Ethical theories

Ethical principle	Quote	General pros	General cons
Deontology - holds that certain things are right or wrong regardless of consequences	"Always recognize that human individuals are ends, and do not use them as means to your ends" Immanuel Kant	Emphasises duties people owe to each other.	What are the principles and where do they come from? If principles are not absolute, in what situations can they be breached? Ignores the importance medical practice places on consequences of different treatments.
Consequentialism - judges whether an action is right or wrong based on consequences it produces. **Utilitarianism -** most good act is one that results in most human happiness	"Actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness."- John Stuart Mill	Evidence-based medicine Relatively easy to apply in all situations and practical.	What is good? Unpredictable - we don't often know the consequences of our actions. What about motivations? May overlook justice and rights - Can produce a result that many feel is instinctively wrong e.g. doctor has 4 patients in need of organ transplants, kill a nurse? Places too little weight on autonomy and permits doctor to carry out procedure if overall consequences are beneficial.
Principlism - Beauchamp and Childress, 4 principles: 1. Autonomy 2. Non-maleficence 3. Beneficence 4. Justice	"Above all, do no harm" - *"The right to determine what shall be done to ones body is a fundamental right in our society".* JS Mill *Should take into account both the instrumental and intrinsic value of autonomy. Being able to make our own decision is a fundamental aspect of being human and allowing us to flourish.* *'The only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good either physical or moral is not sufficient warrant'. JS Mill*	Accessible, usable approach Culturally neutral Flexible	Can be argued it's too simple and anything can be justified. Contradiction between principles e.g. autonomy and beneficence. Fails to capture other moral principles e.g. respect, purity etc.
Virtue ethics - in assessing what is morally correct, the virtues motivating your actions matter, not the consequences. Good habits will direct human nature towards good actions.	"...the habits which result from doing just and temperate acts count for all. By doing just acts the just man is produced…" Aristotle	Doctors are required to act in a compassionate, honest and fair manner.	How do we decide what 'good' virtues are? Difficult to assess what motivates a person. Focus on virtues could uphold unacceptable activities as moral. Difficult to apply to medical law e.g. imagine a law requiring someone to act compassionately.

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Ethics

Consent to surgery/blood products

Discuss the ethical arguments for and against operating on a child without consent, in an emergency.

For operating	*Against operating*
Doctrine of necessity- cannot wait until they can consent	**Autonomy-** pt's body, should have control. Consent not taken from child nor parents. Child liberationalist approach
Beneficence	**Jehovah's witness-** could be going against beliefs if blood given, so may not be in BIs (suicide of that young JW)
Consequentialism- increases survival	**Consequentialism-** intervening without parental consent may result in distrust, affecting care as parents may not trust doctor's advice
Paternalism- child's values are unstable so adults should make decisions for what is best for child	
You operate as that is clearly in the BIs of the child, the parents do not seem to be around as the situation is urgent and has arisen quickly, and you can assume the child is unconscious and unable to consent. There is nothing to suggest the child would not want to be operated on, and even son, as he is 14 you act in his BIs regardless.	

Briefly discuss three ethical arguments that should be considered when deciding what is in a child's best interests. Do you think parents should decide what is in a child's best interests?

WhatsApp

Discuss ethical arguments for/against doctors being based offsite when on call

For being offsite	*Against being offsite*
Utilitarianism- Allowing doctors to lead normal lives outside of work improves wellbeing and prevents burnout, especially if on-call hours exist on top of an already busy schedule. Could be argued that since the doctor is less stressed for the majority of their working week, more patients will have better outcomes	**Altruism** – Best outcomes for everyone occur when the doctor is present as and when the patient needs care. With this argument, the wellbeing of the doctor is irrelevant.
Doctor needs to self-care	**Consequentialism-** Long waiting times, especially in emergencies, are dangerous.
	Justice – Is it fair that patients being seen during the day, when more specialists are on shift, are subject to better care than those seen in emergencies at night? Equal provision of care.
It is ethical to be offsite as long as you can get to the hospital fairly quickly.	

Discuss the ethical arguments for and against using WhatsApp to share patient information.

For WhatsApp	*Against WhatsApp*
Beneficence- Much faster and in an emergency case it is in the best interest of the pt as they will be able to receive better care as soon as the SpR arrives, as she will have all the information prior to arriving	Increases the chance of making mistakes as the SpR is going off on the images alone and may not assess the patient as she would normally as her judgement is clouded by the images
Sending images is more informative than attempt to describe the stab wounds over the phone to a colleague. Important details may be missed out. The images can also act as a record and can be referred back to later on for investigation if need be.	**Confidentiality-** "A photograph sent through the app will immediately be downloaded into the recipient's smartphone photo library unless that setting is manually switched off. All the data is stored in a US server that does not comply with UK GDPR" pt information is not safe or secure and can be leaked. Can be especially dangerous when gangs involved
Moral Absolutism/ Virtue Ethics: Kant's moral absolutism- action is morally right dependent on the goodwill of the person doing it. In this case the FY2 and SpR have a good intention, so the action of sharing photos is morally acceptable.	**Being too vague in interests of confidentiality-** could lead to confusion of which patient is being treated. This leads to more errors- As Gould says, a deliberately vague phrase such as "the person from this morning with the infection," creates the possibility for confusion and a potential risk to patient safety.
	Was there an actual need to see the images beforehand? Could've waited and seen them herself. But the extra time would have given her time to plan the management before arriving at the hectic scene.
Not use whatsapp, the idea of quick information transfer is beneficial to patients but as it is not safe or confidential, it is not worth the potential risks associated with it. Better to have an app which is separate from doctors social lives and more integrated with patient notes so more accurate information can be given.	

A good messaging service- msgs remain on the server for **only a short time** i.e. 30 days. **Integrate msgs** with electronic patient records. Forward, for example, includes patient profiles with diagnoses and treatments, and a list of tasks for each patient that can be **prioritised** and sent to the appropriate team member to be carried out. Streams app for **the diagnosis of acute kidney injury**, bringing together information from various sources (such as blood results, radiology reports, and microbiology results) onto a single platform and allowing clinicians to share comments. Clinical alerted if pt in danger of developing AKI.
Arranging shift cover to sharing patient observations." Careflow Connect, he says, organises alerts in such a way that users can immediately **see the most relevant and important alerts**.
No clear frontrunner has emerged, but the successful apps will be those that combine the simplicity and ease of the consumer leader with the security and interoperability that a clinical setting demands.

Medical errors

Is it necessary to report medical errors to the patient/family?

Yes it is necessary	*No it is not necessary*
Duty- Healthcare professionals have a moral duty to be open and honest with patients when mistakes are made. GMC "you must be open and honest and trustworthy in all your communication with pt and colleagues**"**	**Avoiding repercussions, consequentialism-** "avoids embarrassment, shame, fear of punishment, damage to reputation…". Worrying about the stigma associated with making mistakes will mean HCPs are less likely to try new techniques or procedures.
Virtue- Honesty and integrity is one of the essential virtues of a doctor upon which the pt-dr rapport is built. Being honest with pt increases compliance and encourages them to be open with you.	**Non-maleficence-** pt may become depressed (esp if a debilitating mistake made), pt may no longer trust HCPs
The statutory duty of candour- will require all health and adult social care providers registered with CQC to be open with people when things go wrong. This will be a legal requirement	**Conc- should** tell patients as it is part of a doctor's professional and moral duty to the patient and is legally required. The patient has a right to know about what has been done to their body (or parents if patient is a minor).
Pt cannot make **autonomous choices** unless they are made aware of everything done to them.	
Best interests- enhances trust as they can be reassured that suitable action is being taken. If they were to find out from elsewhere they will start doubting the competence of the medical staff.	

Utilitarianism- by ensuring staff are held responsible for their actions, they are less likely to make these mistakes again and it results in the greater good for the most people.	

Safety of overworking

Should the SpR have stayed operating for as long as she did?

Yes she should have	*No she should not have*
Doctors must always 'recognise and work within the limits of your competence', according to the GMC Good Medical Practice. This implies that doctors **will be aware of their own limitations** when it comes to their practice- they can recognise when they are being overworked and will not put patients at risk if they feel like this.	**Virtue ethics-** doctor's behaviour of working overtime where it is not needed because they 'relish the challenge' can be seen as selfish and has the wrong motivation. Conversely evidence shows that some doctors just do not want to 'let patients down'. This suggests the motivation is sound so the action is morally acceptable.
Beneficence: The more time doctors spend in their profession, the more benefits this will have for patient care as they will be looking after their patients. They can perform more surgeries, see more patients in clinic and in general practice. Overall, this will be beneficial for society.	**Beneficence and non-maleficence-** putting pts at risk, *but* do have continuity of care
Utilitarianism - The GMC orders all doctors to keep their knowledge and skills up to date. Therefore, it can be argued that the SPR challenging herself to better her own clinical skills is acceptable. More people will benefit with her improving her clinical skills, working under pressure etc.	**Non Maleficence-** 'Make the care of your patient your first concern'. (GMC Good Medical Practice). Overworking can lead to a poor standard of practice and care. Furthermore, it is stated in the GMC Good Medical Practice that doctors should protect patients and colleagues from any risks posed by their health. Doctors may be motivated by money and authority to work longer hours, and this may lead to adverse effects on their patient manner and behaviour. They are no longer putting their patients first, which could lead to poor patient health outcomes.
Although it is encouraged to improve your clinical skills so that you are better equipped to dealing with challenges in the future, it should not be done on the expense of patient safety. Ideally there would need to be a balance between challenging yourself but recognising self-competence and prioritising patient welfare.	

Discuss the ethical arguments for and against inexperienced doctors having responsibility for vulnerable patients?

For using inexperienced doctors	*Against using inexperienced doctors*
Utilitarianism. Medical training has traditionally been similar to an apprenticeship – see one, do one, teach one. Commonly believed this leads to more effective teaching, both with regards to time and the quality of a doctor's knowledge/skills, especially in surgical environments (Ktosis and Chung 2013). Good training leads to more patients being treated well in the future.	**Non-maleficence-** evidence suggests that inexperienced doctors are more likely to cause medical errors, leading to poorer patient outcomes
Beneficence- Nationwide deficit of doctors means the workforce needs inexperienced doctors to provide care. Care provided by inexperienced, but qualified doctor arguably better than the care provided by experienced doctors burdened with an overload of patients? Higher doctor:patient ratio leads to better patient outcomes (Hewitt et al. 2005).	**Deontological-** GMC Guidelines Domain 1 Point 8 – 'You must keep your professional knowledge and skills up to date'. Having to have textbooks to hand could indicate knowledge is not appropriate?
We do not have the luxury to *not* use inexperienced doctors. Doctors need to learn, patients need to be looked after.	

Children and consent/capacity

Discuss the ethical arguments for and against overriding the child's refusal to back to surgery for nerve re-exploration?

For overriding refusal	*Against overriding refusal*
Beneficence and duty - doctors have a duty of care towards patients. Drs should take actions that serve the best interests of patients and their families. Nerve damage could threaten patient's long-term hand functionality and thus quality of life.	**Autonomy:** Going against a patient's expressed desires would undermine the patient's autonomy and could lead to distrust in the medical profession. Using consequentialist approach to dissect this ethical question, it could be argued that a loss of trust in the medical profession could lead to greater long term harm for the child (in future scenarios he may avoid seeking healthcare support). As healthcare professionals, maintaining patient's trust is one of the four domains described in the Good Medical Practice guidance, hence is not something that should be readily dismissed. Should take into account both the instrumental and intrinsic value of autonomy. Being able to make our own decision is a fundamental aspect of being human and allowing us to flourish.
Consequentialism: providing treatment may prevent further complications. **Resource Allocation:** future treatment may cost more than early intervention. Carrying out the nerve re-exploration surgery could help prevent long term damage to hand function and disability, hence reducing the need for future hospital visits - this would not only directly benefit the patient, but in the long term it would reduce the need for future medical admissions - resource allocation, justice and utilitarianism are all important factors which can come in to play.	**The harm principle** holds that the actions of individuals should only be limited to prevent harm to other individuals. John Stuart Mill articulated this principle, where he argued that *"The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others."* In this particular case, the child's refusal of re-exploration surgery does not put any other individual in harm's way.
Paternalism- doctor and parent knows best	**Parental responsibility -** We are unaware of the father's status regarding parental responsibility. Legally, the child's father can consent to the re-exploration surgery if the parents are married, or if the father is named on the child's birth certificate, but if neither apply, the father cannot consent.

John Eeekelaar- Basic, developmental and autonomy interests are the interests necessary to ensure current well being and development into an autonomous adult. Respecting autonomous choices will usually be crucial to this development. But if the choice will result in death or serious harm then **the basic and developmental interests take precedence** because they are necessary to reaching adulthood.	**Child Liberationist Approach:** Autonomous children have the same rights as autonomous adults. Adults make bad decisions all the time. The values, aspirations, priorities and beliefs of adults change over time. Even as adults we often don't appreciate the implications of our decisions for our future lives.
Law: Gillick competence allows minors to accept treatment but cannot reject treatment that it is in their best interests. If the child is <16 and Gillick competent and refuses treatment then it is based on parental permission. And father agrees to treatment.	
Given his father was keen on continuing with the surgery, this parental permission should be used in deciding to operate in accordance to the law. Ethically, overriding a competent refusal of treatment may be viewed as an act of *hard paternalism* (overriding an autonomous decision because of the harmful outcomes likely to arise as a result of that decision) and should not be undertaken lightly due to the points listed above, namely the harm principle and undermining of trust. If it was deemed that nerve re-exploration surgery was in the child's best interest, before pursuing it further, the patient's 'own ideas and concerns' s should be addressed.	

Discuss the ethical arguments for and against overriding patient's refusal to a blood-borne virus screen?

For overriding refusal	*Against overriding refusal*
Repeating view of parents- *Herring J. Medical law and ethics. Seventh edition.* *Chapter- 4 – The court would hesitate to deem a child as Gillick competent if they only seemed to be repeating the view of their parents. In our case the child states that his father told him that he must refuse the test rather than giving any reasons of his own.*	**Autonomy:** The patient is usually best placed to know what is in their best interests and autonomy promotes best interests therefore the patient should be the one to decide whether they want their blood taken or not
The problem with children's choices are that children may lack cognitive ability and that their values/aspirations may change: the child may not even understand the impact of his decision and the benefits of consenting for the blood test and it may not be the same decision he might make in 10 years time.	**Child Liberationist Approach:** Autonomous children have the same rights as autonomous adults. Adults make bad decisions all the time. The values, aspirations, priorities and beliefs of adults change over time. Even as adults we often don't appreciate the implications of our decisions for our future lives.
John Eekelaar- If autonomous choice results in serious harm, then basic and developmental interests take precedence (over autonomy interests) because necessary to reach adulthood. Duty of parents to enable children into autonomous adults. But need to override choices if in overall best interests and to reach adulthood.	*Children should have the opportunity to participate in decisions made about their future - Children Act 1989*
Beneficence- it is in the child's best interests to know viral status	**Consequentialism-** going against father's wishes, may impact his trust in HCPs and therefore may place barriers in between his child and accessing healthcare
Justice – doctors undergo intense and stressful situations on the daily to provide the best possible care for patients under their care so in return it should be reasonable for them to be able to make sure their health is not at risk, especially when the screening process is free of physical risks to the patient. *'the psychological impact of not knowing the source's viral status. healthcare workers who are already distressed (and often embarrassed) at having stabbed themselves may feel alienated and unsupported'* RESOURCE 5	**Virtue based ethics -** a virtuous doctor would act with integrity and respect whether he agrees with the decisions of the patient or not. To carry out the blood test without the patient's consent would be disrespecting their decision. **Legal view -** *Testing without consent breaches autonomy and undermines public and political confidence in healthcare profession therefore GMC withdrew the guidance that previously allowed testing without consent in exceptional circumstances. - Hartle AJ. Editorial: Need(le)less confusion. Anaesthesia. 2010;65(9): 875-7*
Utilitarianism/consequentialism - Having the blood test done could lead to positive consequences as the FY2 will feel at peace because there would be no uncertainty anymore and there is no physical harm to the patient from the procedure. Furthermore, if the FY2 was to find out he acquired a bloodborne disease he can seek medical help which would ensure the FY2 is fit and well to treat other patients in the future. With this argument doing the blood test could be seen as ethically right as there are a number of positive consequences. '*It's in society's best interests that healthcare staff receive the best possible care in cases of occupational injury.*' RESOURCE 5	
Faults in the clarity of the Human Tissue Act- *'the Human Tissue Act may not be engaged at all in needlestick injury as it serum, rather than cells, that is tested for blood borne viruses!'* RESOURCE 5 Additionally, the Act notably prohibited private individuals from covertly collecting biological samples, such as hair and fingernails, for DNA analysis, but excluded medical and criminal investigations from the offence.	
Overall, it is important to consider that the FY2 with this occupational injury is now a patient too, with the same rights of autonomy. Thus, since the Human Tissue Act 'may not be engaged at all in needlestick injury as it serum that is tested for blood borne viruses', the FY2 should be able to obtain blood without consent provided that only serum is used and none of the patient's DNA-containing material. Also to do the BBV screen is in the patient's best interests, could ask courts to confirm too and go-ahead with procedure.	

Problems with Children's Choices

- The ability to understand information increases with age.
- The ability to appreciate the impact of current decisions on the future increases with age.
- The ability to decide independently of parental and social influence increases with age.
- Values, aspirations, priorities and beliefs change as child grows.

- A child's views of his or her best interests changes with time.

Due to these factors, a child's values are unstable and therefore it is difficult for a child or teenager to make truly autonomous decisions

The Child Liberationist Approach

- Autonomous children have the same rights as autonomous adults.
- Adults make bad decisions all the time.
- The values, aspirations, priorities and beliefs of adults change over time.
- Even as adults we often don't appreciate the implications of our decisions for our future lives.

Parental Autonomy

The Best Interests Argument

- Parents usually know their children better than anyone else.
- Generally no one will love a child in the same way as a parent.
- The welfare of the family will usually be highly relevant to the welfare of the child.
- Therefore, parents are generally best placed to decide what is in their child's best interests.

BUT

- Parents may be so emotionally involved that they can not objectively weigh up the benefits and burdens of treatment.
- The personal views or beliefs of parents may lead them to consider effective treatments as unacceptable.
- There may be a clear conflict between what is best for the child and what is best for the other children in the family.

The Parental Rights Argument

- Individuals have a right to their own personal values and beliefs.
- Therefore, we should respect the personal views and values of others.
- It is desirable for parents to share their values and belief system with their children.
- Therefore, we should not interfere with the decisions of parents provided they are motivated by the welfare of their child/children.

BUT

- Individuals do not have a right to impose their own personal values and beliefs on others.
- Parents have a duty to enable their children to reach autonomous adulthood.
- Therefore, parents should not be able to martyr their children to their values and belief system.

Professional Guidance

Research on children should only be carried out when:

- it carries minimal risk of harm.
- it is not possible to carry out the research in adults.
- the condition being studied is specific to young children.
- parental consent is obtained.

Confidentiality

Discuss the ethical arguments for and against breaking confidentiality when the patient has given you information on the crime, that they have requested stay secret.

For breaking confidentiality	*Against breaking confidentiality*
Consequentialism- police potentially wasting resources by having armed police where there is no real threat	**Deontological/confidentiality-** you have a duty to maintain the pt's confidentiality, and he has expressed he does not want this info shared
Best interests- social worker should know the situation in order to best help him, and the police need all the info so they can carry out a risk assessment *GMC Confidentiality: reporting gunshot and knife wounds* ***The police are responsible for assessing the risk posed by a member of the public*** *who is armed with, and has used, a gun or knife in a violent attack. They need to consider: „ the risk of a further attack on the patient „ the risk to staff, patients and visitors in the emergency department or hospital „ the risk of another attack near to, or at, the site of the original incident*	**Best interests/autonomy-** it is up to pt to decide his best interests, and he believes informing police of this "would make things worse"
Utilitarianism- threat of the perpetrator, police need to investigate crime so no one else hurt.	**Consequentialism-** might ruin the pt's trust in healthcare professionals. ***RESOURCE-*** *GMC. Confidentiality:– Disclosing personal information without consent. Trust is an essential part of the doctor-patient relationship and confidentiality is central to this.* ***Patients may avoid seeking medical help, or may under-report symptoms, i****f they think that their personal information will be disclosed by doctors without consent, or without the chance to have some control over the timing or amount of information shared.*
Child is a minor- therefore may not be able to process the dangers of keeping this a secret, as he has yet to fully mature and cognitively develop.	***RESOURCE-*** *GMC. Confidentiality: Make the care of the patient your first concern* If the patient's treatment and condition allow them to speak to the police, you or another member of the healthcare team should ask the patient whether they are willing to do so. **If they are not, you, the rest of the healthcare team, and the police must abide by the patient's decision**
Paternalism- doctors know what is in best interests, including whether or not to disclose information	
Inform senior of new information, who would inform police. Would speak to pt and try to address concerns, but tell pt that police have to be informed of this. Ideally get pt's consent for this, but if not possible, police should be informed of the fact that the pt knows the perpetrator, as this person could be a risk to the general public. *GMC: Confidentiality:– Disclosing personal information without consent* *If there is any doubt about whether disclosure without consent is justified, the decision should be made by, or with the agreement of, the* ***consultant in charge or the healthcare organisation's Caldicott or data guardian.***	

Discuss the ethical arguments for and against the father disclosing his medical history, when his son and the FY2 may be at risk.

For disclosure	*Against disclosure*
Consequentialism- the moral worth of an action depends on the resulting outcome: the child's health, thus no consent would be needed to access father's medical history.	**Autonomy-** father has a right to have his medical history kept confidential, even from his son. And there is no immediate benefit of disclosure to the child.
Paternalism- This involves overriding the father's autonomy based on what the doctor believes is in the child patient's best interests.	**Maintain the doctor-patient relationship**- so the father trusts the doctors will do the best for his son and act in integrity. The GMC states that "*Trust is an essential part of the D-P relationship & confidentiality is central to this".*
Beneficence- May be an opportunity for the family to find out and support the father too in whatever condition he has as well as the child.	**Moral absolutism/deontology-** Doctors have a moral and professional duty not to breach confidentiality without permission from patient as there is an implied promise between Dr+Pt GMC- '*When a medical professional gains info from a patient. there is an implied promise it will be kept confidential, and duty to keep this promise.'*
Father's autonomy and right to confidentiality as well as maintaining trust in a doctor-patient relationship outweighs counter-arguments. There is no real immediate benefit to the child for the father disclosing his medical history.	

Patients may have many reasons for not disclosing their assault to the police. They may be too frightened of reprisals, they may not want their own behaviour scrutinised and they may make a judgement call that the police won't take action. … My take on this is that this means that others could be seriously harmed or killed by the perpetrator…. It is reasonable to tell the police whether a weapon was used, the location of the assault and the time of the assault. Boyle A. Revised gunshot and knife wounds guidance: my view from A&E.

When deciding whether the public interest in disclosing information outweighs the patient's and the public interest in keeping the information confidential, you must consider: **a** the potential harm or distress to the patient arising from the disclosure – for example, in terms of their future engagement with treatment and their overall health **b** the potential harm to trust in doctors generally – for example, if it is widely perceived that doctors will readily disclose information about patients without consent **c** the potential harm to others (whether to a specific person or people, or to the public more broadly) if the information is not disclosed **d** the potential benefits to an individual or to society arising from the release of the information **e** the nature of the information to be disclosed, and any views expressed by the patient **f** whether the harms can be avoided or benefits gained without breaching the patient's privacy or, if not, what is the minimum intrusion. GMC. Confidentiality: reporting gunshot and knife wounds

Discharge

Discuss the arguments for and against allowing patients to self-discharge.

For allowing discharge	*Against allowing discharge*
Beneficence – being away from a hospital environment and going home could benefit the child's mental health and overall be of greater benefit than staying in hospital. They could evaluate the pros and cons of the **re-exploration surgery in an unpressured environment.**	**Non maleficence/consequentialism-** allowing self-discharge means the child could potentially have gained a blood borne disease or have nerve damage. Premature discharge of a patient could increase chance of relapse of health and readmission. The patient may then drain more resources in the future bc they refused to comply with advice to stay in-patient.
Autonomy/Child Liberationist- the patient has a right to make their own decisions which should be respected if they are competent	**Paternalism-** The doctor knows better. The doctor knows when a pt needs further in-patient treatment.
Consequentialism – keeping the child in hospital despite his wishes to leave – this could negatively affect his perception of healthcare and prevent him from seeking help in the future	**Safeguarding concerns-** maybe the father is pressuring the child to leave the hospital to avoid the blood test. The child may need to be taken into care given the violence against him and potential of gang-involvement, plus suspicious secrecy from father
Deontology- is it right to keep the child in hospital against his will if he is competent. A duty to allow patients freedom to leave, a duty to not restrict pt's freedom	**Not informed-** the father wanted his son to have "all the information before reaching a final decision for a prospective surgery". No indication in the text that this took place. So should not be allowed to leave
Resource allocation/utilitarianism- can free up beds for other pts in need (must be balanced with long-term implications and potentially increased future resource use though)	
If a patient desires to self-discharge, you must ensure that they **are informed of the potential consequences** and have the **capacity** to make this decision - and these discussions with the patient must be documented. *From MDU: Should any harm come to a patient who misses an appointment, and a claim is made, the doctor would need to demonstrate that:* • *Their actions had not fallen short of those of a reasonable clinician* • *Their approach was supported by a responsible, authoritative body of medical opinion practising in the same specialty.* • *The practice should be able to demonstrate that all reasonable and timely steps were taken to investigate the circumstances and need for care.* • *Previous knowledge of a patient's circumstances, including the severity of their condition necessitating referral or follow-up, will need to be taken into account.* Given the severity of the patient condition, it would have been best had the **patient been kept in hospital**. Discussions should have taken place with the social worker, and safeguarding concerns should have been raised. Potentially also consider taking the pt into care.	

Discuss the arguments for and against the patient being Gillick competent (4 marks)

For being Gillick-competent	*Against being Gillick-competent*
Child understands the nature, purpose and potential consequences of any proposed medical treatment	**Repeating view of parents-** *Herring J. Medical law and ethics. Seventh edition.* *Chapter- 4 – The court would hesitate to deem a child as Gillick competent if they only seemed to be repeating the view of their parents. In our case the child states that his father told him that he must refuse the test rather than giving any reasons of his own.*

If the child has capacity (demonstrating an ability to understand, retain, weigh up and communicate back the decision), his/her consent is sufficient and parental consent is not required (if the decision is in child's BI)	**Unconscious-** Child has undergone major surgery for which of most he would have been unconscious.
	Fear- the child is in a terrifying situation, fear and potential intimidation from gang members may diminish the child's ability to think properly
It has been established in medical law that a child under 16 who understands the nature, purpose and potential consequences of any proposed medical treatment is considered to have legal capacity to consent. In this particular case, it is essential to determine if the child, aged 14, has capacity. We are informed in the passage that the child 'should have all the information before reaching a final decision for a prospective surgery', suggesting that the child was not given all the required information prior to making his clinical decision. As a result, his refusal of the re-exploration surgery and blood test did not come from an informed position.	

Clinical Communication

Emergency situation and handovers

How should information be communicated in an emergency? Describe any frameworks. (i.e. SBAR)
SBAR framework: used to clearly + concisely transfer info between HCPs esp in acute setting.

Situation- ID who you are, ID pt, purpose of call, ID Dr you are calling "14 year old child" should give name
Background- Reason for admission/ call, relevant Hx, BG info, current status "eviscerated bowels, multiple stab injuries"
Assessment- vital signs, contraction pattern, clinical impression. "they think he's going to lose his left arm"
Recommendation- explain specifically what you need/ request for guidance + time frame, make suggestions, clarify expectations "you'd better call your senior" other types of immediate action should also be communicated here e.g. going into surgery

State and describe verbal and non-verbal techniques to ensure effective communication in an emergency situation

Non-verbal communication

Eye contact Body position and spatial distance Paralanguage e.g. tone, gesture, facial expression, hesitation Touch Shuffling, wincing, facial expression, wincing, distracted.	Main channel to convey attitude, emotions and affect Continuous and must be congruent with verbal communication Skills can assist in demonstrating attentiveness and forming relationships • Impacts pts perception of clinician empathy • Help to see what patient is feeling by observing their non-verbal • Varies in culture e.g. eye contact or spatial distance or touch

Handovers:

Purpose	Transfer of info between HCPs, continuity of care, pt safety, team approach, educative benefits, identify problems
Content	Depends on purpose, focus on ongoing management, key info exchanged, verbal or non-verbal. Updates on patients, any concerns, discussing care so far, what should be done in the next shift.
How long? Where and when?	10-30mins. Anywhere, ward round, bedside review/shift change, unplanned
Obstacles to effective handover	Insufficient time, lack of prep, insufficient attention to verbal handover, not reading written handover info, incomplete info, imprecise role function, nominating lead prevents overlap of talking, two-way process between two teams, inadequate IT
Benefits to HCPs	Education, professional protection, reduction of stress, job satisfaction
Benefits to patients	Improved safety, less discontinuity of care, decreased repetition, increased service satisfaction

SKILLS- speak clearly at all times, appropriate volume, offer to repeat info, listen attentively, check info is heard and understood, have relevant info at hand, clarify instructions, paraphrasing, logical order, brevity. Handover during emergencies requires a specific set of skills. Doctors were less satisfied than ambulance officers with handover. Doctors may have been "distracted" by presence of the patient during verbal handover so may not have completely attended to ambulance officer handover. Only 19% of ambulance officers had received training. Further, systems were largely not in place for medical staff to give feedback to ambulance officers on handover (Thakore & Morrison, 2001)

*Taken **from 'Safe Handovers, safe patients: Guidance on clincal handover for clinicians and managers (BMA)***

- current inpatients
- accepted and referred patients due to be assessed
- accurate location of all patients
- operational matters, directly relevant to clinical care such as ICU bed availability
- information to convey to the following shift
- patients brought to the attention of the critical care outreach team (where appropriate)
- patients whose 'early warning scores' are deteriorating (where in use).

The following, as well as being included in the written handover, should be discussed within the handover meeting. This verbal handover is vital to highlight pts with anticipated problems and unfinished tasks

What important information does the day team need to know (link to Q in para 2 on why handovers are important)

The day team needs the essential info such as patient details, Hx, concerns as well as any received instructions and proposed actions but because the situation in our case was an emergency; the SBAR approach may be sufficient information for the handover. This would mean informing the day team of the initial and current situation of the case i.e. what has been done since the patient was brought in/what surgical procedures have been carried out/status of the patient currently; any background knowledge i.e. stab wounds/eviscerated bowels/tourniquet left on; assessment or what they think is going to happen/needs doing i.e. they think he might lose his arm; recommendation i.e. what advice/instructions should the next team coming on keep in mind such as exploration of major nerve and stab wounds etc.

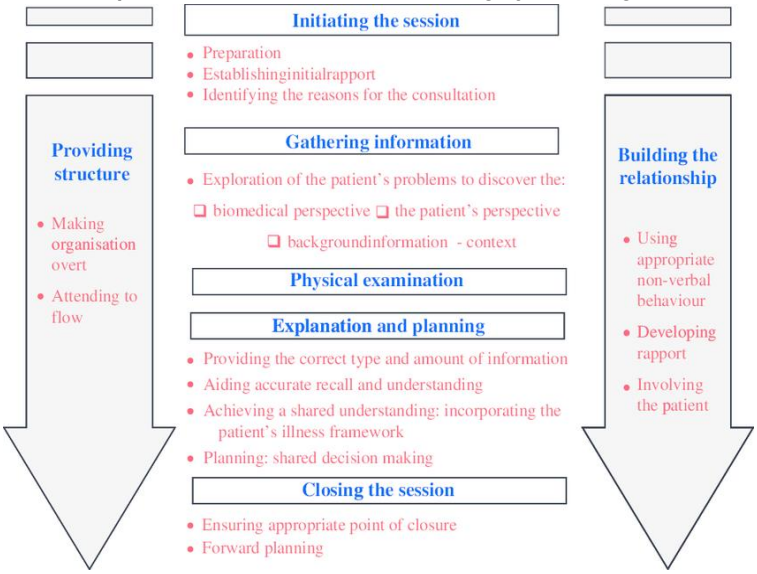
Emergency history- After A to E approach and primary survey you can use SAMPLE- signs/ symptoms, allergies, medication, pertinent medical history, last oral intake and events leading to present illness. OPQRTS- for pain- onset, provocation, quality, radiation, severity and time. Skills: pick V/NV cues, be explicit and clear, ask only relevant questions, sign post to move on quickly

Communicating with family/about procedures

How to communicate with a patient:

Patient centred-ness	Paternalism
Definition = identifies, acknowledges and responds to pt in a way that encourages participation and ensures that the patient's agenda is part of consultation process Putnam and Lipkin 1995 - 6 PCI classifications: 1) Allow pts to express major concerns 2) seeking pts specific requests 3) Elicit pts expectations of illness 4) Facilitate pts expressions of feelings 5) Give pts information (don't assume how much info they want) 6) involve pts in developing treatment plan Research - benefits: improve diagnosis efficiency, patient satisfaction, adherence to treatment, recovery, reduce no. of symptoms, may translate to reduced further investigation/referral. Advantages to patients: explored concerns and expectations, patients feel they have more control, improves doctor-patient relationship	Definition= doctor dominates agenda, sets goals and decision making, condition largely defined using biomedical terms and the pts voice in largely absent Benefits:pts unlikely to fully understand medical info and may put undue stress of rare complications, unable to fully weight up info. Less medical knowledge. Places less pressure on pts to make decisions. Problems: Without a patient-centred approach, patients are less satisfied, less empowered, and may have greater symptom burden and higher rates of referral (Little et al)

Models for patient-centredness interviews - Calgary Cambridge model



Explanation and planning stage:
1) Providing the correct type and amount of info
- Find out what patient already knows and how much info they would like
- Chunk and check
- Discover further info needs

2) Aiding accurate recall and understanding
- organise info, use explicit categorisation or signposting
- repetition and summary
- use concise and easily understood language, avoid jargon
- visual methods to convey info
- check understanding

3) Achieving a shared understanding: incorporating patients illness framework
- relate explanation to ICE
- provide opportunities and encourage participation
- pick up and respond to cues
- elicit pts beliefs, reactions and feelings

4) Planning: shared decision making
- collaborative approach
- sufficient time to decide
- share own thinking as appropriate, involve pt, ascertain level of involvement, mutually acceptable plan and check

Interactional alignment - Maynard's perspective display series
Found that when doctor established views of parents, greater likelihood that they would accept diagnosis. Identified perspective display series which consist of 1) clinician's request for patients view, 2) patient's response 3) clinicians report. The more that the doctor tried to align with the parent's view in delivering his report, the greater chance the diagnosis and treatment recommendations would be accepted.

Transformed clinical method model
6 main components: Exploring both the disease and illness experience, understanding whole person, finding common ground, incorporating prevention and health promotion, enhancing dr-pt relationship, being realistic

Affective skills (encourage and maintain relationship)	Instrumental skills (relate to task-oriented behaviours)

Non- verbal behaviours e.g. eye contact) Social verbal cues (greeting, time to speak, not interrupting) Facilitating behaviours (nodding) Empathy, acknowledging feelings	Type and content of questions Open-ended questions Clarifying what pt means, allowing them to express concerns Keeping consultation focused Summarising / signposting

Communicating DURING a procedure
Listen to your patient
Pick up verbal cues
Be explicit about what you want the patient to do during
Look at your patient for non-verbal cues e.g. facial expressions, skin colour, fidgeting, conscious state

Content addressed when explaining procedures
When? How long? Where? Preparation? Pain? Experience? Who will perform procedure? Who else is present? Aftercare? Risks? Consequences of not having it? Alternatives? Consent form? how/ when results available? Changes to daily life afterwards?

Ways of reducing stress in situations where there is no or little shared common language (Mares et al, 1985)
Try and pronounce the patient's name correctly
Allow more time
Try and find out if the patient has any specific fears or worries
Give plenty of verbal reassurance
Try to communicate some info about what's going to happen even at a simple level
Keep checking throughout if they understand
Keep case notes (avoids asking patient same questions)
Try to ensure the patient sees the same staff
Write down important info clearly and simply on paper for the patient to take away
Simplify English and speak slowly

How do you deal with difficult patients and relatives

- Ensure interaction occurs in person/in comfortable setting. Provide plenty of time for the discussion to take place/ensure no interruptions.
- Identify CAUSE of upset and elicit reasons for this (ICE)
- Explain rationale for decision (to do a blood test) and reassure them .
- Show respect for the father's view and explain your medical perspective and your ethical and legal obligations to the patient (deontology and beneficence).
- Clear acknowledgement and apology of the needle stick injury and damage to the nerves in the boy's arm.
- Provide the father with people to contact to raise further concerns and information about independent advocacy, counselling or other support services. For example Action against Medical Accidents.
- Set boundaries: don't back down OR become defensive. Use phrases such as "do you understand why?"
- Summarise/paraphrase to show you are listening. *GMC: Recognise principles of patient-centred care, … and, where appropriate, their relatives or carers.'*
- *You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.'*

Breakdown of communication:

Failures	Improvements
SpR notices details during surgery	Formal handover so she knows the full history, see importance of good handover
Tourniquet left on arm, no one was aware	Better handover from the paramedic team. It would have been addressed that a recommendation from the paramedics should be to take off the tourniquet before a certain time.
Uncertainty of extent of stab wounds, no detailed summary from the sister in charge	Clear description and details in number should be given, see benefits of SBAR
Theatre staff are unfocused	Ensuring WHO checklist is performed and everyone is aware of their roles in the situation and what to expect of the operation. Part of the WHO checklist on part of the surgeon is 'How long will the case take', unlikely to have been addressed. Systematic review by the BMJ 2014 showed adherence to checklist improves patient safety worldwide https://qualitysafety.bmj.com/content/23/4/299

Risk

Explain the different ways of informing the patient and his father of the risks associated with the surgery to repair the nerve.

Numerical - Paling 2003 - use absolute risks/actual numbers/ frequency statements etc Many question if patients truly understand this**?**	**Verbal -** Calman 1996 - e.g. 1:1000 = high risk. Retained better by patients. No empirical basis/ Considerably overestimates the risk of side-effects by laypeople, patients and doctors/ Results in judgements of increased risk to health and reduced intention to take the medication compared with equivalent numerical presentations of risk

Avoid framing risks e.g. 70% success rate vs 30% failure rate. To avoid, can present both ways "70% do well but the rest don't".

Absolute risk	The probability that an individual will experience the specified outcome during a specified period
Absolute risk reduction	Absolute difference in risk between experimental and control group. Used when risk in control group is higher than risk in experimental group (AR in control group – AR in experimental)
Number needed to treat	average number of people needed to be treated to prevent one additional adverse outcome or beneficial outcome (1/ARR)
Relative risk	The number of times more likely (RR > 1) or less likely (RR < 1) an event is to happen in one group compared with another. It is the ratio of the absolute risk (AR) for each group.

Telephone calls

Effective telephone communication in emergencies/ critical moments:

Content: State name and role Use name of HCP you are calling State purpose of call Essential info - relevant pt details, current status, relevant history, concerns Make clear request for help/guidance Summarise received instruction and clarify if further advice needed	**Skills:** Prepare what you want to say in advance, have relevant info at hand Identify yourself, speak clearly Deliver key info clearly and directly Offer to repeat info, listen attentively Check info understood, clarify by paraphrasing or repeating Document the call

Communicating medical errors

Calgary Cambridge model
Prepare- put patient in a comfortable environment and give more time for the appt, begin- summarise and update patient, give name and role, patient's perspective- establish what patient knows, share info- explain a mistake was made, be sensitive- understand patient may be angry, plan and support- offer help and plan ahead

SPIKES model (Baile et al 2000)- breaking bad news
Set up interview, patients perception, patient invitation- understand how much they want to know, give knowledge, address emotions, strategy and summarise

Mistake Disclosure Management Plan Petronio et al 2013
Step 1: Physician preparation for mistake disclosure, Step 2: Formulating and delivering mistake disclosure messages

Breaking bad news

1) Ensure pt/relatives in private space	6) move directly to telling news. Allow time for patient to respond and take in info and ask questions
2) Introduce yourself and know who they are	7) if you think they've understood info, move on to next stage, explain what will happen next and what can be done. Provides pt with sense of control
3) keep intro short, and take a seat	8) give positive, practical support and information
4) establish their perspective or what they know 5) acknowledge pt view and prepare ground in some way	9) Offer follow up appointment, telephone number, helpful agencies

How to elicit ICE

Ideas (beliefs)

- *Why do you think we are doing the blood test?*
- *Have you any ideas about why your father is objecting to the test?*

- *Do you know why you are being asked to undergo the operation on your arm?*
- *What do you think will happen in the operation?*

Concerns

- *'What are you concerned about regarding the blood test?'*
- *Why do you think your dad is worried about the test?*
- *'Is there anything worrying you regarding the operation on your arm?'*
- *'Are you worried about telling the police the truth? Why is that?*
- *Are you worried about going home?*

Expectations

- *'What were you hoping we might be able to do for your arm?'*
- *'What do you think might be the best plan of action?'*
- *'How might I best help you feel at ease with telling the police the truth?'*
- *'You've obviously given this some thought, what were you thinking would be the best way of tackling this?'*
- *What were you hoping for in the follow up appointments?*

Confidentiality/sensitive info

Sensitive probing – use empathetic statements, encouraging, emotional support. Non-judgemental. Acknowledge the sensitive nature of the topic and seek permission to continue. Thank patient for opening up and avoid interrupting.

Health professional can control the situation by how they intervene:

- If **positive** (patience, avoidance of judgement) can lead to reduced anxiety, increased confidence, improved communication and care.
- If **negative** intervention (frustration, impatience, giving up), then this leads to poor communication and stress.

Why do patients not attend follow-ups? How would you contact a pt you are worried about? How can hospitals decrease DNAs?

Reasons for not attending - MDU

- Patients may not fully understand the need to attend an appointment.
- Patients may not understand how the appointment system works.
- There may be other health and social problems which, although not immediately apparent, might contribute to a patient's failure to attend.
- Should any harm come to a patient who misses an appointment, and a claim is made, the doctor would need to demonstrate that:
- Their actions had not fallen short of those of a reasonable clinician
- Their approach was supported by a responsible, authoritative body of medical opinion practising in the same specialty.

- Initiation – introduce yourself and greet the patient in a friendly way.
- Ask them how they are to build rapport – demonstrate interest in the patient
- Setting – private setting where the patient can comfortably discuss issues. Reassure the child that it is a safe space to discuss any issues.
- Body language – keep it open, have a wide stance – welcoming, as opposed to having arms and legs crossed,
- Maintain eye contact to show you are listening and engaged
- Empathise with the patients situation, express emotion + simple statements eg 'I understand this must be really difficult for you'
- Determine what the patient already knows
- Use simple, clear and concise language to explain the patients options – pros and cons
- Clearly explain why a consult is needed
- Outline the structure and signpost to allow the patient to follow through your points easily
- Check if the patient understands by asking them to explain it back to you – flags up any misunderstanding – repetition and summarise
- Check if patients need a translator
- Provide opportunities for the patient to ask questions
- Ask about any anxieties/ concerns
- Pick up verbal and non-verbal cues - 'sheepish: non-verbal cue'

Non-verbal cues:

- Facial expressions (e.g. if patient suddenly winces)
- Eye contact
- Body positioning (if patient shuffles in and offers no eye contact, might suggest they're anxious)
- Level of attention (distracted?)
- Could give him resources (website/pamphlet) to read which could help him come to a decision
- Agree on a rough timeframe of when you will check up on the patient to see if he has made a decision – do not make it feel like there is a time pressure

How else can you go about reaching out to the patient?

- Try various methods of contact via telephone, text, email, post
- If still no luck, try to contact the patients next of kin
- If there are severe consequences to missing an appointment, can send someone to have a discussion with them at their home (costly)

How to prevent missed appointments

- Ensure your practice or clinic has a clear, consistent protocol for making appointments and dealing with missed appointments. Make sure all clinical, reception and administrative staff are familiar with it.
- Ensure your practice or clinic has a system for identifying patients who fail to attend for follow-up.
- Where a patient continually misses appointments, it may be worth exploring whether there is an underlying problem – such as anxiety.
- Keep patients' contact details up to date.
- Keep clear records of steps taken to investigate missed appointments, and attempts made to inform the patient of the importance of attending.

Cross-cultural communication

Use of language Use of foreign language (i.e. patient and clinician must communicate in a language they are not fluent in) Use of slang Accent/dialect Giving ofence through over-familiarity	**Use and interpretation of non-verbal communication** Physical touch Body language Proximity – closeness/distance Eye contact Expression of afect/emotion
Cultural beliefs and healthcare Interpretation of symptoms – what is considered normal and abnormal Beliefs about causation Beliefs about efcacy of treatment alternatives Attitudes toward illness and disease Use of complementary or alternative sources of healthcare Gender and age expectations about roles and relationships Role of doctor and social interactions related to power and ways of showing respect Perceived responsibilities regarding adherence to medical recommendations Family life events (e.g. rituals and beliefs with regard to arranged marriages, pregnancy and childbirth, older adult caregiving, treatment of elders, death) Psychosocial issues (identifying common stressors, awareness of diversity in family/community supports) Role of clinician in mental health	**Sensitive issues** Sexuality – including sexual orientation, sexual practices and birth control Uneasiness about some physical examinations Use and abuse of alcohol and other substances Domestic violence and abuse Sharing bad news **Health care practice issues/barriers** Extent of clinician-patient partnership, extent of family involvement, personal and family responsibility for healthcare and treatment Ethical issues in care Doctor's assumptions, stereotyping or prejudices Concurrent consulting with a practitioner of complementary or alternative medicine
Ways of reducing stress in situations where there is no or little shared common language (Mares et al, 1985) Get the patient's name right Try to pronounce the patient's name correctly Allow more time than you would for an English-speaking patient Give plenty of verbal reassurance Try to communicate some information about what's going to happen next, even at a very simple level Keep fuller case notes (this avoids subjecting the patient to repeated unnecessary or complicated questioning) Try to ensure that the patient always sees the same staff as far as possible Try to fnd out whether the patient has any specifc fears or worries Write down any important points clearly and simply on a piece of paper for the patient to take away	**Also:** Clearly state your intentions at the commencement of the interview Try to identify the patient's presenting complaint as well as their, worries and concerns at the beginning of the interview Work with your patient to prioritise these symptoms, worries and concerns Check you understand what your patient is saying Summarise Invite your patient to ask questions or clarify anything you say

PPD:

Professionalism - RCP = "medical professionalism signifies a set of values, behaviours and relationships that underpins the trust the public has in doctors"
Values - integrity, compassion, altruism, continuous improvement, excellence, team work
GMC - Medical Act 1983 - law gives 4 main functions:

1) up-to-date registers of qualified docs	3) Promoting high standards of medical education
2) Fostering good medical practice	4) Dealing firmly and fairly with docs whose fitness to practice is in doubt

Stress

"**Resilience is about personal strength; it's about how well we can absorb and ignore the knocks and experiences of everyday life at home and work and maintain the energy and determination to drive through ideas and actions in the face of challenges."**

Factors that determine resilience: optimism/ freedom from anxiety/ openness/ adaptability/ positive and active approach to problem solving

Coping strategies: balanced diet and exercise/ prayer or mindfulness/ have a vision/ organisational support (SU, occupational health, BMA)/ aware of responsibilities/

Learning: fixed vs growth mindset. Fixed (intelligence is static/ desire to look smart/ avoid challenges/ give up easily/ see effort as fruitless/ ignore useful negative feedback/ feel threatened by success of others)

Stress: can help us perform effectively however too much leads to mental and physical problems e.g. decreased memory and concentration, poor judgement, low mood and anxiety, tiredness, irritability. Share problems with family and friends, seek help early, have protected time for yourself, view situations from different perspective, balanced diet and exercise.

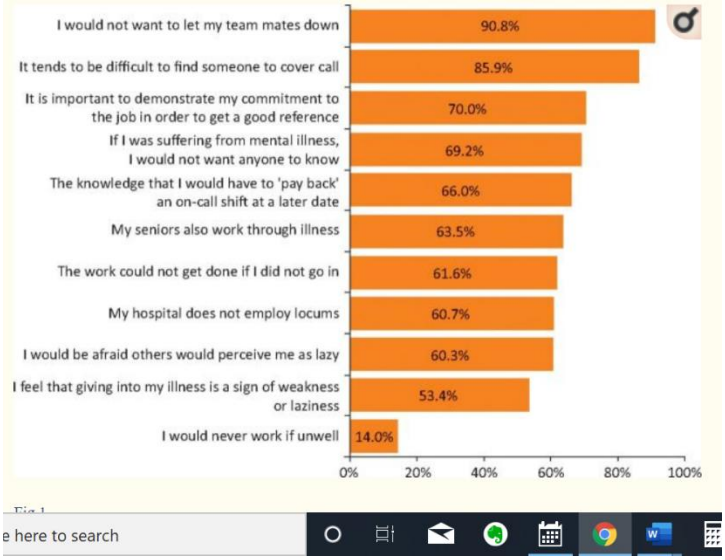
Self-kindness and compassion: identifying and taming inner critique, taking responsibility but not beating yourself up, become your own best friend

Impact of stress on pts-

- Anxiety and stress increases the chances of mistakes being made (Swiss cheese model) as the F2 is stressed, he is easily letting things slip that he may not normally= one mistake leads to another and if they all align, it could lead to a grave mistake

- If the patient can see that the doctor is anxious, they may not trust the doctor as much as they may feel that they are incompetent. This affects the quality of care that the patient receives as they may not disclose as much information to the F2 as the dr- pt rapport starts to break down.
- The doctor may inadvertently project his anxiety onto the patient, thereby making the patient more anxious in the process

What are the barriers to a junior doctor seeking help when dealing with stress?



A key difficulty is the issue of unconventional access to health services. Studies have shown that doctors often engage in **self-prescribing,** self-referral**, 'corridor consultations'**, denial and **symptom minimisation**.[2,3,7] Many work through illness which can impact negatively on the care of their patients.[2] The main factors that definitely or probably deterred respondents included **being too busy** (86.0%, n = 461), **GPs not being open when off work** (68.0%, n = 361), **self-prescribing being easier** (67%, n = 357), **and feeling that they 'should' be able to manage their health problems** themselves (54%, n = 288).

Since qualifying, 79% (n = 520) of respondents had at some stage felt too unwell to work. Of these, 60.2% (n = 313) were rarely or **never able to take time off** when unwell

Over half (55%, n = 330) had **moved away from their partner** or dependents due to work commitments, the majority (82.9%, n = 274) of whom reported that this negatively or very negatively affected their ability to deal with stress.

What are common coping strategies?
I watch a movie/TV programme 38.6, I talk it out 37.7, I exercise 36.9, I listen to/play music 34.6, I binge-eat 21.0, I am not aware of feeling stressed 18.3, I withdraw into myself 17.1, I take it out on others 13.9, I pray/mindfulness/meditate 13.4, I drink more alcohol 12.0, I smoke more 7.3, I take prescription meds 2.7, I take herbal remedies/OTC 1.8, I write in my diary 1.3, I take non legal drugs 0.5
What would NCHDs find useful to improving health behaviours?
A relief system whereby a floating SHO/SpR can fill gaps in teams due to annual/sick leave 65.3 (extremely helpful), a free, independent and confidential counselling service for NCHDs 45.7, Pleasant and spacious doctors' rest area where colleagues would feel comfortable spending recreational time 44.8, An offer of a free GP consultation everyone one to two years for a general check-up 43.0, A designated GP service for NCHDs within close proximity to the hospital 32.2, A practitioner health programme – a confidential nationwide service to which doctors who have significant health concerns can self-refer or be referred 26.4, Postgraduate modules on the management of personal stress and illness 25.0, Written information given at induction on any hospital or local sports or social clubs in the area which may be of interest 24.8, An educational module for medical students dealing with personal stress management and illness 22.8, Written information given at induction on the availability of local primary care services (GPs, counsellors etc) 17.6, An information session delivered at induction, in relation to healthy living and what to do if unwell 15.3

Help a distressed colleague-

- Clin comms: Non-verbal cues: position yourself, have open body language, eye contact, ensure private space, take a seat. Verbal cues: be empathetic, listen to the concerns of the FY2 and offer advice when warranted.
- Provide F2 with sense of control
- give positive, practical support and information
- establish their perspective or what they know
- acknowledge their view and prepare ground in some way

Role of a medical student

Yes let it be known you took the history: 'be honest and open and act with integrity'. GMC Good Medical Practice. You are not yet fully trained to take histories in emergency situations- you may miss key details. So you should tell doctors so they can take a history and fill in the gaps that you may have missed. 'Work with colleagues in the ways that best serve patients' interests'. GMC Good Medical Practice.

Duties of doctor/ medical student

Duties of doctor	**Duties of med student**
Keep skills and knowledge up to date Recognise and work within the limits of competence Doctor must record their work clearly, accurately and legibly Comply with rules designed to protect patients and improve quality Raise concerns and support others about patient safety Work in partnership with patients and good communication Work collaboratively with other HCP to ensure treatment of patient Responsible for supporting less experienced members Safe transfer of patients, share relevant info Respect patients (no prejudice), treat fairly without discrimination Maintain confidentiality Act with honesty and integrity	Participate fully in the learning process and reflect Recognise limits of competence (more mentioned below) Same - make it clear you're a student Can contribute Applies to med students too - must raise concerns about patient safety, dignity or comfort. Moral duty not legal duty. Manage learning and development Prioritise time well and ensure good work life balance

When is it appropriate for medical students to practice skills on a patient?
Achieving good medical practice: guidance for medical students- GMC:
You should only attempt practical procedures if you have been trained to do so, and only under supervision that is appropriate to your level of competence. You must:

- recognise the limits of your competence and ask for help when necessary
- make sure you clearly explain your level of competence to anyone who supervises you on a placement, so you are not asked to do anything you are not trained to do
- make sure patients, carers and colleagues are aware that you are a medical student and not a registered doctor
- take action if you think you're not being effectively supervised on a clinical placement
- it is imperative that when a medical student is in a clinical environment, that they value their responsibility as a professional to ensure patient safety,

Medical students also have a moral responsibility to raise concerns about patient safety, dignity and comfort. Professionalism is not about doing the minimum – it is about doing what is necessary to protect patients.' From the GMC Achieving Good Medical Practice: guidance for medical students.

Whistle-blowing

Defined as the raising of concerns in the public interest by a worker, whether to their employer or externally through a range of designated channels GMC duty of doctor to raise concerns. Negative consequences: demotion, isolation, threats, pressure to resign, career setback, treated as traitor.

Confidential ways of reporting	GMC confidential helpline, NHS whistle-blow helpline
How to whistleblow - NHS guidelines	1- initially raise concern with team or with manager 2 - if concerns not addressed, escalate issue to medical director 3 - inform chief executive (ensure medical director knows this) 4 - once exhausted all local policies, consult GMC 5. Only go to local elected representative if employer has record of ignoring concerns

Advantages	Disadvantages
Deontology: duty to protect patients from unprofessional conduct and unsafe clinical practice **Utilitarianism:** prevents harm to future patients and improves the quality of healthcare provided (clinical governance), promotes Px health and confidence that the mistake is recognised and rectified	Can face retaliation from employer. Can take several years. May have misunderstood the situation and causes unnecessary distress. Puts NHS in bad light if publicised. Makes an example of one person who was doing what many would've done. Causes that person embarrassment, distress and unemployability.

MDT

Advantages	**Disadvantages**
Tang et al: "Consists of members with different professional backgrounds and skills that can compensate for each other and work together toward the same direction to achieve the same goals." Iliffe: Improved coordination of care/ improved care/ greater job satisfaction/ potential to develop creative solutions to problems/ gaps in knowledge avoided	Need good team work skills to work together effectively otherwise can cause conflict. Lack of communication means things aren't done well. Reliance on other members of the team to do work meaning some work may not get done. Group think - group members refrain from expressing doubt/opinions in order to reach a decision that may be irrational. Those at lower stages may feel unable to share opinions. Patient has to repeat themselves many time to different people within MDT.

Belbin questionnaire

Personality	**Strengths**	**Weaknesses**
Plant	Creative, imaginative, unorthodox, solves difficult problems	Weak communicating and managing ordinary people
Resource investigator	Extrovert, enthusiastic, communicative, explores opportunities, develops contacts	Loses interest once initial enthusiasm has passed
Coordinator	Mature, confident, trusting, good chairman, clarifies goals, promotes decision making	Not necessarily most clever/ creative member of the group
Shaper	dynamic , outgoing, challenges, pressures, finds way around obstacles	Prone to provocation and short lived bursts of anger
Monitor evaluator	Sober, strategic, discerning, sees all options, judges	Lacks drive and ability to motivate others
Team worker	Social, mild, perceptive, accommodating, listens, builds, averts friction	Indecisive in critical situations

Implementer	Disciplined, reliable, conservative, efficient, turns ideas into practical actions	Inflexible, slow to respond to new possibilities
Completer finisher	Painstaking, conscientious, anxious, searches out errors and omissions, delivers on time	Inclined to worry unduly, reluctant to delegate
Specialist	Single-minded, self-starting, dedicated, provides rare knowledge and skills	Contributes only on narrow front

Hierarchy

Is professional hierarchy beneficial to medical practice?

YES	NO
- Chain of command with each level of personnel having their own sets of duties and responsibilities. Allows for organisation, accountability and efficiency. Clear defined roles of responsibility - Juniors know who to go to for advice	- Timm et al: failure to report bullying because of fear and disempowerment in hierarchical structure. - Walton et al: "Maintaining a good relationship with those higher up the ladder understandably becomes a prime focus, often at the expense of other priorities such as reporting on errors or on poor patient care." - promotes bullying culture - HCPs may feel undermined

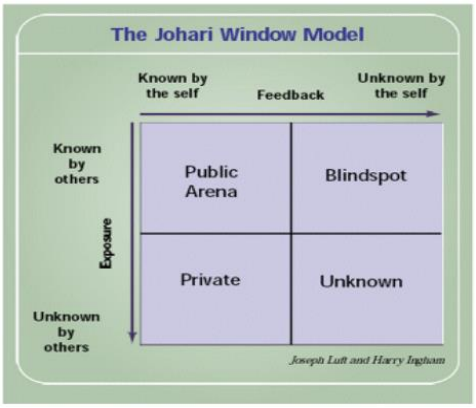
Medical error

London Protocol:

Factors underlying adverse event caused by human error	Examples from case
Third party characteristics e.g. communication problems, illness, disability, personality	*Child is critically ill with multiple stab wounds. He is unconscious, and (I'm assuming) alone – limiting the history that can be taken.* *He has been rushed to theatre and from team to team, with no handover or clear communication.*
Task related e.g. inadequate instructions, poor design, new/difficult task	*The discovery of 14 new stab wounds.* *Tourniquet on left arm with no recollection of how long it has been on for.* *Extremely long and tiring procedure.*
Individual factors e.g. stretching beyond expertise, lack of knowledge/skill, stressed/tired, attitude	*FY2 – new to the department. Tense, anxious and visibly stressed.* *The surgeon may be already tired-she is 'on-call'. She continues working into the next shift.* *The surgeon may be arrogant and lack insight into his limitations.* *Other members of the team may be over-stretched.*
Team factors e.g. poor teamwork, inadequate supervision, poor communication, poor team morale	*Specialist registrar is absent initially. A full history/handover should have been completed)* *FY2 is stressed and on edge, and doesn't seem to much use*
Environmental e.g. defective equipment, inadequate staffing, support services, distraction (family, noise)	*The operation is done out of hours at night- the team may be less efficient and effective at this time and other support services may be unavailable.*
Organisation/management e.g. poor leadership, coordination of services, management	*There should be a policy in place re the minimum requirements in terms of staffing and equipment for any major procedure.*
Institutional e.g. financial constraints, economic and political climate	

Swiss Cheese: Errors occur when the barriers align and create a 'trajectory of accident opportunity'. As each layer is broken, an error become more likely. Holes in defence due to:

Latent Conditions	FY2 was lacking confidence and stressed. SpR was 20 minutes away despite being on call. Emergency situation. Lots of different teams involved in care
Active Failures	Whoever put the tourniquet on didn't document it in the notes. Poor team communication
Failed/Absent Defences	Poor documentation in the notes. FY2 was the most senior doctor present



Johari's Window
A disclosure/feedback model (developed by Luft and Ingham) designed to compare how you view yourself and how others view you. You can learn more about yourself by seeking feedback from others and disclosing personal feelings – this allows you to open up the public area. There are errors in your ways that may not be apparent to you but can be seen by others **(blind spot)**, so receiving regular, constructive feedback from those around you can help narrow this area.

Three bucket model for assessing risky situations - Self, context and task. 'The fuller your buckets, the more likely something will go wrong, but your buckets are never empty.'
'Self' bucket
FY2 felt they had a lack of knowledge and surgical experience. Their feeling of stress compounded by the needlestick injury contributes to the 'self' bucket. Also that this was a night shift can add to fatigue.
'Content ' bucket
Examples from case: lack of organisation of the team in theatre as the SpR tries to maintain focus. The SpR being focused on 'relishing the challenge'= absent leadership. Inadequate handover. Night shift so less support.
'Task' bucket
Examples from the case: first time the medical student or FY2 had encountered this. Multitasking- having to deal with the patient coming on and long surgery, needlestick injury. In the aftermath- med student trying to consent the child for nerve re-exploration, blood test and at the same time dealing with conflict of breaking patient confidentiality.

Needlestick injury

If you sustain a needlestick injury, take the following actions immediately:

- Wash the wound with soap and water.
- Alert your supervisor and initiate the injury reporting system used in your workplace.
- Identify the source patient, who should be tested for HIV, hepatitis B, and hepatitis C infections. Your workplace will begin the process to test the patient by seeking consent.
- Report to employee health services, the emergency department, or other designated treatment facility.
- Get tested immediately and confidentially for HIV, hepatitis B, and hepatitis C infections.
- Possible treatment + follow up

Moral distress

Moral distress: "When one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action' (Jameton A. Nursing Practice: The Ethical Issues. 1984)

Institutional constraints:

Internal constraints	External constraints
Lack of assertiveness/ self doubt/ socialisation to follow orders/ perceived powerlessness/ lack of understanding of full situation	Inadequate staffing/ hierarchies/ lack of collegial relationships/ lack of admin support/ policies conflict with care needs/ compromised care due to pressure to reduce costs/ fear of litigation

Self-prescribing

- Prescribing for self will enable you to get onto treatment quickly - You will not need to disrupt others and take time off work But - You cannot be objective about yourself; another professional's opinion is needed - The GMC guidance clearly states that doctors should not self-treat. - You may need time off work-certified + counselling or other expert help - You may be putting others at risk

Sources of support

1. Colleagues, friends & family who know the NCHD well and can advise + offer support and care
2. Members of the firm/ward/team – they may be experiencing similar difficulties
3. GP: If depressed, can give an objective clinical assessment and who has: experience in managing depressive disorders, access to counselling and pharmacological prescriptions
4. MDU/MPS: A Professional and legal advice and support. Help with composing and reviewing summaries required as part of responding to a complaint
5. Medical counselling service: Confidential service providing consultations for medical professionals with psychiatric problems.

If you feel incompetent-

Speak to your seniors SpR or consultant. They are responsible for you and your welfare.

- educational supervisor
- Speak to nursing staff, many of them have a lot of experience and may be able to help you with
- Speak to your welfare tutor who you are allocated to. They are separate from the ward you are on so they can be impartial
- Speak to other colleagues

BMA support services – counselling for doctors = 24 hour service

Medical schools tend to have multiple support systems which could benefit the medical student in helping him to deal with the feelings of remorse and 'regret'. These include:

- Personal tutors - who help students by providing information on the medical school's support services and other support available through the university
- The university's support services through the student union. They can help on many things, and they may provide peer support
- The university's student health services. To get support on stress or anxiety
- Confidential counselling services offered by the university.

Medical Law

Consent, capacity and refusal in adults

Acting without consent can result in court action. Criminal offence, i.e. assault, battery or common assault (comb. of both). May result in civil action from pt such as claim for damages.

Consent **not needed** in emergency, implied, waiver, best interests.

Valid consent= A competent person that understands the nature of the treatment based on information in "broad terms" without coercion who then gives permission.

Competent= understand, retain, weigh up, communicate

It is the responsibility of the person doing a procedure to ensure that there is adequate consent.

Mental Capacity Act 2005

MCA- there is a functional approach to the determination of capacity- not diagnosis driven. 2 stage approach. 1) is there impairment/disturbance of brain/mind functioning. Is the impairment sufficient to impair capacity?

Under Common Law - mentally incompetent person cannot consent and no one on their behalf can consent. So treatment is only lawful if necessary (cannot wait until capacity regained AND in best interests)

Expert assessment of capacity will only be required for a serious decision and when there is doubt or dispute.

Best interests

- Bolam principle (group of doctors agreed on BI. Common law rejects using this solely **bc only determines pt's best *medical* interests**)
- Substituted judgement- what would they have wanted if competent. This is meaningless in someone who has never had capacity
- Least restrictive alternative- an action will not be BIs if the same objective can be achieved in a way less restrictive of the person's rights and freedom of action. If it requires restraint, must be proportionate. And consider family view. Equal consideration and non-discrimination.

Presumption of capacity: all adults presumed competent unless shown otherwise. Task specific. Ensure circumstances aid understanding.
Principle of equal consideration: decision based on evidence not on appearance, age, race, gender, assumptions, unwise choice etc.
Patients lacking capacity - maximise capacity and unless emergency, MUST consult family in all major decisions.

Lasting power of attorney:

- Only created when adult has capacity
- Must comply with regulations and registered with Court of Protection
- Extent of decision-making must be specified (e.g. welfare/financial/personal/refusal of life sustaining treatment)
- Donee's decisions **must be** in best interests
- Donee can only make decisions once capacity lost

Court of protection:
Certain decisions need to go to court to determine best interests:

- Withdrawal of artificial nutrition in patients in PVS
- Organ donation/ bone marrow transplants
- Sterilisation for non-therapeutic purposes e.g. contraception
- Some termination of pregnancy
- Major decisions where there is doubt/dispute over best interests

Court appointed deputies:

- Can make decisions (if significant decisions need to be made regularly that would otherwise go to court), must be in BI, court defines scope and duration.
- Cannot refuse life sustaining treatment

Life-sustaining treatment;

- May be lawfully discontinued if treatment not in Bis
- Decision maker must not be motivated by desire to bring about person's death
- If BIs doubted, court declaration may be sought but no legal obligation to do so

Unless it is an emergency requiring an immediate decision, the family has a right to be consulted for all major decisions.

Independent mental capacity advocate (IMCA):
Statutory duty to appoint appoint IMCA if patient lack capacity, has no one to represent them and there are:

- Decisions relating to serious medical treatment or proposal to move into long term care (>8w) or move to different hospital/care home
- Role is to represent and support person. Ascertain beliefs and alternate courses of action and obtain further medical opinion if necessary. Can appeal to court if they believe decision not in BI.
- Cannot make decisions

Advance decisions:

- Only created when adult has capacity
- Only allows refusal of treatments. Cannot refuse basic care and oral food/drink. Cannot request treatment.
- If it rejects life sustaining treatment, must be in writing, signed AND witnessed and signed by 3rd party. But for other decisions, can be oral. Doctor decides whether a given treatment is life sustaining.
- Takes precedence over LPA (unless LPA made after) and court appointed deputy. Best interest not applicable. Only exception is Mental Health Act, i.e. cannot refuse treatment under the Mental Health Act.
- Invalid if withdrawn when competent (can be oral), LPA made after or acted in a way inconsistent with advance decision. Inapplicable if there has been a significant change in circumstances e.g. pregnancy or of prognosis/treatment of condition since. An exception is treatment under the Mental Health Act i.e**. cannot make an advance decision to refuse treatment under the Mental Health Act**.
- If doubts over validity of AD, in an emergency doctor can provide treatment. If non-urgent, apply to court for declaration. Also doctors must take reasonable step to enquire whether an AD exists.
- Cannot be withdrawn once capacity is lost

Children and the Law

The Children's Act 1989 Principles

Child's welfare is paramount	Rights of parents are secondary to welfare of child
Presumption of no order	Assumes in most cases the court will not force an order upon the parents/local authority. Court orders only made when beneficial for child. Local authorities must work together with parents for welfare of child.
Welfare principle in practice	Wherever possible, brought up by family. Should be safe and protected if in danger. Should participate in decisions made about them. Parents continue to have responsibility of children even if they don't live with them so they should be informed and participate in decisions about their children.
Parental responsibility	Gives either (mother only if unmarried/disagreement) or both parents (married/birth certificate) the right to decide for their children. Other people with parental responsibility, legal guardian or local authority.
Abuse of children	Details of situations where local authority needs to intervene (physical, sexual, neglect, emotional). Keep a list of 'at risk'.

Consent
Family Law Act 1969 - age of consent to medical treatment if 16. <16, only those with parental responsibility (if more than one, only need one person) can agree to medical treatment or if Glillick competent. For major decisions where parents in disagreement, court. Parental responsibility ends at 18.

Emergency and no one available - can treat without consent under the legal principle of necessity. Treatment necessary if in patients best interest and can't wait until consent can be obtained.

Gillick exception - children under 16

1. Ask the child if you can tell one of both of her parents	If they agree - can treat with parental consent. If not - respect confidentiality
2. Assess maturity in terms of treatment	Do they understand treatment and complications? If so consider:
3. They are likely to suffer physical/mental harm without treatment and in BIs to receive it	Can be extended to all forms of treatment

No lower age limit but lower the age, more justification needed of maturity and BIs.

Refusal of treatment
If Gillick competent, could refuse treatment but it's unlikely to be in their best interests so cannot refuse.
Also, as parental responsibility for the courts (as opposed to parents) ends at 18, possible to overrule pt refusal, or ask court for permission if **child 16/17** but if younger, usually permission from one parent is fine.

If the child and parents disagree: can provide treatment in the following conditions:
o Gillick competent child consents but parents disagree

o Parent with parental responsibility consents but Gillick competent child objects
o Court authorises treatment, despite objections of parent and child

Confidentiality

Basic principle - info acquired by HCP shouldn't be divulged to others.

Exceptions: **1. Implied consent by presence to MDT** **2. With express consent outside MDT** a. How much info? To whom? b. Family - parent of child who is not Gillick competent or patient lacks competence 3. **Required by statue (consent not required)** a. Notification of death b. Notification of abortion to Chief Medical Officer c. Treatment of drug addict with specified drugs d. Notifiable infectious diseases (e.g. cholera, Plague, relapsing fever, smallpox, typhus) 4. **Assisting the police** Basic principle applies. Exceptions: a. Under a warrant from circuit judge b. Identify drivers suspected of offences. No requirement to give any other info or provide evidence unless asked by court c. All matters with suspected terrorist patient, doctors should assist unlike above pt	5. **Wider public interest** No legal duty but professional guidance states that only if you believe pts continued driving poses serious risk of harm to others and are unable to encourage individual to disclose, can tell DVLA (not employer).Only necessary info given. Minimum breach. --- Children under 16: ● not Gillick competent, can breach if in best interest or with parental consent ● Gillick competent, child can refuse to consent to disclosure BUT can be breached if in best interests Children over 16: ● Presumed competent, disclosure only made with consent but can be lawfully breached until 18 if in best interests. However, generally not in their best interest of a competent child to override their competent refusal.

End of life

Possible criteria for defining death:

LEGAL DEFINITION: permanent loss of brainstem functions	2 doctors must agree: - Must be concluded that the coma is not the result of a reversible cause - Must demonstrate that several components of brain stem have been permanently destroyed including the respiratory centre - Proved that the patient is unable to breathe spontaneously
Permanent loss of consciousness	What we understand it is to be human. Problem is it would classify people with severe mental illnesses as dead
End of breathing and heart	Medical advancements - stopping of heart doesn't lead to end of brain activity
Cessation of cellular function and processes	Treats body like machinery. Also takes time for all processes to stop so would make organ donation very difficult
Death as a process with no clear point of death	

The law and end of life

- State not entitled to prevent a person of full capacity from taking their own life. But that person has no right to call a third party to help end his life
- Mentally competent person allowed to refuse life sustaining treatment
- A doctor cannot advise a patient how to kill themselves. Against the Suicide Act 1961
- Medical treatment intended to alleviate pain and discomfort are not unlawful only because incidentally shorten patient's life
- 3 situations where doctor is not breaching duty by failing to provide treatment:
    - Competent patient refuses
    - If treatment is not in the patient's best interests
    - Where the doctor has to allocate scarce resources between patients

Life sustaining treatment

Basic care (e.g. oral fluids) cannot be withdrawn.

Mental Capacity Act - Decision must be in best interests - Must not be motivated by hastening death - Have to consult family and those close to the person	Patients lacking capacity - Check for advance decision - Check if LPA has ability to make decisions on life sustaining treatments - Court appointed deputies cannot refuse life sustaining treatment

Requesting treatment

- If a doctor concludes that a treatment is not clinically indicated he or she is under no legal obligation to provide it (although should arrange a second opinion)
- However, there is a duty to care for the patient and this will normally require doctors to provide CANH

Abortion and Disability

Ethical arguments- gradualist approach, fetus is a human being, fetus is not self-aware and without autonomy so not a person, fetus has lesser moral value bc it hasn't formed relationships. Thomson's violinist

Legal status of foetus and father

Once born, acquires full rights.	Paternal rights: Father has no legal rights during pregnancy. No legal right to request/veto or consulted/informed of abortion. Once born, father has legal responsibilities.

The fact that a woman is pregnant, doesn't affect her legal rights. She can engage in lawful behaviour that is harmful to the foetus. She can refuse medical treatment including C-section even if it risks the life of the baby.

Abortion Act

Abortion is a criminal offence (under offences against the person Act or infant life preservation Act) unless:

Less than 24 weeks	At any stage of the pregnancy
Must be <24w and the risks to the physical and mental health of woman and children greater if pregnancy continued. (accounts for 97% of all UK abortions)	Necessary to prevent grave/permanent injury to mother OR continuing pregnancy would be at a greater risk to the life of the mother than termination OR serious disability