ProgrammeAndScenarios_PPB_EthicsLaw_1.doc

Medical Ethics and Law : Professional Practice Block 2015

TUE 28th APRIL 2015	**Polwarth Auditorium 14.00-15.00 and 16.00-1700**	
General Ethical and Legal Principles; aspects of Capacity and Consent. Advanced Directives.		
	Introduction to the Medical Ethics and Law teaching in the PPB	**Dr Gordon Linklater**
14.00 – 14.30	Brief review of principles of decision making in Medical Ethics	**Dr Ruth Stephenson**
14.30 – 15.00	Capacity: legal and ethical aspects. Advanced Directives.	**Dr Gordon Linklater**
15.10 – 16.00	**Small Group Work**	**Various sites**
16.10-17.00	PANEL DISCUSSION	**Dr Ruth Stephenson, Scott Styles, ?Dr Owen Dempsey, ?Dr Derek McHardy (Facilitator: Dr Gordon Linklater)**

WED 29th APRIL	**Polwarth Auditorium 09.00-10.00 and 11.30-12.30**	
Further Aspects of Capacity and Consent including Psychiatry, Mental Health Legislation, Children and Adolescents, Child Protection. Obstetric dilemmas involving mother and foetus		
09.00-09.30	The Mental Health Act; Capacity and Mental Health	**Dr Elizabeth Willox**
09.30-10.00	Capacity and Decision Making in Children and Adolescents	**Dr Gillian Winter**
10.10 – 11.20	**Small Group Work**	**Various sites**
11.30-12.30	PANEL DISCUSSION	**Dr Elizabeth Willox, Dr Gillian Winter, Scott Styles, ?Dr Derek McHardy (Facilitator: Dr Gordon Linklater)**

THUR 7th MAY	**Polwarth Auditorium 09.00 – 10.00 and 11.30-12.30**	
Responsibilities to Patients and Society: Confidentiality, record keeping, GMC requirements including not exceeding your areas of competency, common medico-legal problems inc Medical Negligence, relationships with Police and Courts		
09.00-10.00	Medicolegal Topics of particular relevance to the FY1	**TBC**
10.10 – 11.20	**Small Group Work**	**Various sites**
11.30-12.30	PANEL DISCUSSION	**Scott Styles, Dr Ruth Stevenson, Dr Fiona Garton, TBC (Facilitator: Dr Gordon Linklater)**

Medical Ethics and Law, Professional Practice Block 2015
15 scenarios for the 3 Sessions (I on 28/04/15, II on 29/04/15, III on 07/05/15).

[I]. 28/04/15 General Ethical and Legal Principles; aspects of Capacity and Consent. Advanced Directives.

Scenario for Student Group Discussion	Comments/points/questions (for use by group tutors initially, but will be posted on University Website at the end of the morning)
[I A]. A patient with Alzheimer's Disease has developed a life-threatening pneumonia. She has left an Advance Directive stipulating non-treatment in this event. However, members of her family are strongly of the view that she should be treated. How should you proceed?	Assessment of Capacity: note that while this patient might well not have Capacity (because of dementia and possible superadded delirium) the scenario does not explicitly state this. The scenario also raises the question of the "rights" of the Next of Kin in making decisions in this situation (actually, quite limited unless they have previously set up formal legal arrangements such as Welfare Guardianship or Lasting Power of Attorney). The utility or otherwise of Advance Directives could also be discussed, especially as they are likely to become more common in the future.
[I B]. A 77 year old lady has a gangrenous foot. She also has a chest infection and is generally very frail. Without an amputation she will die. Both the anaesthetist and consultant surgeon are keen that her chest infection is treated before they operate. You are told to put in a venflon so iv antibiotics can be started. She whispers to you that she does not want the operation. What do you do?	Aspects of Capacity. Concept of implied consent vs explicit consent in regard to everyday procedures such as venepuncture or iv insertion. Additionally, in this Scenario, a doubt about consent to the surgery itself raises questions about the role of the junior doctor in representing patient interests and/or challenging decisions of senior colleagues. Is there a possibility of gathering more information which will clarify the ethical/legal position. General points about Duty of Care.
[I C] Compare these two cases: **(i) A patient with a heavy previous intake of alcohol and cigarettes is responding to therapy for pneumonia and is no longer needing parenteral antibiotics. (He is not thought to be at risk of Delirium Tremens). The plan of his regular medical team was to send him home to his bedsit in three days or so. However, he wants to sign himself out immediately because he is not allowed to consume alcohol and smoke cigarettes on the hospital premises.** **(ii) A patient of 75 with moderate dementia and limited insight demands that you immediately call a taxi to take her home, where she lives alone. She is unsteady on her feet, and to have any chance of managing at home would need a major care package that will take a week to organise.**	Two cases showing contrasting levels of Capacity (the first patient probably having Capacity while the second almost certainly does not). Possible conflicts of Autonomy vs Beneficence in the first case. Is there need to adopt formal powers (and, if so, of what type) to detain the first or the second patient for their own protection? Scope for negotiation (e.g. nicotine patch + stay extra day for the first patient) or lateral thinking (would it be ethical to pretend that you have called a taxi in the case of the second patient and to hope that she forgets all about it?). General points about Duty of Care.
[I D] Compare these two cases: **(i). A female patient of 85 has a delirium due to an acute urinary tract infection. She usually takes tablets when they are given to her by the nurses, and the nurses are asking for a temporary increase in sedatives because the patient is in danger of harming herself by pulling out iv lines, catheters, and attempting to stand upright without support.** **(ii). A female patient of 85 has a delirium due to an acute urinary tract infection. She usually takes tablets when they are given to her by the nurses, and the nurses are asking for a temporary increase in sedatives because the patient is noisy and is keeping all the other patients on the ward awake.**	The patient lacks Capacity but note that formal Capacity legislation tends to deal mainly with the non-emergency situation and offers a certain amount of leeway in emergencies. The first situation asks for a balance of beneficence and non-maleficence in a patient who lacks the ability to make an autonomous decision. The second case points to the fact that any treatment given to a patient needs to be justified in terms of the benefit <u>to that patient</u>, and not to the benefit of others or for hospital administrative convenience. Possibility of alternative approaches (? move to single room or being "specialled" by a nurse) but what if there are no rooms available, or if the patient is an a multi-bed receiving unit? If time allows, the subject of <u>covert</u> administration of drugs could be raised, but this is an area of ethical and legal difficulties and might be better discussed by the Expert Panel
[I E]. You are in A&E, a patient is brought in from a road traffic accident. One of the nurses tells you that they are a Jehovah's witness. The patient has suffered massive bleeding and their only chance of survival is if you administer blood. The patient is semi conscious – what do you do?	While the Jehovah's Witness scenario is a particularly old chestnut, it is established that a competent adult Jehovah's Witness is allowed to refuse blood even in life-threatening situations, although they are <u>not</u> allowed to make the decision on behalf of their children. This particular Scenario, however allows some latitude: the patient is semi-conscious, you only have hearsay evidence that the patient is a practising Jehovah's Witness. There is also the general A&E principle, (as also used in patients who have taken overdoses), to err on the side of treating life-threatening emergencies, pursuing the belief that not dying is generally considered a more beneficent outcome than dying.

[II] 29/04/15 Further Aspects of Capacity and Consent including Psychiatry, Mental Health Legislation, Children and Adolescents, Child Protection. Also Obstetric dilemmas.

Scenario for Student Group Discussion	Comments/points/questions (for use by group tutors initially, but will be posted on University Website at the end of the morning)
[II A]. A 15 year old girl has been admitted to your ward with abdominal pain. She initially alleges that she has been sexually abused by her father and says she also suspects that some of her other siblings may also be current victims of abuse. A short time later however, she changes her story. She says that she was trying to "get back" at her father for criticising her choice of boyfriend, that she made up the story about abuse, and that she does not wish any further action to be taken, and that her abdominal pain is now improving. She expressly forbids you to write anything in the notes about this or even to mention this to anyone else including your senior medical colleagues or her GP.	Note that the girl is under the age of consent (16), but that under the Gillick principle and common medical practice she might well be judged capable of making autonomous decisions and having her Confidentiality respected without parents being involved. The extra dilemma here is an allegation of criminality, which it would normally be your duty to report unless you were absolutely sure the initial accusation was unfounded . The junior doctor would almost always seek senior help, whilst trying to get the patient's consent for this. The students should be aware of local child protection guidance. Other actions that partially breach confidence without going directly to the police might be to involve a Social Worker or GP with or without consent of the patient – again see child protection guidance.
[II B]. A young woman has been hospitalized following self-injury. She absconds from the ward and returns intoxicated with alcohol, having inflicted a deep incision to her arm. She announces a wish to leave the ward on a second occasion "to do it again", and is heading for the door. She has knowledge of biology and is deliberately cutting close to major arteries. Should you physically stop her from leaving?	Does she have Capacity? Is the Mental Health Act relevant here? What is your duty of care? Is this just a "gesture" or a true suicidal attempt? As a junior doctor on the spot should you (can you legally?) physically stop the patient from leaving until you can call for senior help. [Students may also want to surmise whether a "knowledge of biology" means that the patient is more likely to successfully commit suicide or that it simply implies that she is knowingly avoiding doing herself serious harm].
[II C]. A 10 year old comes to the hospital with a severe derangement of her diabetes (diabetic ketoacidosis). She is crying and distressed and says she wants to go home. Her parents have decided to accede to her wishes and are leaving A&E with her. You are the only doctor in A&E at the moment and the nurses ask you to "do something". What do you do?	This Scenario was originally constructed so that the wishes of child and parent were in conflict. With a 10-year old, under such circumstances, then the wishes of the parents would usually prevail, particularly if they were favouring a course of action that was in accord with standard medical opinion. Instead, however, the Scenario has been changed to the more extreme situation where the Duty of Care to the child would seem to be to override the expressed wishes of <u>both</u> parents and child. Are you allowed (do you have a duty) to stop the parents removing the child? If necessary do you stand in their way, summon the police and apply to a Court? Are there less dramatic ways around the dilemma?
[II D]. A pregnant patient has a placenta praevia and is actively bleeding with foetal distress. She is scheduled for an emergency caesarean section and the senior staff are away arranging this. You have been asked to put in a venflon, but as you start to do this the patient says she has changed her mind about the operation. She tells you that she has a real fear of needles and forbids you to put a venflon in. What do you do?	The "higher level" ethical dilemma here is whether an operation should be carried out against the wishes of the mother to save the life of her child and possibly herself. In this regard, there would be an urgent need to clarify whether the patient is in fact refusing <u>any</u> surgical intervention, or whether a needle phobia is the true problem. The "lower level" but more immediate ethical dilemma for the FY1 is whether they should "obey orders" from their seniors and put in a venflon explicitly against the consent of the patient. Are there less dramatic ways around the dilemma, such as a local anaesthetic cream prior to needle insertion, or asking the anaesthetist to induce anaesthesia with a mask rather than a needle?
[II E]. A 13-yr-old girl is admitted to A&E with pain and vaginal bleeding. She is accompanied by her mother. The girl tells you in confidence that she had a surgical abortion 5 days ago, but her family do not know. Her mother is demanding to know what is wrong.	She is under the age of consent but is entitled to confidentiality if she is judged mature enough to make autonomous decisions. The mother may be "demanding" but does not have an absolute right to know. For an FY1, the pragmatic and ethical way would probably be to say that their level of experience does not allow them to speculate on the gynaecological pathology. However, it is almost certainly going to be in the long-term interest of the girl to have the full and informed support of her family, and this should be discussed with her in the absence of her mother. Child protection issues also important – if the abortion was legal these may already be in hand. Who is she having sex with? Students should be aware of recent media coverage of child exploitation etc.

[III] 07/05/15 Responsibilities to Patients and Society: Confidentiality, good record keeping, GMC requirements including not exceeding your areas of competency, common medico-legal problems including Medical Negligence, relationships with Police and Courts

Scenario for Student Group Discussion	Comments/points/questions (for use by group tutors initially, but will be posted on University Website at the end of the morning)
[III A]. A case conference has been called to discuss arrangements for getting Fred home. He has metastatic prostate cancer but is otherwise well. You are asked to be the medical representative at this meeting because the more senior medical members of the team are on leave, in a clinic, or on a half-day. When you go in to the meeting room you see that a nurse, physio, OT, social worker and Fred's son and daughter are present. When you sit down the discussions begin. Are there any unaddressed ethical issues in this scenario?	The key principles are Autonomy (in the absence of evidence to the contrary, it should be assumed that Fred has Capacity – has he agreed that a case conference be conducted in his absence?) and Confidentiality (does Fred agree that all these people are going to be told about his various problems?). There is also the issue of professional relationships with other members of the multidisciplinary team – the FY1 is not going to be popular with everyone else if he/she obstructs or objects to a meeting that may have taken days to set up, particularly as the meeting might well prove beneficial to the patient.
[III B] **(i) A patient asks you to show them their medical notes. What do you do?** **Alternatively:** **(ii) A man dies in your ward. His wife asks to see his medical notes. What do you do?**	A chance to air the issues of who "owns" the notes, and who has a right to information. Are you on firm legal and professional grounds if you show a patient or a relative what you have written in the notes yourself (as opposed to what others have written) or should you go through established administrative procedures with all their necessary delays? What about transparency, openness, truth-telling, and putting the patient at the centre of his/her care? Might the contents of the notes be harmful to reveal to patient/relative at this stage? Should you try to ascertain <u>why</u> the patient/relative wants to see the notes, or is this irrelevant?
[III C] **(i) On Monday morning your fellow F1 appears, smelling of alcohol. He asks you to cover for him as he goes for a quick nap. What do you do?** **(ii) Alternatively, Your fellow F1 has turned up late on the ward on three consecutive Mondays. He smells of alcohol, and does not manage to take blood from, or cannulate, any patients over the course of the morning. What do you do?**	Contrasting cases relating to Fitness to Practise, but which recognise that under GMC regulations you have a duty to inform an appropriate person if you or another doctor may not be Fit to Practise (a further point for discussion within the Scenario is <u>who</u> should be informed) . The second Scenario is of particular concern as it is more immediately threatening to patient care if the doctor stays on the ward to treat patients even though he is probably unfit to do so.
[III D]. You are the FY1 on a busy orthopaedic ward and are about to go to theatre to assist the surgeon in the morning list. A theatre nurse runs up to you and tells you that the consent form the first patient has signed is for fixation of the left big toe and the right big toe is marked for operation. The patient is now asleep and the consultant anaesthetist is cross. What do you do? **[On a more general point, what should be the role, if any, of FY1s in "consenting" people for surgery]**	Are there indirect ways around this problem, or should the anaesthetist wake the patient up and delay the operation, perhaps for weeks? What if there is strong evidence that the right big toe is diseased and that the only problem is a "slip of the pen" on the consent form? In such cases, are you allowed to alter the "L" into an "R"? Should the FY1 subsequently tell the patient what happened, even if no harm resulted? Would the patient have a legal basis to sue for negligence in that situation? Does the FY1 have a wider duty to look at mechanisms to ensure that the problem does not arise in the future? Aspects of relationships with other professionals are raised by the approach of the FY1 to the "cross" anaesthetist and the fact that seniors and/or the management may not be keen for the patient to be informed if no harm occurred. What if the seniors argued that it would be better for the patient's peace of mind if he/she was to remain blissfully ignorant of the event? In regard to the general question on obtaining valid consent, the person doing this should have sufficient knowledge of a procedure to be able to inform the patient fully of the technical details, risks and benefits.
[IIIE]. A 44 year old self-employed lorry driver is admitted to your ward having had a seizure in A&E. The fit was caused by a brief episode of accidental strangulation. He had a short tonic-clonic seizure before making a full recovery. You have informed him about the need to contact the DVLA. He and his wife ask you if this is really necessary?	Was it a "real" fit? In terms of the DVLA legislation, does it matter if the fit was due to temporary anoxia rather than true epilepsy? Where can the FY1 find the relevant DVLA regulations? What if the patient says he will tell DVLA but the FY1 is sure he won't? Should the GP be old (with or without the patient's consent).Should the FY1 contact the DVLA directly? If the FY1 decides to go against the patient's wishes, should the patient be told about this? Could the patient complain to the GMC? Opportunity to explore individual vs public interest.