

---

## SELF ASSESSMENT EXERCISES

---

### Self Assessment Exercises – Legal And Ethical Dilemmas In Medicine

JE Smith, LA Wallis

You are working in the Accident and Emergency Department of a Military District Hospital Unit in the United Kingdom. The following scenarios could occur during a normal, if unlucky, working day.

1. You walk out of the resuscitation area having been involved in the assessment and treatment of a driver involved in a motor vehicle collision. The attending police constable asks you to divulge the details of the patient, asks how the patient is doing, and what injuries he has sustained. He then asks if the patient has attended the department before.

a. How should you respond and what information should you provide?

2. A middle grade doctor comes in to start his shift smelling strongly of alcohol and slurring his words. You are the only other doctor on duty in the department.

a. What should you do?

3. You attend to a young male patient who has sustained a head injury during an alleged assault. He is self-ventilating and haemodynamically stable, but is agitated with a reduced Glasgow coma score, and will require intubation prior to CT scan of his head. His mother is in the relatives' room waiting for a progress update. The nurse helping you suggests you could get consent from his mother before performing rapid sequence induction and intubation.

a. Can you act without the patient's consent?  
b. Can his mother give consent? What are the issues?

4. A 30 year old woman attends the department stating that she has taken a potentially lethal dose of paracetamol. She refuses treatment and threatens to leave.

a. What should you do?

5. A 14 year old girl attends the department asking for the morning after pill. She says that she had unprotected intercourse with her boyfriend the night before.

a. Can you prescribe this without the permission of her parent or guardian?

6. A 42 year old cleaner attends the department having sustained a back injury during a fall at work. She says she slipped on a wet patch and fell backwards, and now has pain all over her low back. You examine her and find no abnormality other than some low lumbar tenderness, with no neurological deficit. X-rays reveal no abnormality. You discharge her with advice regarding analgesia and mobilisation, and having thanked you she requests a copy of the notes you have made so she can sue her employer.

a. What should you do?

### Answers to self assessment questions

In considering all of these scenarios, remember that the first thing to do if you are unsure is get advice from a senior colleague. The duty consultant bears ultimate responsibility for issues on the shop floor and will want to be informed at the earliest opportunity about legal or ethical problems within the department. Another good point of contact if you are in doubt is your defence union, who have staff available around the clock to give advice regarding these common problems.

In such dilemmas there are often several potential courses of action, all of which may be acceptable. There are specific guidelines issued by national bodies regarding many of the situations you will encounter, some of which are included in the reference list at the end of this paper. Individual trusts often issue guidelines regarding other situations. In general, be certain you have the best interests of the patient at heart when deciding your course of action.

### Question 1 Confidentiality

a. You should give the name and address of the driver. Clinical information should not be given without the permission of the patient.

We are faced by confidentiality issues every day. The majority of these are quite straightforward if you follow the premise that

Surg Lt Cdr JE Smith  
MBBS MSc MRCP  
FFAEM RN  
Specialist Registrar in  
Emergency Medicine  
Defence Medical  
Services  
Emergency  
Department,  
Derriford MDHU,  
Plymouth, PL6 8DH.  
Email:  
jason.smith@doctors.org.uk

Dr L A Wallis  
FRCSEd (A&E)  
FFAEM  
Consultant in  
Emergency Medicine  
University of Cape  
Town, South Africa.  
Email:  
leewallis@bovinevalleyretreat.co.za

all information regarding a patient, including the fact that they have attended hospital at all, is confidential and this should be respected at all times. Every patient has a basic right to confidentiality, not only morally and ethically, but some would argue legally as well (1,2). However, under some circumstances it is necessary to divulge information about a patient, and there are specific guidelines governing these (3,4).

The most obvious situation where you are able to release information is where the patient consents to information being given. If you are asked to produce a statement for the police about a hospital attendance, the patient should provide a signed consent form allowing you to release information. Other situations where you are obliged by law to release information to the police are:

- In a motor vehicle incident, the name and address of the driver should be given (Road Traffic Act 1988).
- If you have information about a planned or actual terrorist act (Prevention of Terrorism Act 1989).
- Under order of a court.

Consideration should be given to releasing information to the police under other circumstances if it may help to solve or prevent a serious crime, or if it may be justified in the public interest (Police and Criminal Evidence Act 1984). New guidelines have recently been distributed regarding patients attending emergency departments with gunshot wounds, stating that the police should be informed whenever an incident has occurred (5). In general, you should seek a patient's consent to disclosure of information wherever possible, anonymise data where unidentifiable data will serve the purpose, and keep disclosures to the minimum necessary (4).

### Question 2 *Disciplinary procedures*

a. Contact the duty consultant. The doctor needs to be removed from clinical duties.

The NHS Disciplinary Procedure is interpreted locally from trust to trust, but in general trusts follow the national guidelines described in the NHS Handbook (6). This book includes sections on procedures for dealing with personal and professional misconduct. The sequence of events in the disciplinary process starts with informal counselling, progressing to verbal and written warnings, through to dismissal if things do not improve. Depending on the gravity of the offence, the process can be entered at the appropriate stage, and for gross misconduct issues (see Box 1) dismissal is the usual result.

Turning up to work smelling of alcohol is unacceptable for any reason. As patient safety and respect is paramount, the doctor in question should first be removed from clinical duties. Practically speaking, in this

case the issue should be directed upwards to the duty consultant, who needs to assess the situation and make a balanced judgement bearing in mind both patient safety and support for a member of staff. The member of staff in question may have had a precipitating event to cause an uncharacteristic lapse in performance, and this will have to be

*Box 1: Examples of gross personal misconduct.*

- Theft
- Fraud
- Deliberate falsification of records
- Assault
- Incapacity due to alcohol or drugs
- Gross insubordination
- Gross negligence causing unacceptable damage, loss or injury

judged on an individual basis.

### Question 3 *Consent*

a. Yes, in an emergency you can proceed under the common law doctrine of necessity.

b. Nobody can consent on behalf of a competent adult. You must act in the best interests of the patient.

The issue in this question is consent, and who is able to give consent to treatment in this case. The patient is an adult, and therefore is usually assumed to have capacity to either consent to, or refuse, intervention. However, this patient is unconscious. Nobody can consent on his behalf, and so the issue must be resolved by the medical team involved in his care who are obliged to act in his best interests (7,8). Relatives often think they can consent on behalf of a patient but this is not the case, although it is obviously good practice to involve them in your management decisions. In emergency situations, you must do what is appropriate to prevent worsening of the patient's condition until consent can be gained. This could range from taking blood for cross matching to performing a resuscitation room thoracotomy.

### Question 4 *Capacity*

a. The first step is to assess her capacity to accept or refuse treatment.

This is another question about consent, and in particular capacity to accept or refuse treatment. The patient should undergo an assessment of capacity (9) by the most senior

*Box 2: Assessment of capacity.*

- Ability to comprehend, retain and believe what is said.
- Ability to understand the consequences of refusal of treatment.
- Ability to make a balanced judgement based on the above information.

doctor available involving the elements outlined in Box 2.

If the patient is assessed as having capacity, then her refusal must be respected, and any treatment would constitute an assault. This is quite a common problem in Emergency Departments and the input of a senior member of staff will often help to clarify the best course of action. By talking to the patient and explaining the options it is often possible to obtain consent for assessment and treatment. The fact that she has presented to the department at all would suggest that help might be accepted. If the patient is assessed as not having capacity to refuse treatment, treatment may be given under the common law justification of necessity. The assessment and subsequent decisions must be clearly documented, and you must be prepared to defend the course of action you take. Often it is good practice to obtain a psychiatric opinion to further assess the patient's mental state.

There is no clear advice that would apply to all cases. The management of patients who deliberately self harm and then refuse treatment is complex. For a useful summary see Hassan's paper and Hewson's subsequent review in the *BMJ* (10,11).

### Question 5 *Gillick competence*

a. You need to assess her level of understanding and decide whether she is Gillick competent.

The question of whether a minor (under 16 years old) has the independent right to make a decision to accept treatment is based on the case of *Gillick versus Norfolk Health Authority* (12). A mother challenged her health authority over their decision to allow a General Practitioner to prescribe the oral contraceptive pill to her daughter without her knowledge. The court ruled that if a minor is sufficiently mature and has enough understanding to make an informed decision, and the doctor decides that the child may potentially be harmed by not giving treatment, then they can be treated without informing those with parental responsibility. The concept of Gillick competence as in this case concerns the capacity to accept treatment. Refusal of treatment by a minor is not covered by this case.

Therefore, the decision must be made as to whether the child is Gillick competent. This is a difficult issue and will obviously have

serious consequences whichever way the decision is made. Involve the duty consultant at the earliest opportunity.

### Question 6 *Access to records*

a. Advise her to apply in writing to the department for a copy of the records.

In NHS hospitals, the clinical records of a patient are the property of the trust or health authority. Therefore, the patient does not have a right to the originals. However, as a result of the Access to Health Records Act (1990) and Data Protection Act (1998), patients have a statutory right to obtain a copy of their health records if the request is made in writing. A copy must be provided within 21 days of the request (or 40 days if the records were made more than 40 days previously). This applies to health records made after 1 November 1991. You may deny access to the health records if you feel that they may result in harm to the physical or mental health of that person, or if the records breach the confidentiality of a third party. Further details can be obtained from the guidance provided by the Medical Defence Union (13).

### References

1. Data Protection Act 1998. London: HMSO, 1998.
2. Human Rights Act 1998. London: HMSO, 1998.
3. Medical Defence Union. Confidentiality. London: Medical Defence Union, 2001.
4. General Medical Council. Confidentiality. London: General Medical Council, 1999.
5. General Medical Council. Reporting Gun Shot Wounds. Guidance for Doctors in Accident and Emergency Departments. London: General Medical Council, 2003.
6. Merry P. Wellards NHS Handbook 2003/4. Wadhurst, East Sussex: JMH Publishing; 2003.
7. General Medical Council. Good Medical Practice. London: General Medical Council, 1999.
8. General Medical Council. Duties of a Doctor. London: General Medical Council, 1999.
9. Assessment of mental capacity. Guidance for doctors and lawyers. A report of the BMA and Law Society. London: British Medical Association, 1995.
10. Hassan TB, McNamara AF, Davy A, Bing A, Bodiwala GG. Managing patients with deliberate self harm who refuse treatment in the accident and emergency department. *BMJ* 1999; **319**: 107-9.
11. Hewson B. The law in managing patients who deliberately harm themselves and refuse treatment. *BMJ* 1999; **319**: 905-7.
12. *Gillick v. West Norfolk and Wisbech AHA* [1986] AC 112, [1985] 3 All ER 402.
13. Medical Defence Union. Can I see the records? Clinical notes – disclosure and patient access. London: Medical Defence Union, 2000.