Clinical Law: What do clinicians want to know? *The demography of clinical law*

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Contributor statement:
RW collected the data over 12 years by providing answers to clinical enquiries and recording them. He produced the first draft of the text and Tables and dealt with some of the administration required to submit to the JME. He also dealt with the substantial changes suggested by NH
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Structured Abstract

This is the first description of the questions that clinicians ask a department of clinical law, relating to the legal rules applicable to the care of their patients.

Objectives

To describe in detail the demography of clinical legal enquiries made by clinicians of all professions concerning the care of their patients. To collate and categorise the varieties of enquiry, to identify phenotypic patterns. To provide Colleges, regulators, commissioners, educators, and the NHS with an insight into hitherto undescribed subject matter, better to understand and respond to this aspect of clinical practice.

Design

Prospective collection of all clinical legal referrals recorded in writing over 12 years by a department of clinical law.

Setting

An English Tertiary Hospital NHS Trust.

Participants

Clinical staff of the regulated professions, all seeking to have their clinical legal enquiries answered.

Main outcome measures

The description of the demography of clinical law

Results

1251 written records were identified and reviewed. These were divided into nine broad clinical legal subject areas (domains): Mental disorders, Parents & Children, Incapacity, Consent for Treatment, Disclosure of private information, Other Statutory, Regulated Practice, Professional Practice, Clinical Practice. Within these, 149 clinical legal phenotypes were identified to which each case could be assigned.

Conclusions

Amongst a broad range of enquiries, recognisable clinical legal phenotypes exist and have for the first time been described and categorised. These are clinical situations which clinicians need to be able to recognise and equipped to deal with. Doing so will likely facilitate timely and better treatment.

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Introduction

Whilst lawyers and ethicists have for many years contemplated the legal framework within which patients are managed, it is only recently that clinical law has emerged as a subspecialty field of *clinical* practice. In response to increasing requests from clinicians for legal advice in this field, a Department of Clinical Law was established in our hospital in 2009.[1] This new clinical activity commenced after consultation with and approval of representatives of the General Medical Council. Advice is provided based on the information which would be offered by a consultant to her trainee in the usual way, based on the consultant's specialised knowledge within a field of basic science (or in this case, the field of medical law). For this reason, the advice is in the form of a clinical opinion, rather than a definitive legal statement.

To our knowledge there are no published data on the questions that clinicians ask departments of clinical law (or equivalent organisations) in relation to the legal (or regulatory) rules that have a bearing on their patients. This is largely, as far as we are aware, because the provision of a clinical legal service within the NHS is unique. Nonetheless we speculated there would be benefits to understanding the content and breadth of enquiries. If it is possible to identify what clinicians want to know in the field of clinical law; and quantify the relative frequency with which those clinical legal phenotypes emerge in practice, a notion of where educational resources should be deployed may emerge. Furthermore, it may be possible to recognise the phenotypes that need to be covered in greater depth and hence assign the priority with which Colleges, educators, regulators, and commissioners need to address gaps in knowledge within the clinical workforce; some of these lacunae may have been reflected by the enquiries we have received.

There are clinical situations that the body of law either has yet to address, or where statute, common law and ethics may be interpreted in different ways; or where uncertainty remains. For these reasons, enquiries into some of the phenotypes we encountered required escalation to regulated legal practitioners for resolution. Some enquiries originated from the Clinical Ethics Committee (CEC); equally, some of the tentative solutions proposed within the department of clinical law have then been presented to the CEC for comment and modification. Questions which are predominantly ethical were referred to the CEC.

We describe the demography of referrals from clinicians to our service over a period of 12 years. In so doing, we aim to describe the 'phenotype' of the clinical legal problems that staff of all the clinical professions regulated in the UK considered to be of sufficient importance to resolve.

Methods

None of the results in this study are identifiable to the individuals who submitted the enquiries, nor to the subjects of the enquiries. For these reasons, no research ethics clearance was sought or obtained.

Data on all referrals received were collected prospectively from the inception of the Department in 2009 until August 2021.The department is in a tertiary hospital providing all specialities other than solid organ transplantation. There are 7,500 clinical staff, and 960,000 outpatient attendances each year. Details of all the referrals to the department of clinical law were recorded, along with a note of the opinion provided. All cases that were responded to with a written response are included in this report.

All data recorded and advice given resides exclusively within the hospital's patient records system (or that of the external referring organisation), ensuring compliance with information governance. Advice thus remains private.

The Department is run by a consultant surgeon, who has undergraduate and postgraduate degrees in law and is a Senior Lecturer in clinical law. Other members of the department include a consultant intensivist with postgraduate legal qualifications, and two other consultants (respiratory, maxillofacial) midway through postgraduate law and ethics courses. There is a senior trainee embarking on postgraduate law and ethics education and research, and medical students pursuing clinical law projects, based upon the phenotypes set out in this paper[2]. Clinicians might choose to direct clinical legal enquiries elsewhere, either to other colleagues, to the hospital claims department (and thence to the Trust solicitors) or to colleagues or organisations outside the hospital. We are unable to estimate the denominator of total enquiries that may have arisen in this 12-year period. Common queries and new laws are dealt with by the department separately from the enquiries set out in this paper; both local guidelines and around 80 occasional bulletins are published on the departmental website[3]. Some of these provide guidance on the clinical approach to legal dilemmas.

In broad terms, the enquiries relate both to the substance of the law, and the necessary clinical response. The legal 'substance' may be written in the common law or statute or its derivatives, or in the guidance from the GMC and other regulators. By example, enquiries specifically about the effect of children's competence were made on 15 occasions, and illustrate the diversity of the type of enquiries, and the response.

Dealing with the case of a child who was sufficiently mature and intelligent to agree to the excision of a Spitz naevus, the clinician asked whether the child was entitled to give consent independently of her parents. Matching the specific facts of the case to the substance of the law, our advice was that the child was competent to provide consent, although the clinician would be prudent to encourage her to involve her parents. Another enquiry related to whether 'Gillick' and 'Fraser' competencies were synonymous. The answer to the question could be derived from the relevant judgement[4] and literature[5], and advice was given. Whilst on the face of it, the answer to an enquiry as to whether a competent 15-year-old could refuse life saving surgery was available in the substance of the law; but this question was referred to the Trust solicitors because of its gravity. When asked whether it would be lawful to deprive an incompetent 16-year-old of her liberty based on her parent's authority, our immediate referral to the Trust solicitor was passed to counsel, since the legal point was contentious.

In 2009, a statutory framework and body of common law underpinned the clinical regulatory framework covering medical practice in the United Kingdom. However, it was unknown what specific questions clinicians would ask, or what areas of legal and ethical practice were of concern to them. Initially, nine broad clinical legal subject areas (domains) were identified, loosely based upon a basic structure of healthcare law as set out in the leading contemporary textbook[6]. Some headings such as 'research' and 'end of life' were not adopted, since in both cases their clinical application covered diverse domains already accounted for. Others, such as duties in contract, causation and defences were not adopted since none of these topics are considered to be the usual 'basic science' upon which a consultant would provide advice to her trainee. By contrast, regulatory and professional matters were prominently dealt with in the textbook, thus each was adopted as a domain.
Each referral was assigned to at least one of these domains (Table 1). As data analysis progressed, we were able to develop a list of different phenotypes within each domain to which each referral was designated. The decision on phenotypic classification was based on the substance and legal context of each enquiry; allowing us to describe the demography of this practice. Thus, the approach to developing the taxonomy was reactive; where a new phenotype was required since an enquiry did not fit well into any of the existing phenotypes, a new one was considered. This decision was usually made after discussion with clinical staff within the relevant medical specialty. On several occasions a phenotype was abandoned as too generic and rephrased in more specific terms.
Having made early attempts to follow the progress of the patient involved, this proved impractical.

Finally, at the end of the categorisation process the number of enquiries falling within each phenotype was documented.
New clinical legal issues continually emerge, and our early use of the phenotypes and domains already demonstrates incongruities. Whilst reorganisation will become necessary, we will defer that for 18-24 months, anticipating that the frequency of anomaly discovery will decline in a logarithmic fashion. Reorganisation now would be too soon.

The description of the clinical legal domains is set out in Table 1. It should be noted that in terms of primary legislation (Acts of Parliament) e.g., the Mental Capacity Act 2005 there are over 150 Acts providing a foundation for healthcare law in the United Kingdom. From these are derived another 60 or so statutory instruments to bring the Acts into effect, and perhaps twice that number of European legal instruments and legislation. In addition, there are tens of thousands of common law judgements, and copious regulations. For this reason, we have provided in the Table only a single illustrative statute for domains where this is appropriate; it is hoped that this will be a useful starting point for further exploration of the subject.

Table 1

Clinical legal Domain	*Description*
1. Mental Disorder	This domain deals with phenotypes relating to patients with a disorder or disability of their mind. These mainly involve questions about assessment, treatment, and confinement, either on a voluntary or compulsory basis. There is an inevitable overlap with other domains; capacity, consent and confidentiality play a central part in many of these clinical decisions, and the legislation is applicable to all age groups. The topic is founded on primary and secondary legislation, as well as the common law. The Mental Health Act 1983 and its Code of Practice is the starting point for this area of clinical law.
2. Parents and Children	These phenotypes are related to family law, touching the relationship between the clinician, the child, and her parents, as set out in the Children Act 1989.
3. Incapacity	This domain concerns clinical decision-making in incapacitated patients of 16 years and older, as set out in the Mental Capacity Act 2005.
4. Consent to Treatment.	Consent for clinical interventions (as opposed to consent for the disclosure of private information) is largely founded on the common law and is the first-amongst equal element of clinical legal practice. The topic is dominated by questions about what constitutes reasonable disclosure prior to seeking consent.
5. Disclosure of private information.	This domain deals with confidentiality; that of a single individual; competing interests within families; and the tensions between clinicians and patients. The distinction from consent to treatment was made not least because the consequences of an unlawful disclosure of information may be so very different for the patient when compared with those of the unlawful touch; and severe in a dissimilar sense. The Data Protection Act 2018 applies.
6. Other Statutory.	Enquiries relating to clinical legal topics covered by statute but not dealt with in other domains. These include questions appertaining to the Human Tissue Act 2004; Freedom of Information Act 2011; and Gender Recognition Act 2004; as examples of the many statutes and Statutory Instruments that have a bearing on the phenotypes in this category
7. Regulated Practice.	Concerning areas of clinical practice either prescribed or proscribed by the nine national healthcare regulators, and/or enquiries in the hinterland governed by Practice Directions or guidance recognisable as a regulation.
8. Professional Practice.	Enquiries relating to professional conduct rather than clinical interactions with patients. Whilst it is therefore unfortunate that the domain of Professional Practice is of course ultimately under regulatory control, the latter was intended to distinguish the idiosyncratic reasonable practice of clinicians (such as contemplating administering an anaesthetic in the patient's home) from the broader regulatory brush, such as seen in the duties of candour.
9. Clinical Practice.	Enquiries into clinical interactions that will not fit easily into the other eight domains. In retrospect, the phenotypes in this domain would have been better distributed into the seventh or eighth domains, since the distinctions anticipated at the outset proved far less clear in hindsight.

Results

Between 2009-2021 1251 referrals ('enquiries') from clinicians were received. Most of these referrals originated from the clinical staff at our own Trust, although some also came from local hospitals, hospices, general practice, and care homes. Most enquiries came from doctors and nurses; fewer than 50 enquiries were received from the other regulated professions, although all of these were represented. Overall, 149 distinct clinical legal phenotypes were identified to which each referral could be assigned (Table 2). Within each domain the number of phenotypic subjects ranged from 10 to 25 as follows: Mental disorder (11); Parents & Children (22); Incapacity (19); Consent for Treatment (11); Disclosure of private information (10); 'Other' statutory (17); Regulated Practice (19); Professional Judgement (25); Clinical Practice (15).

The frequency of enquiries per phenotype ranged from 1 to 72 and for most phenotypes there was more than one enquiry. However, in 23 instances, the substance of an enquiry generated a new phenotype, and no further examples of this factual pattern were then encountered during the study period. We made no effort to amalgamate these singleton phenotypes into an 'others' group, for obvious reasons of data loss. The most frequently encountered phenotype related to incapacitated adults.

Although most cases could be assigned to a single phenotype, there were some that involved more than one. For example, the question of the incapacitated man with atrial fibrillation who wished to abandon his oral anticoagulation, with his next of kin's connivance; this undoubtedly involved consideration of vulnerability, safeguarding, human rights, consent, the status of 'next of kin', and a test for incapacity, amongst other obvious subject areas. Thus, one enquiry could easily and unhelpfully generate numerous data points. In this report the referral above was, based on the facts of the case, counted as dealing with only two phenotypes: 'Best interests' and 'bad faith/unbefriended/IMCA (Independent Mental Capacity Advocate)'. In this way, within 1251 written replies to 1251 referrals, 1482 enquiries were ultimately recorded.

Frustratingly, a further discrete phenotype has emerged since the data collection closed; that of disagreement between surrogate and intended mothers over antenatal management. Up until 1st August 2021 our series included five referrals concerning surrogacy in the postnatal setting, but none drawing our attention to the possibility of enquiries about foetal surrogacy. Since the foetus has no legal personality, clinical legal dilemmas concerning unborn children are substantially different from those involving the postnatal phenotype, where the welfare of the newborn child is one of our paramount considerations. Thus, illustrating the ubiquitous truth that medical practice continuously generates fresh clinical and legal dilemmas.

Discussion

In this novel review of a department of clinical law's practice over a 12-year period, we have identified 149 clinical legal phenotypes representing dilemmas about which clinicians were seeking clinical legal knowledge, and advice. Referrals emerged from both the wider health community, and within every clinical discipline of a hospital that provides almost every form of medical care. Each dilemma reveals a particular combination of medical and legal facts. In all but 23 instances, the phenotypic combination emerged more than once in the 12 years reported here. It seems likely that when considering all hospitals in the United Kingdom, each of the 149 clinical legal dilemmas present somewhere in the four nations every year.

A key purpose in classifying these enquiries into phenotypes is to assist the clinician in identifying the clinical legal aspects of their patient's case with which they may not find themselves familiar. An obvious example is of a patient whose decision is (apparently) to either refuse limb amputation or not accept it. The clinical question is whether they have the capacity to decide to refuse treatment. In our series, this phenotype was encountered 11 times. In most familiar 'medical' phenotypes, the demographic combinations are well known and the teaching relating to them is ubiquitous. The combination of peripheral vascular disease, diabetes and frequent requests for distal amputation is familiar to practitioners and there are countless references in the undergraduate and peer reviewed literature. Clinical staff involved in this phenotype rarely request external medical help in its management. But with the addition of incapacity in a person who nonetheless expresses wishes to retain their foot, despite the relative frequency of this situation across the country, significant delays in resolution of the clinical legal dilemma can be incurred. A review of the medical literature reveals no publication of a series of diabetic incapacitated patients who wish to retain their gangrenous foot in the face of medical opposition. No guidance on the clinical legal dilemma based on evidence is offered.

In stark comparison, the common law is rich in factual context [7]and replete with such cases. It provides detailed guidance on the analysis of incapacity, the role of those befriending the patient; necessity for a court application; and if needs be, its timing. There is a schism in knowledge, whereby medicine and the law are dealing in parallel with identical phenotypes, yet apparently oblivious to the benefits of sharing experience between the professions. There is undoubtedly a range of clinical legal knowledge and support, not least that set out by the General Medical Council[8] which is translated into teaching in medical schools and postgraduate education. Perhaps this could go further, integrating law into postgraduate education as 'clinical evidence'[9], where legal and medical facts command equal importance. In the meantime, this clinical problem could be addressed in advance of the next case if clinicians recognised the clinical legal phenotype and prepared for that contingency; just as they prepare for the endocrine emergency with insulin; or potential blood loss with a precautionary cross match.

We hope that by providing evidence of these medical, surgical, psychiatric, paediatric, obstetric, and other 148 clinical legal phenotypes to academic lawyers, ethicists, and clinicians; these groups might collaborate to identify new practical solutions to commonplace medical dilemmas that may nonetheless be grave and require knowledge to solve.
We acknowledge that the incidence of any phenotype may be influenced by many factors, including the effect of an educational effort based on the receipt of a previous enquiry. We have not considered the date of enquiries, so it is possible that a 'glut' of a particular phenotype was encountered mid-way through this study only to drop away sharply when fresh legislation or a new judicial decision intervened in that year….and that we have failed to spot that decline. However, temporal patterns of phenotypes may become relevant as each is scrutinised and could provide useful information on the effect of law making. Multidisciplinary research will be required to achieve new practical solutions, ideally in universities with schools of medicine and nursing and law and ethics, together with the other clinical professions and social care.

In the meantime, now that the process of recognising and describing the phenotypes has begun, the various aspects of lawful and ethical health service provision can be adjusted to respond to them. Services can be better planned, strategies developed and rehearsed to manage patients who present with this multiplicity of dilemmas:
Behavioural researchers might identify reasons why some patients on home oxygen resolve to continue to smoke if this phenotypic cohort was scrutinised. Equally, the psychological management of capacitous women who choose to refuse urgent Caesarean section might be modified to reduce the risks to mother and child, if the cohort of this phenotype could be brought together and better understood. At the very least, persuading solicitors to present 'predictable refusal' cases to a court in a timely fashion[10], seeking anticipatory declarations[11] in relevant cases, would make the emergency less stressful for clinicians and patients alike.

With further work on the clinical and legal framework relating to the cohort of children and young people who require compulsory detention because of mental illness, a more effective case for funding tier 4 beds[12] might be presented to the Secretary of State for Health. The incidence of young people and adults swallowing dangerous objects could be reduced if patients of that phenotype were gathered and studied from the perspective of their capacity and attitude to risk taking; better to inform the legal and clinical balancing act of determining what type and level of observation and risk avoidance should be employed in the clinical units that look after them.

It is beyond the scope of the description of written responses described in this report to comment in detail on the similar number of enquiries (probably more) which were answered orally and informally during the same time period; in the hospital's stairwells, corridors, and carparks as well as the more formal clinical environments, usually during chance fleeting encounters. No written record or tally of this 12-year oral workload was maintained, but it is certain that these informal conversations related to questions which were immediately recognisable as elementary and uncomplicated; otherwise, they would have

resulted in a written record and response. Nevertheless, the fact that such elementary oral questions are so frequently asked '…at what age does a child become an adult?' by itself reflects the surprisingly low level of clinical legal knowledge of the healthcare workforce in this century. These lacunae in clinicians' knowledge of the legal context of their patient's presentation to the NHS and social care should concern educators and regulators.

Our demography therefore may also benefit those considering the education of the medical workforce in clinical legal matters. Healthcare law as taught to clinicians in the UK focusses perforce on basic legal notions; consent, confidence, ownership of tissue, parental responsibility, etcetera. But apart from the very occasional well publicised sally into case law (*Montgomery*[13] as an exceptional example) only the principles distilled from these cases are broadcast to either students or practitioners of the regulated professions. The rich factual context provided in law reports of judgments is rarely presented to the clinician, and the fact that many decided cases follow a recognisable contextual pattern is thus entirely lost in the broadcast of bare principles to clinical staff. In every clinical legal subject area, the number of enquiries related to 'unusual' legal contexts eclipsed in frequency the predictable 'bare principles' questions (See Table 2). Nowhere in the current clinical legal teaching will you find guidance on dealing with the patient with a personality disorder who continues to swallow sharp objects. What our demography adds is the clinical context in which such a legal phenotype presents. Equally interesting are the enquiries that were not made, although we concede that there is a difference between what clinicians want to know when compared with what they need to know.
One of our early findings is a tendency amongst clinicians not to disclose feasible alternatives to treatment[14]. Despite having identified 24 enquiries into the substance of disclosure for consent, not one related to proffering alternatives.

We acknowledged in Methods some potential limitations to our development of the taxonomy. Most evident is the initial broad categorisation into nine domains at the outset. An initial set of domains was necessary to manage a dataset of an unknown size at the outset in 2012, and the nine broad clinical legal domains seemed a reasonable approach. But medicine itself is not easily classified, nor neatly filed. Take the 15-year-old with a personality disorder whose ingested button battery impacts above cricopharyngeus and erodes into her aberrant right subclavian artery resulting in death by exsanguination. Is her case best classified in psychiatry, foreign body ingestion, oesophageal perforation/fistula, vascular anatomical variant; or safeguarding? Does anyone presume to assert the most significant feature of her story? Hence our difficulty in filing clinical legal enquiries straddling numerous clinical legal domains. It maybe that an alternate set of domains may be equally appropriate, or that in the future these domains can be revised and improved based on further data. An example of the stepwise iterative development of such a taxonomy can be found in the field of outcome measures research.[15]

We acknowledge that the extent to which UK demography is replicated in other cultures and legal frameworks is unknown. The identification of clinical legal demographic patterns will allow us and others to focus upon the subjects relevant to our own cultures and fields of medicine, and resolve the interplay of clinical, ethical, and legal factors. The latter are in Western Europe very often articulated in terms of human rights.[16] In other legal, ethical, and cultural traditions, clinical legal phenotypes may be markedly different. But in any tradition, once the local demography is described, relevant clinical legal phenotypes could be recognised and resolved more quickly and effectively than they are at present. We believe the demography to be important since it is applicable to all clinical disciplines in all clinical settings; and useful because phenotype ('pattern') recognition forms the familiar foundation for clinical practice.

We hope that knowledge of what clinicians want to know in this field of clinical practice will help authorities to focus more closely on phenotypes which are rarely taught; but nevertheless, self-evidently, important to practitioners. Insight into a different dimension of the patient's clinical presentation facilitates treatment, so we hope that the illustrations we provide of clinical legal phenotypes will stimulate academic lawyers, ethicists, and clinicians to work collaboratively to identify new practical solutions to what in many circumstances are grave human dilemmas.

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Table 2. Demography of clinical law. (Number of enquiries in each phenotype)

1. Mental Disorder
Search under MHA (1)
Physical treatment under (15)
MHA 1983 general Q (18)
MHA Absconders (3)
Self- harm/suicide on NHS premises (2)
Awaiting Tier 4 beds (3)
Capacity in MHA (7)
MHA logistics (4)
Self-harm and swallowing FB (13)
Fabricated illness (7)
Therapeutic privilege (2)

2. Parents & Children
Refusing to withdraw on any grounds (4)
Surrogacy decisions (5)
Gender dysphoria clinical (3)
Compelling children (non transfusion) (11)
Conflicts over PR/Questions on PR (34)
Distinguishing child/YP/adult (7)
Incompetent children (8)
Using welfare checklist (19)
Parents opposing Rx (25)
LA role in PR (10)
Withdrawal at any age of childhood (16)
Child excluding parents (3)
Restraining children (14)
JW Transfusion [any age] (20)
Paternity (2)
Unlawful separation child from parents (3)
Competence v capacity (5)
Teenage pregnancy and aftermath (6)
Children for simulation (1)
Circumcision [M/F] (2)
Parents performing clinical activity (1)
Saviour siblings (3)

3. Incapacity
Religious reasons against withdrawal (1)
Next of kin (14)
ADRT generally (26)
MCA v MHA for physical Rx (11)
Compelling Rx non-MHA (22)
Sterilising incapacity/capacity (6)
Vulnerability (9)
Fluctuating capacity (2)
Enteral feeding (2)
Promoting capacity (3)
Doubt over veracity LPA/GPA/OPA (26)
Persistent disorder consciousness (8)
Incapacity & capacity (including sex) (72)
Amputation in incapacity (11)
Incapacitated by fear / Needle phobia (7)
DOLS/adult restraint (34)
Deputies/Responsible persons (7)
Best interests catch all (46)
Bad faith/Un-befriended /IMCA (20)

4. Consent for treatment
Recording consent (38)
Substance of disclosure (24)
Delegation of consent (9)
Capacitous P refusing Rx (21)
Failure to get consent (10)
Consent for untried technology (6)
Consent by children (15)
Late withdrawal of consent (2)
Consent logistics (16)
'Rolling' consent for future treatment (8)
Consent for genetic management (3)

5. Disclosure of private information
Consent for disclosure (5)
Access to health records (15)
Disclose to police/authorities/Courts (19)
Disclosing children's records (21)
Health record confidentiality (42)
Competent YP refusing disclosure (4)
Virtual consultations (3)
Confidence of deceased (7)
Amnesiacs/incapax/HIV/Alcohol (11)

6. 'Other Statutory'
Safeguarding (13)
Abortion (2)
Public Health (1)
Fertility (3)
Discrimination (9)
Domestic Violence/aggression/threatening (26)
Freedom of information (1)
Gender recognition (9)
Aggressive photography and recording (5)
Banned cannabis Rx (1)
Relationship to legal authorities (41)
Coronial/suicide (5)
Holding confiscated drugs/materials (1)
ECHR considerations (specific) (3)
Tissue/damage to corpses/transplant (29)
Prohibition FGM (2)
Suspected offenders on premises (3)

7. Regulated Practice
CANH or SMT withdrawal (8)
National jurisdiction (1)
Consent for HIV testing (2)
Wrongful financial inducements (1)
Candour (42)
Discharging patients (10)
Part payment for NHS Rx (4)
Disclosing criminal P behaviour (11)
Legal privilege (1)

8. Professional Practice

Standard of care (63)
Doctors declining to treat patient (16)
Standard for recordings (5)
Patient seeking to reverse treatment (2)
P demands particular doctor (7)
Unsafe swallow in P seeking to drink (8)
DNACPR (22)
Withdrawal /palliation in adults (14)
P refuses a particular clinician (2)
P making unsafe demands (21)
Sterilising P with capacity (1)
Anaesthetising in P's home (2)
Capacitous absconded (1)
Smoking on home Oxygen (5)
Dignity (1)
Covert medication (1)
Commercial enterprise for hospital (5)
Doctrine double effect (1)
Professionalism (26)
Verifying death (1)
Mother chooses hazardous delivery (7)
Sanctity of life (1)
Dealing with incidental findings (4)
Duty of care (5)
Defamation of clinicians by patients (1)
Doctor treating claimant P (3)
Altering hospital records (9)
Assisted Dying (6)
Charging visitors/ NHS P abroad (9)
Wills & legal instruments (4)
Prescription/dispensing (5)
Policies & Guidelines (4)
CRB checking (1)
Doctors treating relatives (2)
Research/audit/Service evaluation (2)

9. Clinical Practice

Dealing with suspected offenders (1)
Resuscitation/ escalation planning (2)
Trialling innovative equipment (9)
Response to scarce resources (8)
Research/audit/service evaluation (1)
Funding exceptional treatment (13)
Commercial enterprises for hospital (5)
Dispute resolution (2)
Interpretation +/- in bad faith (4)
CV19 exigencies (35)
Clinicians as addicts (2)
Developing Clinical Ethics Services (5)
Pregnancy testing prior to surgery (1)
Extraordinary requests (GA for haircut) (9)
Prioritising private patients (1)

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