set of learning aims or goals for all UK medical schools. Those institutions which might seek to curtail it are thus enjoined to explain to their students and quality assurance bodies why that is so. It is fair to say that it will take some time to implement teaching in all these areas, but at least now a road map exists.

Those of us who graduated prior to the implementation of such a syllabus may find ourselves to be relatively undereducated by comparison with our junior colleagues. For this reason, among others, some may seek further learning in law and ethics. This issue is addressed below. It will be noted that the 12 themes contain long-standing issues of clinical ethics, such as confidentiality or life and death, but also newer content. Rights theory, for example, might be termed a

relative newcomer to the clinical law and ethics agenda. Given the recent incorporation of the European Convention on Human Rights into UK law, and the utility of a rights-centred morality to argue through clinical dilemmas in clinical practice, this would seem to be apposite. What is not specified by the authors is a teaching and learning methodology, leaving universities to choose their own implementation strategy. The education literature in the last couple of years is full of the various ways in which this is being done, and has many lessons for those of us who work in the postgraduate domain.<sup>6,7,8</sup>

Third and perhaps most interestingly, there is an obvious difference between the study of clinical ethics at a postgraduate level and beforehand.<sup>9</sup> When clinicians have qualified from university they assume patient responsibility almost immediately. They are making decisions on patient care, including diagnosis and treatment. Medicine and allied professions are by their nature vocational. This process offers potential for reflective practice which should be embraced and that should include the ethical and legal aspects of clinical care. Educational supervisors are of course concerned with clinical development, but that offers many opportunities for consideration of the other issues surrounding the clinical. There may be a matter of moral dilemmas, as sketched out above, but may also explore many other areas. Important also, it will be seen, is learning the skills of reflective practice in itself.

A recent additional development is the whole area of ethics support for clinicians. Rather more advanced in secondary care, this concerns support on a case-by-case basis<sup>9,10,11</sup> for clinicians and institutions where ethical issues are identified that need a full discussion and an expert forum.<sup>12</sup> This role is in contrast to the more traditional role of multicentre research ethics committees and local research ethics committees, which are concerned only with research ethical evaluation.

Clinical practice with all its pressures and rewards removes the abstractions often improperly allocated to the study of clinical ethics. Because of this clinicians often seek to study the subject at a postgraduate level, and the opportunities for so doing are described in more detail below.

## Some newer ethical challenges

The traditional ethics curriculum has been expanded of late as already described, but the challenges that might be termed 'recent' have a generic pattern that one particular author has neatly identified. This chapter will develop some areas of interest that are rarely covered normally but flow from clinical practice in the early twenty-first century especially in the cities, though certainly elsewhere as well.

Our society has been described as 'increasingly open, litigious and multicultural' and thus 'awareness of the ethical dimension of everything we do is crucial'.<sup>13</sup> Harvey<sup>13</sup> identified, in common with others,<sup>14</sup> *openness* as a

positive defining character of not only modern life but also of clinical practice. Accepting that this is so has enormous implications. The word is obviously amenable to differing interpretations but this chapter offers a broad one: when clinicians are open with patients what is described is a relationship uncluttered with unsaid truths.

We might postulate an environment where information of all sorts is available to patients in ways which it might most easily be understood. This might be an account of the information necessary to make a clinical decision autonomously, but also of wider issues. For example, clinicians may have differing roles: as providers of individual healthcare and as commissioners of healthcare. It can be reasonably claimed that where the latter may affect their care, patients should know this. Ultimately, such a rule may lead to a separation of roles in order to avoid conflict of interest. Or another example: often doctors are called upon to write reports on their patients for third parties, such as insurance companies or employers; is that role and responsibility clarified to the patient? To be open is to acknowledge the conflicted role.

Sometimes the conflicted role involves commercial relationships between clinicians as researchers and funding corporations. Recent developments in Canada have led to calls, not just for openness in acknowledging such funding, but even its abolition in the cause of unconflicted knowledge.<sup>15</sup>

These sorts of actions are consistent with recent societal changes anyway and it has been said that healthcare trends reflect social trends. Duncan and Cribb<sup>16</sup> identify three ways in which this can happen.

- Professional authority has been subject to critique from what might be termed 'below': the consumerist. And also from 'above': the influence of encroaching management.
- A greater public understanding of the things that shape our lives.
- Scepticism about professional success criteria so that greater importance is attached to individual decision-making rather than professional.

It could also be said that of the four principles above, respect for autonomy is of greatest importance and merits an ordering above the others. If so, it is sensible to consider openness, honesty and trustworthiness as aspects of clinical practice entirely congruent with respect for patients' autonomous decision-making.

Whether or not our society is more litigious than it was is beyond the scope of this chapter but clinicians' responses to such a threat are undoubtedly within it. Any teacher of clinical law and ethics is aware of the fears of their learners about future negligence claims, in the context of a low professional lifetime risk of law suits. Clinical negligence actions are becoming more common, which seems to evince a greater observed than expected degree of anxiety, so that might afflict individuals. To which it could be added, as do Kennedy and Grub,<sup>17</sup> that the law is an unsatisfactory way of resolving disputes between patients and clinicians.

However, the relationship between law and medicine is complex and a moment's examination may be fruitful. It is necessary to mention again that law is not ethics, and that solutions to the kind of moral dilemmas described above are not usually legal. Furthermore, clinical negligence is but a small part of medical law. What is the greatest part of medical law is that pertaining to specific clinical areas:

- law of consent
- legal issues surrounding death and dying
- the law of confidentiality
- legal issues in reproduction
- mental health law
- clinical negligence.

The law is, of course, always in a state of transition, and at the time of writing there are bills before Parliament concerning human tissue, mental incapacity and euthanasia. The courts hear a constant progression of cases, and negligence claims that have a bearing on interpretation of statute law and thus clinical practice. The Department of Health issues notes and circulars that affect all clinicians and patients and have the status of quasi-law.

Given that clinicians need to be aware of the legal frameworks within which they work, the question needs to be asked as to how this may be kept up to date. For specialists this might be argued to be relatively straightforward, as only rarely do new statutes or important common law affect day-to-day work in a narrow field. For example, pathologists are currently struggling with the implications of the Human Tissue Bill, which emerged after several enquiries.<sup>18,19</sup> Psychiatrists have mounted a lively response to proposals to incarcerate patients with severe dangerous personality disorders on a preemptive basis, part of new mental health legislation.<sup>20</sup> Generalists must be aware of legal issues across a broader field perhaps exemplified by recent Department of Health guidelines on informed consent.<sup>21</sup> Something ostensibly as routine as the seeking of patient's consent to examination and treatment has been re-examined in recent years. This has had a profound impact on clinical practice, in terms of procedure, time and even ethical practice.

When the slightly old-fashioned word 'multiracial' is used in a healthcare context, it is usually a stand-in for 'diversity'. Certainly, there are specific clinical and social issues that rise out of considerations of our patients' race, but race is not the only difference between people. We are a diverse collection of individuals in our race, ethnicity, sexual orientation, religion, age, experience and a host of other factors. This is of particular moment in some communities, such as our capital city, rather than other areas which are less diverse.

What must be of importance is that we as professionals learn how to celebrate that diversity and how to best offer care to diverse communities. To take such a

position is necessarily moral as well as logical. The ethical arena that seems to be worth examining here is termed 'relativism'. A relativist will accept no universal moral rules, preferring respect for individual groups' moral positions wherever they might be. Whereas the opposite position accords respect to universal moral rules.

This is best illustrated by the UK law on female genital mutilation. This is prohibited, other than for medical purposes.<sup>22</sup> In passing such a law, the UK government accords no respect to tribal customs in Africa, and elsewhere, which include female genital mutilation. Interestingly, that lack of respect does not extend to male genital alteration. A universal moral rule against female genital mutilation is raised into statute law. So for elements of our diverse community that might observe such a practice, the nation is utterly intolerant, for reasons that hardly need rehearsing.

But in other spheres clinicians may have to be relativists, respecting moral rules from within our communities that markedly differ from one another. Dangerous, though, is the possibility of assuming that members of particular communities observe all the cultural norms ascribed to them. One of the side effects of a diverse society is that people mix, and thus do not always maintain the moral norms of their own groups. Respect for autonomy of a personal nature as ever should surely be of prime importance.

There is a professional edge to this as well. As clinicians we are diverse, too; we have origins in the same way as anyone else. Several sorts of question arise here. How might we resolve conflicts between patients and clinicians that might be ascribable to differing moral values based on cultural origin? What are the implications of a manpower crisis that leads us to recruit from other European countries and further afield?

One of the initiatives recently implemented in London was to try and attract doctors from other European nations to help with the manpower shortage currently being experienced. It is not a new phenomenon as, for many years, the UK has needed and benefited from a continuing supply of doctors from all over the world, but it is recently reinvigorated. Such a policy has many implications for deaneries in practical terms, such as achieving successful integration to the NHS, personal development of the clinicians involved and awareness of differing procedures. There are also issues arising from working in a system that may have a different ethical milieu.

As said above, in the UK we have moved from a rather paternalist medical model to one where autonomous decision-making on the part of patients is valued above all. This more subtle aspect of practice is not necessarily valued in the same way in other parts of the world, so therefore a doctor arriving from such a place may need particular guidance and support. Without, of course, undervaluing the medical ethics of their country of origin, it seems that a path between relativism and universal morality must be steered. Whether or not the NHS should be recruiting at all from countries where healthcare professional

numbers may be relatively low is also an ethical problem that is rarely addressed.

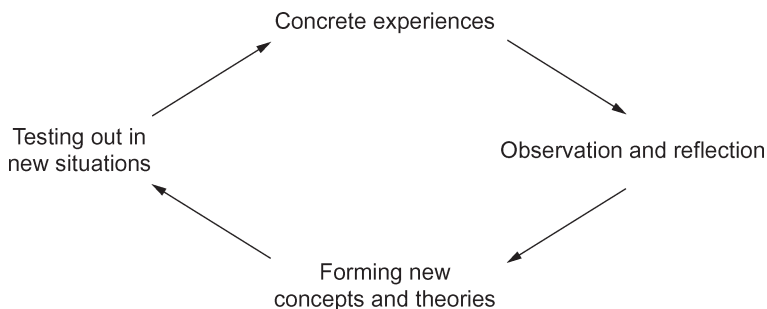
In addition to all of this, as educators, we are faced with the separate issue of how diversity, relativism and choices can best be taught to a clinical audience. Again, the undergraduate sphere in UK medical education has led the way, detailing a host of different methodologies to advance diversity training.<sup>23</sup> Some work has been reported at a postgraduate level, but it remains an underdeveloped field, ripe for application to all healthcare professionals.

## Implications for education

Good education practice requires adequate theorisation: planning learning needs; appropriate teaching and learning methodology; and assessment. Readers may be familiar with the Kolb cycle of experiential learning (Figure 21.1). It is argued that the advancement of clinicians' knowledge, skills or indeed attitudes is best done from the perspective of interactions with patients. In the case of non-clinical specialities, relevant surrogates exist.

It might be further argued that the scope for reflective practice is enormous in clinical ethics. If it is accepted that every patient interaction has ethico-legal content, then every such interaction may merit reflection in this area. Many models for personal reflection exist and whether they are commonly used is arguable, but what should be unarguable is the merit in such a process. Sometimes, such reflection may be guided or facilitated, and indeed it could be said that potentially 'frightening' areas, such as the legal, always need expert input to think through, but this is not necessarily so. For interested clinicians, a wealth of information sources is now available, mainly via the interweb, to complement personal reflection and the acquisition of knowledge.<sup>24,25</sup>

It was argued above that the very fact of professional and life experience rendered clinical ethics a more immediate subject than perhaps earlier in a career. Although the number and quality of many undergraduate assignments gives the lie to such a sweeping statement, nonetheless many clinicians find in their middle careers, a need to study ethics more formally. This could lead to a



**Figure 21.1** The Kolb experiential learning cycle.

structured course at certificate, diploma or masters level. Elsewhere in this book is an account of the mechanics of getting such a course of study approved, implemented and dovetailed with everyday work. What follows is a review of available courses for the pursuance of further interests in clinical ethics and law.

When contemplating such a course the important issues to consider are suggested below:

- uniprofessional or multiprofessional learning group
- part-time or full-time
- transferability of awards
- aims and objectives of each course
- arts-based or science-based
- core content and optional modules
- institutional context
- admission criteria.

Furthermore, careful thought about the following areas is recommended before embarking on such a course:

- aptitude for reading potentially challenging material
- available reading time
- confidence, or willingness, in writing assignments and theses
- willingness to entertain unfamiliar points of view and argue accordingly
- an eclectic approach
- reasoning skills, or the willingness to learn about same
- reflective approach, building on professional experience, but ...
- willingness to set aside professional experience and think objectively.

These suggestions are borne out of the observation of many postgraduate students and reflect, it is hoped, no stereotypical attitudes. It should be said that clinical law and ethics modules are part of many more generalised postgraduate masters courses and the same observations may be made, although to a lesser degree.

In London, courses are available at the following institutions. Space prevents a full comparison between them, so the reader is directed to the referenced websites for further information.

- Centre of Medical Law and Ethics, Kings College:<sup>26</sup> MA in Medical Law and Ethics, MA/PG Diploma in Human Values and Contemporary Global Ethics.
- The Worshipful Society of Apothecaries of London:<sup>27</sup> Diploma in Ethics and Philosophy of Healthcare.
- St Mary's College, Twickenham:<sup>28</sup> MA in Bioethics.
- Imperial College:<sup>29</sup> MSc in Medical Ethics.

Outside London, similar courses are offered all over the UK, including the following.

- Unit for the Study for Health Care Ethics Department of Primary Care University of Liverpool:<sup>30</sup> PG Certificate, Diploma and MSc in Health Care Ethics.
- University of Swansea:<sup>31</sup> PG Certificate, Diploma and MA in Health Care ethics; PG Certificate, Diploma and MA in Health Care Ethics and Law; MA in Medical Humanities.

Increasingly, study can be followed on an extramural basis, via distance learning or even online. Ethics and law in this regard is like any other course, although it should be noted that it is a subject which, if nothing else, is discursive and analytic and thus its study benefits from discussion and shared reasoning. Potential students might also wish to examine the following.

- Manchester School of Law:<sup>32</sup> Postgraduate Diploma/MA in Healthcare Ethics and Law.

There are a number of short courses where healthcare professionals can dip their toes into ethical waters, either to fulfil an interest or decide whether to embark on a full course of study. Notable among them is the following.

- Imperial College:<sup>33</sup> Medical ethics course (five days).

These are a selection of formal taught courses in the clinical ethics domain. It is not necessary to commit to such studying to develop and even relish the subject short of obtaining qualifications in it. Professional journals are rarely without at least review articles on these topics, reflecting its general interest.

## Conclusion

It is hoped that readers will take away rekindled interest in the subject of clinical ethics and law, and investigate some of the potential to fan the flames of such a kindling. What can probably not be avoided is the need to have an at least basic knowledge of some of the principles and reasoning discussed above. Indeed, the view might be advanced that mid-career is an ideal time to step slightly back from the *mêlée* of clinical practice and think more broadly about the care of patients. That thinking may lead into management or education, but also into consideration of ethical themes that have been with us for centuries.

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