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As a health professional or student of the health professions you are required to develop a wide range of new knowledge, skills and professional values. An understanding of ethical, legal and professional issues is essential to help you to: maintain professional standards, to negotiate dilemmas in your everyday practice and to respond effectively should you witness unprofessional practice. You may already have some experience of health services as a patient or relative or you may have gained experience as a practitioner. In any case, it is likely that you may feel uncertain regarding the right responses in situations such as the following:

► You are working in the operating theatre and it becomes clear that the anaesthetised patient who is to have a surgical procedure requires a circumcision to gain access to his bladder. He has not given consent for this. The patient’s wife directs the surgeon to proceed with the circumcision. The surgeon asks for your opinion. What would you say and why?

► You are a member of a paramedic crew and you arrive at the home of an elderly couple. You are confronted with a chaotic scene. The woman has a bleeding arm and her husband, who has dementia, is lying on the floor with a head injury. The woman refuses to let you take her husband to hospital. What would you do and why?

► You are working on the Accident and Emergency Department when a 14 year old is admitted with severe abdominal pain. A routine pregnancy test is positive. The teenager insists that you do not tell her parents. What would you do and why?
You witness a colleague being disrespectful towards a couple who have learning disabilities. The woman is pregnant with their first baby. What would you do and why?

The ability to give an account or to explain the reasons for your actions and omissions is an essential component of your professional accountability (see Chapter 2). The clinical reasons for doing one thing rather than another should be based on evidence or research. As a health professional you must, however, also consider the well-being and preferences of patients and family members in the context of care. At times, as in the examples above, there may be a conflict between what you think is in the best interests of patients and what they or a relative wishes. The ability to provide sound ethical, legal and professional reasons for your actions and omissions is essential. As you work through this book you will have the opportunity to explore these, and other, examples of scenarios and to develop an understanding of appropriate responses and the reasons you can give to underpin them.

In this introductory chapter we introduce you to key ethical, legal and professional concepts that are examined in this text, that is, accountability, consent, truth telling, confidentiality and justice. First, we will say something about the nature of ethics, law and professional issues in healthcare.

What Is Healthcare Ethics?

Ethics is an unavoidable part of healthcare practice. It is concerned with reflection on values, with making decisions, with doing the right thing and, it can be argued, with the development of good character. It is important to be able to distinguish between factual and ethical issues in healthcare. Questions such as ‘how many people are on the waiting list for a hip replacement?’ and ‘which treatment saves most lives following a myocardial infarction?’ are factual or evidence-based questions. Questions such as ‘how should we allocate scarce healthcare resources?’ and ‘in what circumstances should we withhold treatment following a myocardial infarction?’ are ethical or value-based questions.

There are different branches of ethics and two are particularly relevant to this text: normative ethics and descriptive (non-normative)
ethics. Normative ethics, concerned with what people should or ought to do or how they should live, is most closely associated with moral philosophy. Examples of questions associated with normative ethics include: Should the patient be told the truth about her diagnosis? Should the confidentiality of a teenager be maintained when she refuses to tell her parents that she is pregnant? Descriptive ethics is concerned with what people do, think and believe in relation to ethical issues in healthcare practice. This branch of ethics straddles moral philosophy and, most commonly, the social sciences. Empirical ethics questions include: What are nurses’ views of assisted suicide? What are patients’ perspectives on dignity in relation to their care? How does ethics teaching contribute to the development of ethical sensitivity? Whereas normative ethics involves thinking or ethical analysis and the application of rules, principles and theories to practice situations (the focus of this text), empirical ethics generally involves data collection from questionnaires, interview, focus groups or observation. The data are then analysed, findings reported and recommendations made.

Healthcare ethics, then, refers to a wide range of practice situations. There are few decisions, actions or omissions that do not have an ethical dimension. Engaging with the scenarios, activities and discussion in each of the chapters enables you to reflect on your own practice and to rehearse how you will respond to ethical issues in the future. It also has the potential to make you more competent and confident in dealing with ethical complexity and uncertainty in everyday practice. There is a rich literature in normative and descriptive ethics to draw on that will illuminate your practice. Overall, healthcare ethics is concerned with doing the right thing and with being a certain kind of person in healthcare situations. Ethical analysis and empirical ethics research findings help with this. In addition to reading texts such as this one, we recommend that you read articles on topics of interest in journals such as Nursing Ethics, Journal of Medical Ethics, Bioethics and Ethics and Social Welfare. Texts that will provide you with an overview of issues and approaches relating to healthcare ethics include those by Davis et al. (2006), Fulford et al. (2002) and, more broadly, Steinbock (2007). The Encyclopaedia of Applied Ethics, the Encyclopaedia of Bioethics available in some university libraries and the online Encyclopaedia of Philosophy are also useful resources (http://plato.stanford.edu/).
Approaches to Healthcare Ethics

You have been introduced to two branches of ethics (normative and descriptive ethics). This section focuses on normative ethics, on the principles and theories that help people think about and justify decisions, actions and omissions in everyday healthcare practice. There are many possible theories and principles that you might appeal to and it is not possible to do justice to all of them here. However, it is helpful to know something of the range of options and how to learn more. Box 1.1 summarises the main types of ethical theory.

Box 1.1 Ethical theories

**Duty-based theories** – This focuses on the duties or obligations of healthcare professionals. It is an approach that underpins many professional codes. In moral philosophy this is referred to as deontology and the philosopher most associated with this theory is Immanuel Kant (Kant 1785, Paton 1948, Baron et al. 1997). There are some very helpful prescriptions within deontology. One of the best known is ‘you must not treat others merely as a means to your own end’, that is, you must respect individuals for their own sake and not merely as resources to help you achieve your own ends or goals. A key question to ask from a duty-based perspective is: what are my duties or obligations as a healthcare professional?

**Rights-based theory** – A right is defined as a claim you can make that is justified on the basis of international or national rights frameworks. Some rights are described as ‘positive’ in that they require something of others and some rights are ‘negative’ in that they require that people are left alone with no interference. Reproductive rights can, for example, be of both kinds. A positive right to reproduce suggests that if a couple is infertile they should be offered fertility treatment. A negative right to reproduce suggests that couples should be allowed to reproduce without interference. Negative rights might be appealed to if, for example, a couple had severe learning disabilities. It is likely there would be debate as to whether they have or have
not a right to reproduce. It is argued that there is a ‘correlativity’ between rights and duties or obligations because duties are necessary to make rights meaningful (Beauchamp & Childress 2009). If, for example, no individual or government has a duty to provide healthcare then it is unhelpful to talk of a right to healthcare. Rights-based approaches to healthcare ethics are particularly strong in emphasising the global context and transcultural nature of ethics (Macklin 1999; Klug 2000; McHale & Gallagher 2003; Hunt 2007). Key questions to ask in relation to rights are: what are patients’ or service users’ rights? What are my rights as a healthcare professional?

Consequence-based theory – One of the most common consequence-based ethical theories is utilitarianism. The two philosophers who developed this approach initially are Jeremy Bentham and John Stuart Mill (Mill 1789). Contemporary utilitarians include John Harris (1985) and Peter Singer (2001). The slogan the ‘greatest happiness for the greatest number’ relates to utilitarianism. In a healthcare context utilitarians focus on the question: what will lead to the most benefit and least harm for most people? This approach is particularly helpful in relation to resource allocation in healthcare but less helpful at the bedside.

Virtue-based theory – The previous three theoretical approaches can be said to focus on the actions or conduct of the healthcare professional, that is, doing my duty, respecting rights and weighing consequences. A theoretical approach that focuses on the character and ethical qualities or dispositions of the healthcare professional is virtue ethics. There is a growing literature relating to virtues and healthcare (see, for example, Crisp 1996; Swanton 2003; Banks & Gallagher 2009) and discussion continues as to which are the most relevant virtues for healthcare professionals. In the discussion in the chapters you will, for example, come across references to professional wisdom, respectfulness, honesty, integrity, courage, compassion and justice. A key question relating to a virtue-based approach to healthcare ethics is: what virtues (dispositions to think, feel and act) do I need to demonstrate in my everyday practice?
The theoretical approaches outlined in Box 1.1 do not exhaust the possibilities for ethical theory. There is, for example, a growing body of work on relational ethics, ethics of responsibility, hermeneutic ethics and ethics of care. Developments in ethics of care are particularly interesting for health professionals. Special issues of the journal *Nursing Ethics* (Issue 2, 2011) and of the *Journal of Ethics and Social Welfare* (Issue 2, 2010) have explored the potential of ethics of care for health and social care practice. Given the many options regarding ethical theory the reader may feel rather overwhelmed if not confused. All of these theories throw light on the moral life and help us to think through the ethical implications of decisions, dispositions and actions. They may also conflict and point to different ways of thinking and deciding.

It is our view that ethical approaches should be: easy to grasp; provide a helpful framework for thinking; and be applicable to everyday practice issues. One ethical perspective that continues to be written about and applied to practice is the ‘four principles approach’. This has been written about by healthcare ethicists such as Beauchamp and Childress (2009), Gillon (1985) and Edwards (2009). This approach has also been criticised for being overly simplistic and too mechanistic. It is a helpful framework but needs to be approached critically and thoughtfully. It is, therefore, only as good as the way it is used. Box 1.2 outlines the approach.

**Box 1.2  Four principle approach (4PA)**

**Respect for autonomy** – The word ‘autonomy’ comes from two Greek words *autos* and *nomos* meaning self-rule or self-government (Beauchamp & Childress 2009). There are different theories of autonomy, some requiring a high level of cognitive functioning. The Beauchamp and Childress approach focuses on ‘normal choosers who act, intentionally with understanding and without controlling influences that determine their action’ (ibid: 110). They allow that actions can be autonomous ‘by degrees’ and that for an action to be autonomous it requires ‘only a substantial degree of understanding and freedom from constraint’ (ibid: 101). The principle of respect for autonomy acknowledges the individual’s ‘right to hold views, to make choices, and to take actions based on their personal values and beliefs’ (ibid: 103). It
supports rules or obligations to: tell the truth, respect privacy, maintain confidentiality, obtain consent and help others to make decisions (ibid: 104).

**The principle of non-maleficence** – This requires that healthcare professionals should not inflict harm on others. It has a long tradition in healthcare and is often considered in relation to beneficence, as principles to do good and to avoid harm go hand in hand. The rule ‘one ought not to inflict evil or harm’ relates specifically to the principle of non-maleficence (Beauchamp & Childress 2009: 151).

**The principle of beneficence** has a long tradition in healthcare and, as has been said, is generally considered in relation to non-maleficence. In medicine, for example, the Hippocratic oath refers to both principles: ‘I will use treatment to help the sick according to my ability and judgement, but I will never use it to injure or wrong them’ (ibid: 149). The principle of beneficence supports rules such as: ‘one ought to prevent evil or harm; one ought to remove evil or harm; one ought to do or promote good’ (ibid: 151). Reflecting on the principles of non-maleficence and beneficence, therefore, requires a weighing up of what it means to do good as opposed to what will bring about harm or wrong. The principles are similar to consequence-based theories but need to be considered in relation to both the principles of autonomy and justice.

**The principle of justice** is one of the most challenging principles to grasp and apply to everyday practice. The concept ‘justice’ refers to ‘fairness, desert (what is deserved) and entitlement’ (Beauchamp & Childress 2009: 241). In healthcare ethics, justice is generally applied when there are challenges regarding resource allocation. Distributive justice, therefore, refers to a range of principles that suggest what fair or justice distribution is, for example, allocation on the basis of need, effort, contribution, merit or give everyone an equal share (ibid: 243). When resources are scarce, difficult decisions have to be made as to how to allocate resources fairly ensuring that the criteria are ethical and people are not discriminated against without good reason. Beauchamp and Childress (2009:241) put it this way: ‘Standards of justice are
needed whenever persons are due benefits or burdens because of their particular properties or circumstances, such as being productive or having been harmed by another person’s acts. A holder of a valid claim based in justice has a right, and therefore is due something. An injustice involves a wrongful act or omission that denies people resources or protections to which they have a right.' Justice has also been discussed as a key virtue for health and social care professionals (Banks & Gallagher 2009).

The four principles approach has limitations but is also very helpful in structuring our thinking as we analyse and discuss ethical problems and make decisions that underpin our actions. The key questions in the ethical analysis of a healthcare issue would include:

- Is this patient/service user autonomous?
- What does it mean to respect their autonomy in this situation? For example, tell the truth, provide information, maintain confidentiality or respect privacy?
- What are the benefits to be gained from the interventions/omissions proposed?
- What are the harms or wrongs that might follow from the interventions/omissions proposed?
- What is the most just response in this situation?

A supplementary question but, we think, a necessary one would be:

- What virtues or ethical dispositions are required to do the right thing in this situation?

What Is Healthcare Law?

The law is a means of regulating society. It can be used to oppress people, for example, in any totalitarian state, or it can be used to protect people’s rights and freedoms and to support a particular way of life. Each country in the United Kingdom has its own law and legal system meeting the country’s own needs. The basic principles in each country are similar although details may be very different. In this book, we are primarily concerned with the law as it applies in England. We have
made specific reference to the law as it is elsewhere where it is impor-
tant to do so. You should be aware, however, that differences may well
become more widespread and important as devolution takes its course.
In relation to the provision of healthcare services, England, Scotland,
Wales and Northern Ireland have their own different systems subject
to the overall duty to provide healthcare services.

Why Is Law Important in the Delivery of Health and
Social Care?

The law is used to:

- regulate professional qualifications;
- ensure competent practice;
- protect the rights of patients/clients;
- give someone harmed a right to be compensated;
- support ethical principles of special relevance to healthcare.

It is essential that all health and social care professionals have at least
a basic understanding of the law as practice must always be within the
framework provided by the law. Failure to follow the rules can lead to
liability to pay compensation, dismissal from employment and loss of
the right to practice, which are a few potential consequences of prac-
tice which does not reach an acceptable standard.

Where Do We Find the Law?

Life would be so much easier for everyone if there were a simple set
of rules telling us what ought to be done in any particular situation.
Unfortunately no such set of rules exists and we are left to make our
own decisions in accordance with the law and are accountable if our
decision or our practice is not lawful.

The law most relevant to readers of this book is found in:

- **Common Law** – principles developed by the courts over the centu-
  ries since 1066; for example, the tort of trespass to the person which
gives us a right to compensation if we are touched without having
given consent;
- **Legislation** – also known as Acts of Parliament or statutes – which
  must be obeyed and can generally only be changed by Parliament;
Treaties of the European Union – principles which underpin all EU law, for example, protection from discrimination on the grounds of gender, disability, sexual orientation, race;

The European Convention of Human Rights – among other issues the Convention forbids torture, inhuman or degrading treatment (Art 3) and protects our right to privacy and family life (Art 8).

Where to Find Explanations of How It All Works?

Case law

Law reports contain brief summaries of the facts relevant to the particular case, an explanation of the relevant part of the law and how it works and a decision in the particular case. Reports are available going back to the 11th century. The importance of a case depends on the status of the court in which it was decided. The most important courts in England are the Court of Appeal and the Supreme Court (formerly the Judicial Committee of the House of Lords). Once a case has been decided, any future case on similar facts involving the same point of law must be decided using the principles of law as explained in the earlier case – the doctrine of precedent. In some limited circumstances the Supreme Court (formerly the Judicial Committee of the House of Lords) may reach a different decision, changing the precedent.

Cases decided in other courts, for example the European Court of Justice and the European Court of Human Rights, are also very important and will influence the way in which English cases are decided. European law can in some circumstances overrule national law or lead to a change of law.

Textbooks and journals

Books are an attempt by the author to explain the law in an accessible way. Journals are a useful means of keeping up-to-date with changes.

Statutory Codes of Practice

Acts of Parliament can be very long and detailed and almost incomprehensible to anyone who is not used to reading them. To help understanding and thus to ensure good practice, Parliament authorises the creation of statutory codes, for example, the Mental Capacity Act 2005.
Introduction

Code of Practice. These Codes must be followed in all cases unless good reason can be demonstrated in a particular situation for taking some other course of action.

Professional Codes of Practice, Guidance

While not the law, Codes of Practice/Guidance are carefully drafted by the relevant professional organisation to ensure that in the vast majority of cases, following the rules will not only meet the appropriate professional standard but also ensure that the practice is lawful. As you read through this book you will find many references to the Codes published by the Health Professions Council (HPC 2008) and by the Nursing and Midwifery Council (NMC 2008, reprinted with numbered paragraphs 2010). At the time of writing, May 2011, the Health Professions Council has agreed a new set of generic standards which will be implemented on a rolling basis over the next two years as the Health Professions Council (HPC) reviews the standards of each of the professions. (HPC New generic Standards of Proficiency accessed at www.hpc-uk.org)

An Outline of Some Laws of Special Relevance to Health Professionals

Are Employees Protected by Their Employers?

An old idea was that employers had control over the way in which employees carried out their duties, including the right to specify what should be done and how. This gave rise to the doctrine of vicarious liability whereby an employer is liable for the wrongdoing of employees in the course of their employment. Cases which illustrate the difficulties of deciding whether an act is within the course of employment include the following:

Poland v Parr [1927] 1 KB 236

An employee assaulted a boy to stop the boy from stealing from the employer’s wagon. The boy fell under the wagon and his legs were injured. It was held that the employer was liable although the assault on the boy had not been expressly authorised. The employee was acting reasonably to protect the employer’s property which by implication he was authorised to do.
Rose v Plenty [1976] 1 WLR 141

Milkmen were forbidden to use a child helper on their rounds delivering milk. A milkman continued to use a child helper who was injured due to the milkman’s negligence. The employer was held to be liable because the employee had been carrying out his duties although in an unauthorised manner. His actions had been in the course of his employment and for the employer’s benefit.

A health professional is therefore protected to the extent that the employer will be liable for any wrongful act committed in the course of employment. This can include liability for negligence, trespass on the person and breach of confidentiality. Generally the employer will not be able to reclaim any compensation paid from the employee.

Negligence

The tort of negligence is used to ensure that where poor, incompetent or inappropriate practice causes a person harm or injury, that person is able to obtain compensation. It is difficult to define ‘negligence’. The lay person might say that it means carelessness; a lawyer might talk about duty, breach and damage. Cases over the years have attempted to provide an explanation by using principles which help to decide what duty is owed and to whom and to set a standard of reasonable behaviour. Past cases are useful examples of how the rules work but every case will be decided by applying the relevant principles to its own particular facts.

In order to succeed in a claim for compensation, the victim of alleged negligence must generally prove that:

- the perpetrator owed the victim a legal duty of care;
- the perpetrator was in breach of that duty;
- as a result of that breach, the victim suffered injury or loss.

A legal duty of care is owed to any person whom we ought reasonably to foresee might be affected by our act or omission. In essence this requires us to carry out a ‘risk assessment’ before undertaking any activity. If any risk of harm is identified, we must put reasonable precautions and safeguards into place to minimise the risk. An early case about negligence which illustrates each of these points is:
Donoghue v Stevenson [1932] AC 562

Mrs Donoghue went into a cafe with a friend who bought Mrs D a bottle of ginger beer. Mrs D drank half the bottle but when the rest was poured into her glass, out floated the remains of a decomposing snail. Mrs D was made ill both by the nauseating sight and the impurities which she had consumed. The judges decided that the manufacturer of goods which reach the consumer untouched by anyone else owes a duty of care to that consumer. The manufacturers had clearly failed to take reasonable steps to ensure the purity of their product and, as a consequence of that failure, Mrs D had suffered damage of the type or kind which was reasonably foreseeable. She was awarded damages.

There will only be legal liability for negligence if harm has been caused by our act or omission. Where no damage or harm has occurred, the professional may still face disciplinary action by employers and/or the professional body governing practice.

The effect of these rules in the context of healthcare is that any person undertaking a task is under a duty to carry it out competently. Professionals must refuse to undertake a task where they lack competence. This may not be easy (or popular with colleagues and/or employer) but the courts make no allowance for lack of experience and/or training. The courts will judge competence on the basis of the way in which a competent professional would have carried out the task in the particular circumstances relating to the particular patient. A fairly modern case which illustrates these points is:

Wilsher v Essex AHA [1987] QB 730

Baby W was born 3 months prematurely. He suffered retrolental fibroplasias which caused his sight to be severely impaired. It was argued that the injury was caused by the negligence of a junior doctor who had failed to notice that a catheter used to measure oxygen had been put in a vein rather than an artery meaning that Baby W had been given too much oxygen. While the judges had sympathy for the junior member of staff involved, they emphasised that patients are entitled to expect that treatment is delivered by someone competent to give it. In the Court of Appeal, it was stated:

The law requires the trainee or learner to be judged by the same standard as his more experienced colleagues. If it did not, inexperience would frequently be urged as a defence to an action for professional negligence. (per Glidewell LJ)
An additional problem faced by Baby W was that the causal link between the oxygen problems and the impairment of his sight could not be established – the damage was possibly caused by other problems suffered by Baby W. In the event, the claim was eventually settled out of court.

The duty of a professional is to act with the level of competence that is required by the circumstances. The decision will be based on the principle known as the Bolam principle:

A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. (*Bolam v Friern HMC* [1957] 2 All ER 118, 121)

While this may suggest that all the professional needs to establish is that other professionals would agree with the action, a later case established:

the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis. ...[and] the experts have [considered]...comparative risks and benefits and have reached a defensible conclusion on the matter. (per Lord Browne-Wilkinson in *Bolitho v City and Hackney Health Authority* [1998] AC 232, 242)

In simple terms, this appears to mean that judges, while having little or no medical knowledge, must nonetheless be satisfied that the opinion can be justified on an appropriate basis. Alternatively, the judges will require to be satisfied that the opinion is ‘evidence based’.

### Consent

Both civil law, through the tort of trespass to the person, and criminal law, the crimes of assault through to murder, reinforce a person’s right to exercise choice in relation to personal and bodily integrity and to have that choice respected (the right to autonomy). As you are unlikely to intend to harm your patient and therefore unlikely to be faced with allegations of criminal behaviour, this part of the book concentrates on the civil law.

Trespass to the person can take three forms:

- **Assault** – putting a person in fear that they may be touched;
- **Battery** – touching a person either manually or using some type of instrument;
- **False imprisonment** – preventing a person from exercising freedom of movement.
When any aspect of trespass happens, compensation is payable regardless of the fact that no harm has actually occurred. The fact of consent, either by the person concerned or by virtue of law, is a complete defence to any legal claim alleging trespass.

It may seem that provided the patient agrees, the health professional will be protected but this is not always so. A patient may say that consent would not have been given had they properly understood the implications of the treatment or the attendant risks. Such a person has no claim using trespass but may succeed with a claim in negligence based on failure to give sufficient information. It might appear that in order to protect the health professional, a patient should be informed in full detail of all the facts, especially those relating to potential side-effects and/or risks no matter how small. This may be the case in other jurisdictions but in England the patient needs to be told about all relevant facts so that an informed decision can be made. What this means precisely is the matter of debate. This issue is discussed in detail in Chapter 3. Generally the Bolam principle will apply so that the health professional must ensure that the patient is given the information which a responsible body of professional opinion believes to be necessary in the particular circumstances (Sidaway v Bethlem RHG [1985] 1 All ER 634). In the more recent case of Chester v Afshar Lord Steyn reiterated the surgeon’s duty to warn the patient in general terms of possible serious risks. He went on to explain:

In modern law medical paternalism no longer rules and a patient has a prima facia right to be informed by a surgeon of a small but well established risk of serious injury as a result of surgery. (Chester v Afshar [2004] UKHL 41, para. 16)

You may quite reasonably believe that the legal rules are less than clear – how in fact should the health professional approach the issue of giving information? Help is available in guidance published by the Department of Health (Good Practice in Consent DoH (2nd ed 2009 Introduction at para.1) which states:

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery.

Both the Nursing and Midwifery Council (NMC), Code (2008, paras. 13–17) and the HPC Standards (2008, para. 9) emphasise the duty of the
health professional to ensure that consent is given, the patient having been fully informed and involved in making the decision to consent to or refuse treatment.

The issue of consent is further complicated in the case of two groups of people namely:

- Adults who lack capacity;
- Children.

The rules are discussed in detail in Chapter 4. The following paragraphs provide a summary of the law.

In the case of adults the position is governed by the Mental Capacity Act 2005 (MCA 2005). It must be remembered, and is stated by the Act in s.1(2) that ‘A person must be assumed to have capacity unless it is established that he lacks capacity.’ In other words, the person alleging incapacity must establish the facts on which this assumption can be justified.

Once it is established that a person is unable to make a personal decision, that is the patient cannot understand the information relevant to the decision, cannot retain that information, cannot use or weigh the information in the process of decision making or cannot communicate any decision (MCA 2005 s.3(1)) then the health professional must make the decision in the best interests of the patient (MCA 2005 s.1(5)). In determining a person’s best interests, the health professional must take into account the patient’s wishes and feelings (MCA 2005 s.4(6)) as well as the views of others involved with the patient, where it is practicable and appropriate to consult them’ (MCA 2005 s.4(7)).

The rules governing decision making on behalf of children are found in the Children Act 1989 (CA 1989). In any decision relating to a child under the age of 16 years, the child’s welfare is the ‘paramount consideration’ (CA 1989 s.1(1)). The effect of this requirement is to make the interests of the child the sole consideration. This has been explained by Lord McDermott:

[This amounts] to a process whereby , when all the relevant facts, relationships, claims and wishes of parents, risks, choices and other circumstances are taken into account and weighed, the course to be followed will be that which is most in the interests of the child. (*J v C* [1970] AC 688, pp. 710–711)
Although the case was decided before the *Children Act 1989* was passed, the explanation remains useful to establish what the ‘welfare principle’ actually requires.

### Confidentiality

It may be taken for granted by most people that all personal information about health matters will be treated as confidential by those to whom disclosure is made. It is clearly important that this belief proves well founded if the necessary trust between the patient and the health professional is to be maintained.

Information does sometimes have to be disclosed. The NMC makes it clear that a patient should be informed how and why information may be shared with others providing care (NMC Code (2008, paras. 5–7). The HPC tells health professionals that information must be treated as confidential and used only for the purpose for which it has been provided (HPC Standards 2008, para. 2).

Information may always be disclosed with the consent of the patient and to others who need to know in order to provide appropriate care for the patient. This extends not only to other health professionals but also to relatives who are providing care. Disclosure may also be made to a third party if the public interest or the patient’s welfare requires it, for example, in matters raising child protection issues which must always be brought to the attention of those responsible for protecting the welfare of children, usually the Local Authority.

Additional protection of confidentiality is found in Article 8 of the *European Convention on Human Rights* which protects an individual’s right to respect for privacy and family life. In deciding whether Article 8 has been infringed the circumstances in which the information is given to the patient are important – would the patient assume that confidentiality applies, would disclosure be to the patient’s detriment?

The legal remedies available for breach of confidentiality are limited to:

- an injunction to prevent publication (in reality of limited effectiveness as it requires the person to have forewarning that disclosure will be made);
- damages which are generally available only where there has been financial loss.
In real life, the common law is not much help but statutes can be more effective. The Data Protection Act 1998 gives people the right to access information about themselves, including access to medical records. There is a right to correct any stored information which is wrong. The person may also require the cessation of the processing of the data if continuing to do so would cause substantial distress.

In the context of the delivery of healthcare, greater protection is provided by the professional bodies which may take action for breach of the professional codes. Disclosure is now governed by guidance setting out what, how and why may be disclosed. The NMC published *Raising and escalating concerns – Guidance for nurses and midwives* in 2010. The HPC published *Raising and escalating concerns in the workplace* also in 2010. At the time of writing, the Guidance has only been very recently published. How effective it will be has yet to be seen but a valuable tool seems to have been created.

The problems raised by confidentiality are discussed in more detail in Chapter 6.

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**A Way to Protect Yourself from Allegations of Incompetence, Unprofessional Practice or other Breach of the Codes**

‘Records’;
‘Records’;
‘And yet more records!!’

The need for accurate records relating to the delivery of care cannot be over-emphasised. Record keeping is an important component in the process of caring for the patient as the record will often provide the only contemporaneous account of what happened. The NMC Code requires ‘clear and accurate records’ to be kept (paras. 42–47) while the HPC states ‘You must keep accurate records’ (para. 10). What makes a good record? Whatever form the record or part of it takes, handwritten, e-mail, correspondence or any other form, it should be factual and accurate. The recorded facts are the basis of any judgment made by the health professional. Remember that the legal standard of care is determined by the Bolam principle. Having the facts on which the judgment was based available means that the competence of any treatment or other decision can be assessed more effectively. Was
the decision within the range of decisions which would be made by a competent practitioner in the specific circumstances of the case in question?

The NMC states:

Records should ... be legible ... [and] not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation. Guidance (2009, reprinted with numbered paragraphs 2010) paras. 1–16

While the Guidance is specific to NMC registrants, the principles are appropriate for all record keeping. Observing the principles is an effective way to create good records.

What Professional Issues and Guidelines Are Relevant to You as a Healthcare Practitioner?

Being a professional or being a student of the health professions requires more than rote learning or repetition of a series of activities. Being a professional means that you can ‘profess’ something, that you have some ideas or aspiration to do good and to make things better for individuals, groups and society. This requires a good deal of knowledge of, for example, physiology, pharmacology and psychosocial aspects of care; a wide range of skills, for example, in communication, teamworking, leadership and negotiation; and an understanding of the value base or ethics of your profession. Codes of professional practice or ethics specify what is required of your particular profession. This relates closely to professional ethics described as ‘the agreed standards and behaviours expected of members of a given professional group and as described in that group’s code of professional conduct’ (Fry & Johnstone 2008: 16). The Nursing and Midwifery Council (NMC) and the Health Professions Council (HPC) codes and other relevant documents provide guidance regarding what is expected of a healthcare professional. It is important to be aware of the contents of your professional code and also to consider how your code differs from the codes of other professionals.

It is recommended that, in addition to becoming familiar with the contents of your own professional code, you examine the codes of your colleagues. You can locate their codes by accessing the websites of their professional bodies, for example, the Health Professions
Council, the Nursing and Midwifery Council or the General Medical Council (GMC). This activity will provide you with some insight into the range of professional issues you need to understand. You will also now be aware of concepts and issues common to all of the health professionals’ codes (for example, consent, best interests, confidentiality and accountability) and to the different ways professional obligations are set out.

Introducing Professional Codes of Practice and Guidance

While not the law, codes of practice/guidance are carefully drafted by the relevant professional organisation to ensure that in the vast majority of cases, following the rules will not only meet the appropriate professional standard but also ensure that practice is lawful. The codes/guidance are also useful in spelling out what is reasonably to be expected from the professional.

Professional codes have a number of important functions. These include:

- **External function** – Codes confirm and support professional identity – how do we want to be? They can also reassure the public.

- **Internal function** – Codes are a guide, giving confidence and promoting reflection on the nature of professional practice.

- **Defining (professional) responsibilities in a relational context** – Codes provide guidance on negotiating relationships and boundaries with patients, service users, families and other professionals.

- **Disciplinary use of an ethical code** – Codes also guide disciplinary panels as they make decisions about poor and unethical practice. They specify professional expectations of individual professionals (Verpeet et al. 2005).

- **Political function** – Codes also have a political function as they point to what the profession stands for and the standards of that profession. A code may also be used to argue for more resources should these be inadequate (Chadwick and Tadd 1992).

You may already have begun to consider the overlap among ethical, legal and professional issues. All three areas are necessary for professional practice. Figure 1.1 illustrates this:
Why Study Ethical, Legal and Professional Aspects of Healthcare Practice?

In addition to the requirements of your regulatory bodies (Health Professions Council and Nursing and Midwifery Council), there are a wide range of reasons why and understanding of these areas is helpful and necessary:

- **Research and technological developments** – new drugs and healthcare interventions are constantly being introduced in healthcare and we need to ask ‘just because we can do it, should we?’
- **Resources** – there is potentially infinite demand and finite resources in healthcare and decisions have to be made regarding how to allocate resources fairly. In addition to higher level funding decisions you also have to make and justify decisions regarding how you allocate your time in practice.
- **Changing expectations of patients** – patients now have much higher expectations and are increasingly aware of their healthcare rights and privileges as set out, for example, in the NHS Constitution (2010). Professionals have to be able to understand their responsibilities as they respond to these expectations.
- **Information accessibility** – the internet has opened up many new opportunities for learning about health status and treatment
options. Responding to requests from patients requires an understanding of the evidence base and of the values underpinning professional practice.

- **Reports of unprofessional practice** – there have, unfortunately, been many media and research reports detailing poor practice. It is hoped that learning from this text will equip you to maintain good practice and reduce the likelihood of poor practice.

- **Possibility of litigation** – if you have a good grasp of ethical, legal and professional issues it is unlikely that you will fall foul of the law or other disciplinary proceedings.

- **Changing legislative and policy contexts** – policy and legal developments continue to be implemented and discussed. You need to be prepared to enter the debate and to challenge policies that compromise professional ethics.

- **Professional status and registration of healthcare professionals** – accountability is an important part of being a professional. Knowledge of ethical, legal and professional issues will enable you to give an account of your practice, providing arguments to support one course of action rather than another.

There are, therefore, many good reasons why you should engage with these aspects of professional learning. We hope you will find learning from this text engaging and interesting with direct relevance to your everyday healthcare practice. We encourage you to discuss the scenarios and content with other professionals, students and also with friends outside healthcare, sharing perspectives and gaining new insights.

**Overview of Chapters**

In each of the chapters that follow you will be introduced to two scenarios focusing on particular professions and patient/service user groups in relation to key ethical, legal and professional concepts. The discussion in each chapter makes reference to the implications for different patient groups. The scenarios invite you to engage with real practice situations that have been anonymised and it is recommended that you consider how you would respond and why before you read the authors’ discussion. An important reason to engage with the content of this text relates to your professional accountability, where you give reasons for
your actions and omissions. This is the topic of Chapter 2. Chapters 3 and 4 deal with consent – when patients have capacity and when capacity may be compromised. Later chapters explore issues of truth telling (Chapter 5), confidentiality (Chapter 6) and justice (Chapter 7). Chapters 8 and 9 enable you to engage with the meaning of professional and unprofessional practice. Although the scenarios in each chapter focus on two of five professions (that is, nursing, midwifery, paramedical practice, occupational therapy and operating department practice), the content is relevant to all health professionals.

Conclusion

This chapter has introduced you to ethical, legal and professional aspects of your everyday practice. The overview should help you to begin to see how each of these three aspects of practice inter-relate and how an understanding of this can enhance your practice. We hope you enjoy your journey through the text and that you will engage with other practitioners and students as you think about and develop a critical understanding of these fundamental concepts in relation to your practice.

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