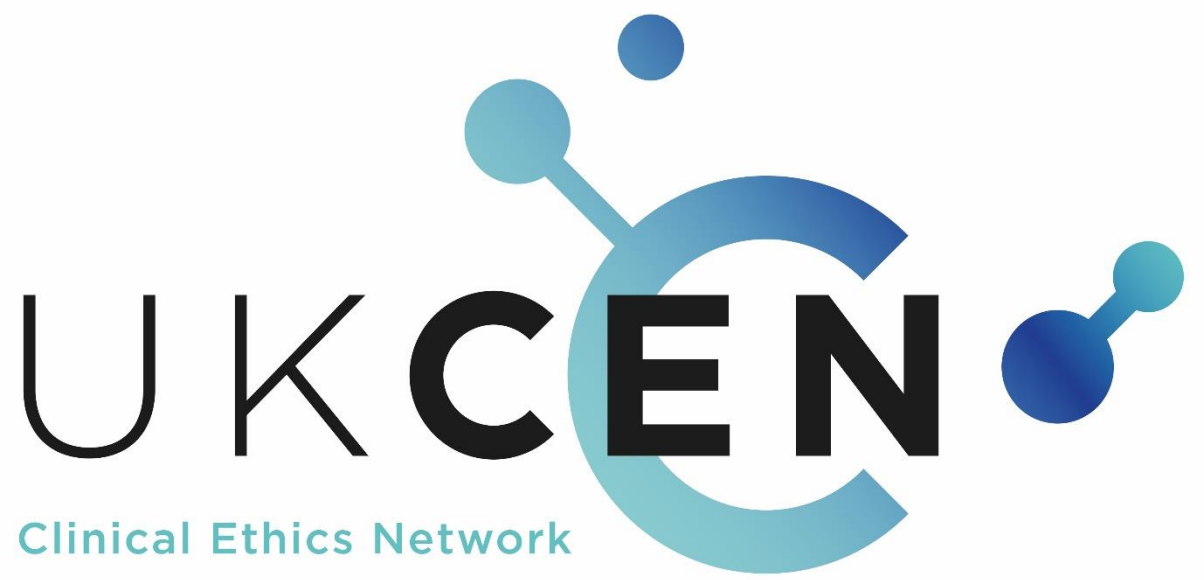

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ETHICAL FRAMEWORKS FOR CLINICAL ETHICS

Prepared by Mikey Dunn, Mark Bratton, Richard Huxtable & Harleen Johal on behalf of the board of trustees of the UK Clinical Ethics Network

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ETHICAL FRAMEWORKS FOR CLINICAL ETHICS

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INTRODUCTION

"For learners and clinicians, use of an analytical framework can help to identify the ethically important aspects to a clinical situation and provide a method for explaining and justifying decisions."

Manson, The development of the CoRE-Values framework as an aid to ethical decision-making. *Medical Teacher* 2012; 34(4): e258

Various approaches have been proposed to undertake clinical ethics case consultations in a structured way. In this document, you will find some examples of **ethical frameworks** that you might wish to adopt when advising on cases.

This document is designed to help you to differentiate between different frameworks, and then to consider how the main frameworks might be applied, in a practical way.

If you are joining a clinical ethics service, such as a Clinical Ethics Committee, you will likely find that the committee adopts one of these frameworks, or a variation of it. If not, you might want to consider implementing one of these frameworks to shape case consultation work on your committee.

WHY USE AN ETHICAL FRAMEWORK?

Ethically challenging situations in clinical practice often feature disagreement about the right thing to do. Resolving the disagreement requires someone to recommend an ethical course of action, and then others to reach agreement on whether to adopt this course of action, or whether to propose something different.

After deliberating, a clinical ethics support service, such as a Clinical Ethics Committee (CEC), will sometimes advise on a single course of action. Occasionally, however, the committee might advise that there is more than one defensible option.

Proposing an ethical course of action (or more than one) involves explaining why this action is ethical – this explanation is known as an ethical argument. Good ethical arguments can help resolve ethical uncertainty and it is possible that we can accept and endorse the reasoned conclusion that an argument gives us, even if significant ethical disagreement between different stakeholders continues to exist.

There are various ethical frameworks available, which can aid a CEC in its deliberations. Ethical frameworks are designed to structure our thinking processes to help to us to come to a decision, which we can justify ethically and then communicate to others. A framework also offers a step-by-step approach for a CEC to adopt when analysing an ethical question and developing an ethical argument to support a recommended course of action. There are three main reasons why adopting an ethical framework is necessary in the context of giving ethical advice within a clinical setting: consistency, transparency, and improving ethical rigour in communal deliberation.

Consistency:

Using a framework is an important way of making sure that clinical decisions, or the advice of an ethics committee, are consistent. If you are faced with a decision in a case, and you remember having decided a very similar case, which you felt was justifiable and right, then it stands to reason that if you follow a similar decision-making procedure you should make a similar decision in the case before you. The only justification for making a different decision would be if, during the procedure, you identified some ethically relevant differences. It makes sense that like cases should be treated alike, and different cases should be treated differently if those differences are ethically relevant. If your decision is going to be a justifiable decision, then you need to come to it in a way that is informed and consistent. An explicit process for decision-making can help to ensure this.

Transparency:

Using a framework helps to ensure that clinical decisions are open and transparent because it forces you to make your ethical reasoning and discussion explicit. A clinician or a committee may well have made the right decision for the right reasons, but the decision will be difficult to justify, and be seen as trustworthy, if the reasoning process which led to the decision remains obscure. It is only by making our reasoning process transparent that we can make our decisions properly accountable.

Improving ethical rigour in communal deliberation:

In addition to these two procedural rationales, there are also substantive, ethical reasons for adopting a framework-based approach. Health care is a value-laden and value-driven activity, but these values often remain implicit and unarticulated in discussions of health care practice. Too often, people talk past each other or don't engage at all because they don't know, ethically speaking, "where people are coming from", or because they want to avoid conflict in their personal or professional lives.

It is only within a framework that requires us to make values – our underlying motivations for action – explicit that we can find a shared, common and well-reasoned strategy to deliberate with each other about what is important in the face of an ethical dilemma, to identify any differences we might have, and then to seek to resolve those differences.

CONFIRMING THAT YOU ARE DEALING WITH AN ETHICAL QUESTION

The ethical frameworks described below are concerned with fostering structured deliberation about ethical questions, not clinical or legal questions. It is not uncommon for a Clinical Ethics Committee (CEC) to recognise, prior to commencing its discussion, that the core question it has been asked to advise on is not, in fact, an ethical question at all. Thus, before applying one or more ethical frameworks, a CEC needs to be sure that it is dealing with an ethical question.

An ethical question is one that is concerned with what should be done when there are good reasons for more than one course of action, when no single course of action is clearly right. (Sometimes, the ethical course of action will be the "least worst" option.) In CEC work, we are interested in *practical* ethical questions – questions that arise when we are uncertain what we ought to do in a specific health care context. This might be a clinical scenario that arises in practice, or it might be a new policy designed to be implemented in practice.

"What should I do in these circumstances?" is a practical ethical question. This question is not the same as:

- What am I legally permitted to do?
- What do policies or regulations require of me?
- What do most people think I should do?
- What does the clinical evidence suggest?
- What is the way we are accustomed to act in this situation?

It can be difficult to completely separate ethical questions from legal, policy, or clinical questions, and rightly so. Good ethics will often depend on obtaining clarity about relevant facts and sensitivity to the political and legal context of decision-making. But answering an ethical question is not the same as answering a clinical or legal question.

There are also different types of ethical question that CECs become involved in. In particular, the question might revolve around:

- An ethically challenging case scenario ("what is the right thing to do when making this healthcare decision in practice?"), or
- An ethically challenging formulation of local health policy ("what is the right policy to shape practice in more general terms?").

We would like to emphasise that the ethical frameworks presented below are concerned with the first of these types of question – those relating to the practice of providing ethical advice in a case consultation. Providing ethical advice in local health policy-making requires either a different kind of ethical framework to be used, or the tweaking of the frameworks below to enable them to capture policy-related ethical considerations explicitly.

TYPES OF FRAMEWORK

Frameworks for the ethical analysis of clinical cases have been developed and refined over decades, in different parts of the world and in ways that reflect different philosophical traditions. Some of these frameworks have their heritage in other contexts – in approaches to teaching medical ethics, or in conducting medical ethics research, for example. Other frameworks have been tailored especially for the demands of clinical ethics consultation or committee work.

Below, we introduce a selection of the main frameworks, focusing especially on those that are frequently practiced in the UK clinical ethics context. We will also provide some information about the heritage of each framework and outline their basic structures. We will further flesh out the operationalisation of each framework by applying them to a common case study.

Before outlining the frameworks, it is helpful to identify an important distinction between the types of framework available. Broadly these can be subdivided into ***substantive*** frameworks and ***procedural*** frameworks.

In **substantive frameworks**, the framework focuses its deliberative requirements around a core set of normative ethical values. These might take the form of formal principles or a set of relevant ethical considerations upon which the framework is founded. In this category, the frameworks require the members of a clinical ethics service to ensure that all the relevant values are given due consideration, or weighted appropriately, in the decision-making process. The **Four Principles Framework** and the **Four Quadrants Framework** are examples of substantive ethical frameworks.

In **procedural frameworks**, no ethical content (specific ethical values) is provided in advance to guide the deliberative process within the framework. Instead, the framework is built upon several required procedural steps that provide a step-wise method for ethical reasoning. In this type of framework, the defensibility of the ethical advice provided is founded in the clinical ethics service's adherence to these procedures. The normative force of these procedures (i.e., why we ought to follow the requirements in turn) differ across the frameworks. In some frameworks, these procedures capture well-recognised standards of justification and argumentation in ethical analysis; in other frameworks, the procedures require different stakeholders' ethical views, intuitions or experiences to be given due consideration in the reasoning process. It is important to recognise that procedural frameworks still require consideration to be given to ethical values in the deliberative process. It is just that these values are not pre-specified in advance, nor do they provide the core foundation upon which the framework is built. The **Ethox Approach** and the **ABC Toolbox** are examples of procedural frameworks.

We next outline a case study before going on to provide worked-through examples of how each of the different frameworks would approach the ethical analysis of this case. Please note that, for each framework, we offer the beginnings of the analysis, but do not intend to offer definitive answers.

CASE STUDY

Mrs Y is 56 years old and has a learning disability. She is admitted to hospital with an ovarian cyst. The cyst is blocking her ureter and, if left untreated, will result in renal failure. Mrs Y would need an operation to remove the cyst. Mrs Y has indicated quite clearly that she does not want a needle inserted for the anaesthetic for the operation to remove the cyst – she is uncomfortable in a hospital setting and is frightened of needles.

The clinician is concerned that if the cyst is not removed, Mrs Y will develop renal failure and require dialysis, which would involve the regular use of needles and be very difficult to carry out given her fear of needles and discomfort with hospitals. The anaesthetist is concerned that if Mrs Y does not comply with the procedure, then she would need to be physically restrained. Mrs Y's niece visits her in the care home every other month. The niece is adamant that her aunt should receive treatment.

Ethical Question: Should the surgeon perform the operation despite Mrs Y's objections?

THE FOUR PRINCIPLES OF BIOMEDICAL ETHICS

"As its tenacity attests, the [four principles] approach is bound to be attractive to the time-pressed clinician, the trainee and the members of clinical ethics committees, whose work will unavoidably involve ethical evaluation, but who cannot enjoy the relative luxury of immersion in moral philosophy."

Huxtable, For and Against the Four Principles of Biomedical Ethics. *Clinical Ethics* 2013; 8: 39

The Four Principles: An Overview

The four principles approach was developed in the USA by Beauchamp and Children, in their book *Principles of Biomedical Ethics* (8th edition, 2019). Since the first edition appeared in 1979, the framework has become widely known. Whilst this approach is typically applied as a broad framework for ethical reasoning in medical ethics research and teaching, as Huxtable notes, the framework may also be useful to clinical ethics services.

As its name implies, the approach invites reflection on four ethical principles, which we have slightly adapted here, in order to make links with the work of Clinical Ethics Committees (CECs):

Respect for autonomy: This principle means respecting the decision-making capacities of autonomous persons; enabling individuals to make reasoned informed choices. The principle is sometimes described in terms of respect for patients as persons, or in terms of respecting a person's right to self-determination. Respect for autonomy requires the CEC to attend to the patient's personal values and commitments in life, usually identified in expressions of their preferences. It also requires the CEC to consider the patient's ability to make decisions, and, if the patient lacks the capacity to make the specific decision, what their preferences and values would likely point towards in this clinical scenario.

Beneficence: This principle captures the requirement for the healthcare professional to act in a way that benefits the patient. It requires consideration of how best to balance the benefits of treatment against any risks and costs. The principle can work in tandem with the principle of non-maleficence.

Non-maleficence: This principle requires the healthcare professional to do no harm to the patient. It has a long history, dating back at least to the Hippocratic injunction, "first, do no harm" (primum non nocere). All treatment is likely to involve some harm, even if minimal, but the harm should not be disproportionate to the benefits of treatment.

The principles of beneficence and non-maleficence together capture the obligation to act for the overall benefit of a patient or patients. Adhering to these principles requires the CEC to think carefully about the beneficial and harmful consequences of potential treatment options from the perspective of the patient.

Justice: There are many different accounts of what justice is and what it requires. Broadly, and especially in ethical issues within patient care, justice involves considering the fair distribution of benefits, risks and costs. It is focused on the idea that patients in similar positions should be treated in a similar manner.

This principle requires the CEC to consider questions of fairness in the clinical scenario. CECs should be alert to considerations of formal and procedural justice (e.g., aspiring to consistency and having clear processes). Some consideration of different political philosophical theories of health justice will be required, as there are different ways to configure the requirements of justice or fairness across these theories. Sometimes specific questions of distributive justice will arise. A concern with justice in this sense recognises that the wider impact of choices should be considered in any decision. This might involve considering whether the options available impact unfairly on other patients and society at large.

Applying the Approach

Here we outline how this framework could apply to the case study. Please note that this is only the beginning of the analysis and is not intended to offer a definitive answer. We indicate how each principle might apply, but the analysis is unlikely to stop there. For example, if the principles point in different directions, then more work will be needed to work out where the balance should fall.

Respect for autonomy: The principle of respect for autonomy entails taking into account and giving consideration to the patient's views on their treatment. Autonomy is not an "all-or-nothing" concept. Mrs Y may not be fully autonomous and she might, legally, lack the capacity to refuse treatment. But this does not mean that, ethically, her views should not be considered and respected as far as possible. She has expressed her wishes clearly; she does not want a needle inserted for the anaesthetic. An autonomous decision does not need to be a decision that other people – such as clinicians – consider to be "wise" or objectively the "right" decision, otherwise individual needs and values would not be respected. However, an autonomous decision is one that is informed – has Mrs Y been given enough information, in a manner that she can comprehend?

Beneficence: The healthcare professional should act to benefit their patient. This principle may clash with the principle of respect for autonomy when the patient makes a decision that the healthcare professional does not think will benefit the patient. Here, we should consider both the long-term and short-term effects of overriding Mrs Y's views. In the short-term, Mrs Y is likely to be frightened to have a needle inserted in her arm and to be in hospital – this may lead her to distrust healthcare professionals in the future and to be reluctant to seek medical help. In the long-term, there will be a benefit to Mrs Y in receiving the treatment. Without treatment, she will suffer serious and long-term health problems that would require greater medical intervention (ongoing dialysis) than the treatment required now (operation).

The benefits of acting beneficently would need to be weighed against the ethical wrong of failing to respect Mrs Y's autonomy. (From a legal point of view, the wishes of a patient who has capacity cannot be overridden in their best interests).

Non-maleficence: This links with the famous Hippocratic teaching, "first, do no harm" to the patient. Here, Mrs Y would be harmed by forcibly restraining her in order to insert the needle for anaesthesia. Yet, if Mrs Y is not treated now, she will require ongoing dialysis a number of times per week. If she does not comply with dialysis, this would be impractical to administer and she may need to be restrained. Which course of action would result in the greatest harm? This assessment relies on

assumptions: how successful is the operation likely to be, and how likely is it that Mrs Y will comply with dialysis?

Justice: It may be relevant to consider the cost-effectiveness of the treatment options for Mrs Y, and the impact the decision about her treatment will have on the availability of treatment for others (such as those who are awaiting dialysis).

A Method for Balancing the Principles: As is illustrated above, the principles are general guides, which leave considerable room for judgment in individual cases. Beauchamp and Childress recognise that there may be cases where the principles come into conflict. Indeed, we would go further; one commonly defining feature of an ethical issue in healthcare practice can be explained by a conflict between two overarching ethical principles – i.e., a genuine ethical dilemma, where it is simply not possible to do what one ought to do. In these scenarios, Beauchamp and Childress recommend following a process of "reflective equilibrium", which was first outlined by John Rawls in his book *A Theory of Justice* (revised edition, 1999) and is described in detail in *Principles of Biomedical Ethics* (8th edition, 2019). As an overview, this method involves moving back-and-forth between moral beliefs and judgments, the principles, and background ethical theories, seeking to achieve coherence by bringing these different elements into balance.

THE FOUR QUADRANTS APPROACH

"… a framework designed to facilitate systematic identification and analysis of clinical ethics problems. It is a kind of ethical stethoscope, increasing the clinician/ethicist's ability to see what is morally relevant while revealing, at the bedside, the moral dynamics of the case."

Sokol, The "Four Quadrants" Approach to Clinical Ethics Case Analysis: An Application and Review. *Journal of Medical Ethics* 2008; 34; 513

First published in 1982, the "four quadrants" approach was developed in the USA by Jonsen, Siegler and Winslade, in their book *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine* (9th edition, 2021). As Sokol notes, the approach may be particularly useful to clinical ethics services.

The Four Quadrants: An Overview

As its name implies, the approach invites reflection on four quadrants, which should be worked through in order. These four quadrants guide the committee to attend to specific domains of ethical consideration:

- **Indications for medical intervention:** What is the diagnosis? What are the options for treatment? What are the prognoses for each of the options?
- **Preferences of the patient:** Does the patient have mental capacity or competence? If so, what do they want? If not, then what is in the patient's best interests?
- **Quality of life:** Will the proposed treatment improve the patient's quality of life?
- **Contextual features:** Do religious, cultural and legal factors have an impact on the decision?

Applying the Approach

Here we outline how this framework could apply to the case study. Please note that this is only the beginning of the analysis and is not intended to offer a definitive answer. We indicate aspects of Mrs Y's case that are relevant to each of the quadrants, but the analysis is unlikely to stop there. For example, if the quadrants point in different directions, then more work will be needed to work out where the balance should fall.

Medical indications: Mrs Y has been diagnosed with an ovarian cyst and so the options for treatment should be considered. What is the prognosis with the operation, considered against the prognosis without treatment (or with ongoing dialysis)? If she does not have the operation and requires dialysis, is this going to be manageable? Will Mrs Y be able to get to hospital many times a week and will this interfere with work or caring commitments she may have?

Patient preferences: Mrs Y has a learning disability. This does not mean that she automatically lacks capacity to make a decision about her treatment. The capacity of an adult patient should be assumed but, in cases of doubt, this may be assessed. If Mrs Y has capacity, she is entitled to consent to, or refuse, treatment. If Mrs Y is

found to lack capacity, then the decision about her should be taken in her best interests. It is arguably in her medical best interests to have the operation, but it is not necessarily in her interests to forcibly restrain her in order to carry out the treatment. The various benefits and risks need to be balanced to arrive at a decision about which course of treatment to follow.

Quality of life: Will the operation improve Mrs Y's quality of life? It is a one-off treatment that, if all goes to plan, will return her to her previous standard of health.

Contextual features: Are there any religious or cultural factors here that may be relevant? What care will Mrs Y receive after the operation? To what extent will Mrs Y's niece continue to provide support? It would be useful to know if there is any particular reason why Mrs Y is so frightened of needles and why she feels uncomfortable in hospitals?

THE ETHOX STRUCTURED APPROACH

"To facilitate a structured ethical assessment of the clinical decision-making process, CECs apply the Ethox structured approach, a tool that divides ethical decision-making into … distinguishable steps."

Garcia-Capilla et al, The Development of a Clinical Policy Ethics Assessment Tool. *Nursing Ethics* 2019; 26: 2259

First published in the Network's *Practical Guide* in 2004, the Ethox structured approach was developed by Mike Parker, Anne-Marie Slowther and colleagues at the University of Oxford. As Garcia-Capilla and colleagues note, the framework is used by some UK clinical ethics services.

The Ethox Structured Approach: An Overview

This framework puts forward 11 progressive stages to work through when deliberating about a case:

1. What are the relevant clinical and other contextual facts (e.g., family dynamics, GP support availability)?
2. What would constitute an appropriate decision-making process? Questions to consider include: Who is to be held responsible? When does the decision have to be made? Who should be involved? What are the procedural rules (e.g. confidentiality)?
3. List the available options.
4. What are the morally significant features of each option? Questions to consider include: What does the patient want to happen? Does the patient have capacity (is the patient competent)? If the patient lacks capacity or competence, what is in their "best interests"? What are the foreseeable consequences of each option?
5. What does the law and/or guidance say about each of these options?
6. For each realistic option, what are the moral arguments in favour and against?
7. Choose an option based on your judgment of the relative merits of these arguments using the following tools. Are there any key terms the meaning of which needs to be agreed (e.g. "best interests", "person")? Are the arguments valid? Consider the foreseeable consequences (local and beyond). Do the options "respect persons"? What would be the implications of this decision if it were to be applied as a general rule? How does this case compare with other cases?
8. Identify the strongest counter-argument to the option you have chosen
9. Can you rebut this argument? What are your reasons?
10. Make a decision.
11. Review this decision in the light of what actually happens, and learn from it.

The authors have also prepared a flowchart indicating the key stages, which you can download from the UKCEN website.

Applying the Approach

Here we outline how this framework could apply to the case study. Please note that this is only the beginning of the analysis and is not intended to offer a definitive answer. This is a procedural framework, which does not specify the ethical considerations to take into account, so it is possible that a clinical ethics service might identify additional or alternative ethical dimensions, which could influence the advice that is ultimately given.

Stage 1 – The relevant facts: Without treatment, there is a substantial risk that the ovarian cyst blocking Mrs Y's ureter will result in renal failure and the need for dialysis involving the regular use of needles. Mrs Y's clinicians agree that Mrs Y needs an operation to remove the cyst. Mrs Y seems to suffer from 'needle phobia' and does not want any needles used on her. She is also uncomfortable in a hospital setting. She has a learning disability, but it is unclear whether her capacity to make this treatment decision has been assessed (we should not presume that Mrs Y lacks the capacity to make this decision simply because she has a learning disability). Mrs Y is visited by her niece monthly, who passionately believes that her aunt should receive treatment, although it is not clear how close their relationship is. These uncertainties need to be clarified. There are several perspectives to consider: the clinicians who have a professional duty of care towards Mrs Y; Mrs Y's niece; and Mrs Y herself.

Stage 2 – The decision-making process: If Mrs Y's clinicians doubt that she has legal capacity to consent to treatment, then this may be assessed. If she has capacity, then she is entitled to refuse treatment. If she lacks capacity, then her clinicians have a legal, ethical, and professional duty to treat her in her best interests. They are responsible for balancing the benefits of a timely operation against the burdens of forcible restraint if Mrs Y is non-compliant. In making this decision, Mrs Y's clinicians will need to take Mrs Y's views and wishes into account even if they are finally overridden. They will need to consider Mrs Y's prognosis with an operation and without an operation, including ongoing dialysis. They will also need to consider the practical effects of dialysis on Mrs Y's life

Stage 3 – The options: There are a wide range of options for action in this case. These include:

- Option 1: Not performing surgery.
- Option 2: Performing surgery.
- Option 3: Delaying a decision until the contextual factors – needle phobia and discomfort with hospitals – are assessed.

Stage 4 – The morally relevant features: There are various morally relevant values and principles. The autonomy of Mrs Y is a relevant factor, as is her physical and psychological integrity, especially if her autonomy is reduced by her learning disability. There is a risk that physical restraint will cause her harm, but there is also a substantial possibility that she will be harmed if she does not receive surgery and is required to undergo dialysis, which will use up resources that might have been employed for other needy patients. There is also the possibility that treating Mrs Y without her agreement may undermine the relationship of trust that should exist between patients and clinicians. There is also a danger that the relationship between Mrs Y and her niece may be damaged if Mrs Y discovers that her niece was in

favour of surgery and was seen to be “colluding” with the clinicians. Clinicians have a duty to treat patients in their best interests if they lack capacity to refuse treatment, considering medical and non-medical factors. This duty of care is qualified, however, where a properly informed patient with the capacity to do so makes a free choice to refuse treatment.

Stage 5: Law and guidance: If she has capacity to make the relevant decision, Mrs Y has an unqualified right to refuse medical treatment, even if the refusal leads to harm or loss of life. This treatment refusal can be contemporaneous or take the form of an “advance directive”, which functions as if the decision were contemporaneous if it is legally valid and applicable. If Mrs Y lacks legal capacity, clinicians have a legal obligation to act in her “best interests”, a concept which synthesises medical and non-medical factors, including third-party evidence relating to the patient’s putative views. Her niece’s perspective on her (Mrs Y’s) beliefs, wishes, values etc. might be relevant in this case.

Stage 6: Arguments for and against each option: There are arguments for and against each of the three options noted above:

- Option 1: Deciding not to operate would respect Mrs Y’s autonomy and/or her physical and psychological integrity. However, not operating would put Mrs Y’s life and health at risk and subject her to repeated invasions of her physical and psychological integrity in the future.
- Option 2: Deciding to operate would promote Mrs Y’s clinical best interests and reduce or eliminate the need for dialysis. It would also promote her emotional and psychological best interests by reducing the need for invasive treatment in the future. However, operating would go directly against Mrs Y’s express wishes and risk undermining the relationship of trust between clinician and patient. This might affect Mrs Y’s willingness to comply with medical advice in future.
- Option 3: Discussing Mrs Y’s reasons for refusing anaesthesia and feelings of discomfort in a hospital setting might allay her misgivings about treatment and lead to agreement with medical advice. The only good reason not to explore these contextual factors would be where it was necessary to operate immediately. If Mrs Y’s concerns are addressed and fears allayed, then – whether she has capacity or not – there would be no barrier to proceeding with the operation.

Stage 7: Choosing an option: The main ethical issues guiding this decision are autonomy, best interests, resource allocation and trust between clinician and patient. Although there are good ethical arguments for and against the first two options, in this case, there is a practical response (Option 3) that will help to clarify the next step – whether to operate.

Stages 8 and 9: Identify the strongest counter-argument to the option you have chosen; can you rebut this argument? What are your reasons?: This stage involves looking at the arguments for and against each option again and picking the strongest argument against the option you have chosen (assuming there is more than one). Once you have identified the strongest counterargument, you should then consider whether it is sufficiently strong to make you change your choice of option at Stage 7. If, as a result, a different option is chosen, then this stage needs to be repeated until a settled opinion is reached.

Stage 10: Decide: Clinicians and ethics services reach a decision (or formulate their advice) preferably and usually by obtaining consensus between the members. If no consensus can be obtained, then voting can be used. Clinical Ethics Committee decision-making is a form of public ethics, in that individuals need to be prepared to endorse collective advice which, if left to you individually, you might not have made. Remember here that you are not making the decision about what ethical course of action should be enacted. Rather, you are deciding what the form of advice offered to the clinical team consists in.

Stage 11: Review: This is an underrated but deeply important stage. Having made the decision, and wanting to get on with things, you stop yourself and ask yourself: Have you given the right advice? Was this advice followed? Has the decision been made in good faith? Have you really taken all the morally relevant factors into account? The review can take place immediately after the clinical team have made the decision and in the light of the consequences that follow from making it. In this case, we can ask whether we would have given the same advice if we had known the outcome in advance. Once again, we should be careful here: not all advice will be ethically justified by recourse to the optimisation of an outcome. In some cases, the advice will be grounded on a claim about the (ethically) *right* course of action, rather than the (ethically) *best* course of action. When this is the case, proxy measures might need to be examined in the review process (for example, if the advice was grounded on the principle of respecting a patient's autonomy, then a possible measure of "success" might be whether the patient subsequently endorses the decision that was made).

THE ABC TOOLBOX

"Doctors, nurses, and other health professionals will normally have good reasons for doing what they do. It would be foolish not to give careful consideration to what experienced practitioners do and think is right. But the role of philosophy, and its application in medical ethics, is to demand reasons and to subject these reasons to careful analysis."

Dunn and Hope, *Medical Ethics: A Very Short Introduction* (2nd edn, 2018)

The ABC toolbox was developed in Singapore in 2013 by Michael Dunn to support clinical ethics decision-making on the frontline in time-limited settings. Originally developed as a teaching and learning tool for "in practice" ethical reflection amongst junior health professionals, it offers a straightforward, and easy to digest, approach to reasoning through ethical issues in clinical cases.

The ABC Toolbox: An Overview

The ABC toolbox is part of the materials that support the *Singapore Bioethics Casebook*. You can freely access the casebook here. Dunn has published some slides explaining the approach, which you can access here. You can also watch a video in which Dunn discusses the approach here.

The toolbox has three tools:

Tool A: Analysing facts and values: All care encounters involve both facts and values. No amount of evidence ("what is the correct dosage of this medication?") or legal knowledge ("what are the rights of patients concerning information about their care?") will resolve a conflict between values ("what is good/right?").

Once you have identified relevant facts, describe the values – the competing versions of good or right action – that are in conflict. Some values conflicts involve the interests of an individual patient or a smaller group versus the interests of a larger group; these conflicts are characteristic of decisions about how to allocate limited resources, for example. Other conflicts may involve values concerning what course of treatment is good or right for a single patient.

Tool B: Balancing principles and intuitions: The ethical values that a healthcare professional should adhere to in the care of the sick are long-established and widely recognised. One influential account, developed in the USA by Beauchamp and Childress, is known as the Four Principles approach.

There are, of course, many other accounts of the ethical principles and values that are important in healthcare. In the ABC Toolbox framework, no pre-specified list of principles is given; these can be chosen flexibly from other established accounts of values in health care, as the decision-making context demands. To protect against bias, a broad, inclusive and ecumenical approach should be adopted here. It is better to include too many irrelevant principles than to risk excluding an important

ethical value from consideration because those in the room have pre-determined views about which principles ought to be considered in such cases.

Separately from selecting relevant principles, people will also have gut reactions about what they believe ought to happen in each situation. This is true of the members of a clinical ethics service just as it is true of healthcare professionals themselves. These moral intuitions reflect the norms of our families, our traditions, our social environment, and our professional culture. Moral intuitions have a powerful emotional component; we can feel strongly that something is right or wrong, even if we have difficulty explaining why this is so.

Once again, in an ethically challenging situation, it is likely that principles will conflict with each other, and that principles and personal intuitions will also conflict. Resolving ethical conflicts involves applying principles to practice, and identifying trade-offs: in each situation, what are appropriate and inappropriate limits on autonomy in the interest of preventing harm, for example?

We also need to be prepared to challenge our own intuitions (or those of other people), and not act simply on gut instinct. This means more than simply developing rational arguments – the human mind is extremely good at finding arguments to justify our gut instincts. The goal of ethical reasoning is to reach broad, good-faith agreement with other people with integrity, on what course of action is consistent with ethically sound practice in the care of people who are sick. This process will, ideally, allay individual moral concerns. However, a perfect reconciliation of ethical principles and individual intuitions may not be possible.

Tool C: Comparing cases: When Tools A and B have been used to advise on a course of action that addresses the ethical questions, it is useful to assess how this decision compares to other situations – to test the ethical defensibility of the conclusion drawn. Is advice being provided in the same way as has been provided in similar situations, and would we be happy to provide the same advice in the future when faced with similar situations?

Case comparison is based upon the importance of consistency in ethical decision-making. If we decide to make different decisions in similar situations, then we must be able to point to an ethically significant difference between the situations.

A practice of comparing cases can also help to direct the modification of ethical recommendations moving forward, in addition to being a prudent retrospective check on the consistency of ethical reasoning. When faced with a new situation, we can ask ourselves and the clinical team presenting a case: what has past experience taught us about this kind of situation? What is similar, and what is different, about the situation at hand?

Case comparison is common in many legal systems, particularly those in which a doctrine of precedent operates. This essentially means that previous court decisions will determine the decisions that are to be made in later, similar cases. We can see the value of case comparison by considering briefly some high-profile legal cases. In so doing, we can examine what seems to be two different decisions being made by the courts in clinical scenarios that looked, on the face of things, very similar.

Comparing Cases: Charlie Gard and Tafida Raqeeb

Charlie Gard was a young boy with severe neurological damage. He required ventilation with no prospect of recovery. The hospital staff wanted to discontinue ventilation and allow him to die, but his parents wanted to take him to another country for treatment. The court found in favour of the hospital and ventilation was withdrawn.

Tafida Raqeeb was a five-year-old girl who also had severe neurological damage and similarly required ventilation with no prospect of recovery. The hospital staff wished to withdraw ventilation and allow her to die, but her parents wanted to take her to another country for treatment. The courts found in favour of the parents and the parents took their daughter to a hospital in Genoa where she settled in well.

The two cases bear some clear similarities. Why, then, would a judge endorse one course of action in one case, and an entirely different course of action in the other? Judges perform case comparisons *par excellence*, because what they are interested in, apart from the law, are the details of the case. They ask what it is it about the details of this case that might lead to the application of the law in a different way. Good ethical reasoning places the same demands on us.

Some of the differences in these two cases which might account for the different decisions, which may or may not be morally relevant, are:

- **Differences in age:** Charlie Gard was one year old and Tafida is a few years older – is that morally relevant? Perhaps it isn't morally relevant unless it is associated with something else.
- **The specific diagnosis is different:** Charlie had mitochondrial depletion syndrome, so he had a progressive neurological condition that was going to get worse. Tafida had an initial insult, a vascular bleed in her brain, so the specific diagnosis in each case was different. This may or may not be morally relevant.
- **The trajectory of the conditions was different:** Charlie Gard was going downhill rapidly. According to the law report, Tafida might live for another 10-20 years on ventilation. Perhaps that is a morally relevant difference.
- **The parents had different reasons underlying their preferences:** One of the reasons Tafida's parents gave was that the concept of the sanctity of life was important to them, as part of their personal values, as part of their religious values, thus there was a value to maintaining the life of the loved one, because they were still there as a person, that life was precious to them, and it wasn't up to the doctors, or the family, to make a decision about withdrawing treatment and allowing that life to end. In contrast, Charlie's parents wanted a treatment they thought would cure their son, or at least make their son better, and they had agreed with the hospital that, if that treatment wasn't available, then the burdens and benefits of treatment were such that they didn't want to carry on treatment. So, once they lost the case in terms of being able to transfer Charlie to have the treatment they thought might make a difference, they weren't then saying that they wanted Charlie to receive treatment, to be ventilated, until he died. So, the parents had different reasons. These are perhaps morally relevant reasons, and the values that inform the reasons would be morally relevant reasons for why the judge might come to a different decision.

- **Differences in the level of suffering and awareness of pain:** In Charlie's situation, his doctors thought he might be aware of and able to experience pain, even though he might not be able to communicate this. In Tafida's case, the court held that she might not be able to experience pain, so continuing treatment was not likely to cause her distress or pain; as such, when contrasting the burden of treatment compared to the benefit, the balance was viewed differently.

Applying the Approach

Here we outline how this framework could apply to the case study. Please note that this is only the beginning of the analysis and is not intended to offer a definitive answer. This is a procedural framework, which does not specify the ethical considerations to take into account, so it is possible that a clinical ethics service might identify additional or alternative ethical dimensions, which could influence the advice that is ultimately given.

Tool A: Our first step is to analyse the relevant facts and values in the case, and to identify any additional facts that are needed to engage meaningfully and properly with the ethical question. Here we know basic medical facts about Mrs Y: she has an ovarian cyst that, if untreated, is likely to lead to a negative health outcome. We might feel the need to inquire further about these risks: what is the likelihood of renal failure? What will the long-term consequences be of Mrs Y living with renal failure? We also know that Mrs Y has a learning disability, but we know little else about this. How severe is this disability? What is its impact on her daily functioning and decision-making? These are facts that are currently 'missing' in the case as presented. In relation to other, non-medical facts about Mrs Y: we know that she has expressed a clear preference against the insertion of the needle. We also have evidence from the clinician that restraint might need to be used. What is the source and reliability of this factual claim? We also have a view expressed by Mrs Y's niece. Has this been confirmed? What values might lie behind her adamant statement? We can also see immediately that a range of values are in play in this case: the value of realising a good health outcome; the value of adhering to Mrs Y's expressed preferences; the value in not using restraint.

Importantly, we see here that a case summary is only likely to be partially useful in terms of shedding light on the relevant facts and values. It is important, in applying Tool A, that we take time to seek out missing facts and values identified in the committee's initial discussions. This might involve one or more members of the clinical ethics service going on a fact-finding mission: speaking directly to the clinician involved, to Mrs Y's niece and, most importantly, to Mrs Y herself. It is right to acknowledge that there will always be imperfect information, particularly concerning future consequences of different options, but high quality ethical deliberation will always be founded on the back of the widest available information.

Tool B: Next, we turn to the critical stage of ethical reasoning within the ABC Toolbox: balancing principles and intuitions. It can be helpful here to start with clarifying the options, in light of the fact and value-gathering exercise now completed. Once complete, it can be useful to turn to raw intuition: to allow all committee members to express their immediate inclinations to what ought to be done. Are they in favour of one option or another? This approach can also help to ascertain whether

the full list of options have been articulated. It also gives an immediate “unreasoned” reference point for more detailed, analytic, structured reasoning.

It is then important to take an open-ended approach to specifying the relevant ethical principles (or wider values) that are applicable in the case scenario. It is likely that well-known substantive principles will be in play (such as those specified in the four principles approach), but the specification of principles should not be driven by an *a priori* commitment to specified principles, but rather identified by close reading of the case scenario. Here, we can see that questions about how to respect Mrs Y’s autonomy are in play, as are questions about beneficence: which course of action would lead to the optimal outcome for her? However, other principles can also be invoked as appropriate. Here, for example, a member of the clinical ethics service might outline a principle more commonly articulated in human rights discourse: a principle of taking the least restrictive alternative, given the worries about the use of physical restraint. Alternatively, the principle of respecting Mrs Y’s dignity might be brought to the table, again in light of concerns about the wrong of using restraint as a means of ensuring that Mrs Y receives the treatment she needs. In all cases, it is not sufficient to simply name the principle. It needs to be outlined clearly, and its application to the case needs to be specified carefully. Principled understanding also needs to be linked to the options identified. Does one or more principles support a particular option? Does the different specification of the principle point towards different courses of action? Is there a “principled conflict” in play between the different options?

If this phase of analysis reveals a genuine dilemma – where mutually exclusive options are underpinned by distinctive ethical principles – then further analysis is required. Once again, at this stage, it can be useful to return to intuitions: have people’s intuitions been modified in light of the analysis conducted so far? Is there an emerging consensus? What principled foundation underpins this consensus? If a principled consensus is still lacking, it will be important to examine the principles, and their relationship to the different options, in further detail. What *precise reasons* do we have for favouring one option over the other? Are these reasons well founded?

Tool C: At this point, the clinical ethics service should have come to a preliminary position about the broad shape of the advice to give, even if there remains dissensus between the members. Next, the members should embark on a process of case comparison to probe the solidity of their advice, and whether it is consistent in its form and structure. It can be useful first to start with real comparisons by asking members of the ethics service (or any members of the clinical team present) whether they have encountered similar situations in their practice, and how the comparable challenges were addressed. This has been illustrated above with comparison between the cases of Charlie Gard and Tafida Raqeeb. If different outcomes were chosen, for different reasons, this raises the spectre of inconsistency in reasoning. Such a comparison would require the committee to look closely at the comparative elements of both cases, and ask themselves: was there a good reason why these cases are to be considered differently? Here the outcome could be multiple, for example:

- there is good reason to a different approach;
- there is no good reason to adopt a different approach, and the previous comparable decision was wrong;

- there is no good reason to adopt a different approach, and the current advice being considered is wrong.

Once these real-world comparisons have been engaged in, the committee members can engage in “thought experiment”-type comparisons. They might pose questions like: imagine if Mrs Y did not have a learning disability, would we reason to the same conclusion? (Such a comparison could usefully function to examine whether the committee’s reasoning is shaped by biased views about the quality of life/decision-making capacity of a person with a learning disability.)

When Tool C has been completed, the committee should feel on firmer ground that their reasoning is sound and valid, through this exercise of probing the decision and scenario in its wider context. In part, this helps to ensure that the ethical argumentation undertaken in Tool B has not been influenced by irrelevant or biased considerations, and that any inconsistent advice being provided is grounded in the unique features or ethical features of the case scenario.