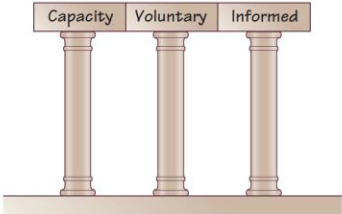



10 Law and ethics

(a) Consent – the three 'pillars'



(b) Elements of capacity



Box 10.1 Principles of the Mental Capacity Act 2007

The law presumes that a person has capacity unless there is evidence otherwise (so just because a person has Down's Syndrome it does not automatically mean they lack capacity)

There are two steps in demonstrating lack of capacity

- There is a disturbance of the brain or mind
- The abnormality must be sufficient to impair capacity

Both of these steps must be demonstrated and supported by evidence

NB: An unwise decision is not evidence of lack of capacity

If the patient lacks capacity:

- Any decision made on behalf of a person who lacks capacity must be made in their **best interests**
- If there are more than one option then the one that is **least restrictive** to the person's freedom must be chosen

Capacity relates to **each individual decision** to be made (you may be able to consent to having your blood pressure taken but not to starting renal dialysis)

People need to be supported in making decisions (e.g. using appropriate tools such as pictures if necessary)

Table 10.1 The 'Four Quadrants' approach to ethical problems

<p>Medical indications</p> <p>The principles of Beneficence and Non-maleficence</p> <ol style="list-style-type: none"> 1. What is the patient's medical problem? Is the problem acute? Chronic? Critical? Reversible? Emergent? Terminal? 2. What are the goals of treatment? 3. In what circumstances are medical treatments not indicated? 4. What are the probabilities of success of various treatment options? 5. In sum, how can this patient be benefited by medical and nursing care and how can harm be avoided? 	<p>Patient preferences</p> <p>The principle of Respect for Autonomy</p> <ol style="list-style-type: none"> 1. Has the patient been informed of benefits and risks, understood this information and given consent? 2. Is the patient mentally capable and legally competent and is there evidence of incapacity? 3. If mentally capable, what preferences about treatment is the patient stating? 4. If incapacitated, has the patient expressed prior preferences? 5. Who is the appropriate surrogate to make decisions for the incapacitated patient? 6. Is the patient unwilling or unable to cooperate with medical treatment? If so why?
<p>Quality of life</p> <p>The principles of Beneficence and Non-maleficence and Respect for Autonomy</p> <ol style="list-style-type: none"> 1. What are the prospects with or without treatment for a return to a normal life and what physical, mental and social deficits might the patient experience even if treatment succeeds? 2. On what grounds can any one judge that some quality of life would be undesirable for a patient who cannot make or express such a judgement? 3. Are there biases that might prejudice the provider's evaluation of the patient's quality of life? 4. What ethical issues arise concerning improving or enhancing a patient's quality of life? 5. Do quality-of-life assessments raise any questions regarding changes in treatment plans, such as forgoing life sustaining treatment? 6. What are the plans and rationale to forgo life sustaining treatment? 7. What is the legal and ethical status of suicide? 	<p>Contextual factors</p> <p>The principles of Justice and Fairness</p> <ol style="list-style-type: none"> 1. Are there professional, interprofessional or business interests that might create conflict of interest in the clinical treatment of patients? 2. Are there any parties other than clinicians and patients, such as family members, who have an interest in clinical decisions? 3. What are the limits imposed on patient confidentiality by the legitimate interests of third parties? 4. Are there any financial factors that create conflicts of interest in clinical decisions? 5. Are there problems of allocation of scarce health resources that might affect clinical decisions? 6. Are there religious issues that might influence clinical decisions? 7. What are the legal issues that might affect clinical decisions? 8. Are there considerations of clinical research and education that might affect clinical decisions? 9. Are there issues of public health and safety that might affect clinical decisions? 10. Are there conflicts of interests within institutions and organisations (e.g. hospitals) that might affect clinical decisions and patient welfare?

(Jonson AR, Siegler M and Winslade WJ; Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine, 7th edition, McGraw-Hill 2010)

What should a GP do when he or she believes that a patient with dementia is no longer safe to drive, or is faced with a mother asking what took place in a recent consultation with her 15-year-old daughter who came in requesting a termination of pregnancy?

These are the sorts of dilemmas that a typical GP can expect to encounter regularly. To be able to practise effectively, safely and on the right side of the law requires a good understanding of the basic principles of ethics and of the law relating to medicine.

Consent to treatment

Before performing any procedure involving a patient, even a simple blood test, the GP must ensure that an adult patient has the **mental capacity** to give consent (see Figure 10a), that their decision is free from coercion and that they have been given sufficient information to make the decision. Without proper consent such procedures could result in a charge of battery.

Of these, assessing mental capacity can be the least straightforward. Since the Mental Capacity Act (MCA) came into force in 2007, doctors have a clear framework to work with. The Act covers adult patients in England and Wales.

To assess capacity the patient must be able to:

- Understand the information being given
- Retain the information in their mind
- Use or weigh the information in considering the decision
- Communicate the decision using any means (see Figure 10b).

The Act also covers the legal basis for decisions made for patients who lack capacity. These are summarised in Box 10.1.

Children under 16 years

Although most consultations with children under 16 years will be with an adult, there are situations where the GP will be faced with a child requesting treatment in the absence of a parent or adult. This may be because the child does not wish his or her parents to be present, for example, a request for contraception.

Treatment relating to children is covered by the **Children Act 1989**. This defines those with 'parental responsibility' who may make decisions on behalf of a child patient. If, say, the child minder brings a child to surgery they would not be able to give consent for the child unless the parent has given their explicit permission. This means it is normally necessary to contact the parent before proceeding. In an emergency, if it is not possible to get hold of a parent, a child can be treated under the Act if it is 'reasonable' to do so.

In certain circumstances children can give consent without the need of a parent or adult. There is no age limit that determines this, instead it is determined by the child's ability to demonstrate 'sufficient understanding and intelligence to enable him or her to understand fully what is proposed' (also known as 'Gillick' or 'Fraser' competence). Where the GP relies on the child's consent in the case of contraception, the GP must also ensure that:

- He or she has sought to persuade the child to involve her parents
- That the child is likely to engage in sexual activity, and
- That the treatment is in her best interests.

Finally, although children with sufficient maturity may consent to treatment, even a competent child may have a refusal of treatment overturned by his or her parents or the courts in the case of life-saving treatment.

Confidentiality

Keeping information gained from patients secret has been a fundamental part of medical ethics as far back as Hippocrates. Doing so serves to protect patient autonomy and trust in the doctor-patient relationship.

In certain circumstances a GP may be permitted or even have a duty to breach patient confidentiality, if:

- It is required by law (e.g. notification of certain infectious diseases; Public Health Act 1984).
- It is justified in the public interest where others may be at risk of serious harm. For instance, a patient with epilepsy who insists on driving.
- The patient consents. Express consent is necessary if identifiable information is to be disclosed. Consent may be implied when sharing information within the healthcare team.

Data protection

GP records hold large amounts of sensitive personal information and are regulated under the Data Protection Act 1998. GPs are responsible for ensuring that data are accurate, secure and accessible to patients.

Confidentiality and the student

As a medical student you also carry confidential information from clerking and examining patients and from seeing the patient's records. You should always take care to protect your patient's confidentiality. Do not talk with colleagues about your patient in a public place (e.g. the hospital lifts). Do not write identifiable details in your patient clerkings (they might get left on the bus). Equally, beware of what you put on Facebook or other social networking sites.

Ethics

The ability to recognise, analyse and resolve ethical dilemmas in clinical practice is a crucial skill for any doctor. There are many tools or frameworks that can be used to help in this process. None are perfect but with a thorough understanding of the clinical issues, the non-medical factors and context of a case, these frameworks help resolve the ethical issues involved.

The **Four Principles** approach is widely used in medical ethics. Although it looks easy to apply, problems can occur when any of the principles conflict, which is all too common in practice. As the approach does not tell us how to resolve such conflicts one is still left with difficult decisions to make.

1 Autonomy. Ensure the principle of self-determination is given due weight, and that patients who have capacity are enabled to make informed choices.

2 Beneficence. Treatment decisions should be aimed at maximising patient welfare. This involves balancing the risks and burdens of treatment.

3 Non-maleficence. Most medical treatment have risks, but any such harm should be minimised and not disproportionate to the benefits of treatment.

4 Justice. The fair distribution of benefits, risks and costs of treatment. Treating patients in a similar position equally.

The **Four Quadrants** approach (Table 10.1), specifies some of the practical questions you should ask in considering the above principles. It is a practical approach which is a useful framework in considering issues in general practice.



General Practice at a Glance

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