



CLINICAL ETHICS NETWORK

Registered with the Charity Commission (No 1120097)

Quick Guide to Setting up a Clinical Ethics Committee or Advisory Group During COVID-19

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1. INTRODUCTION

This document is designed to offer a quick guide to setting up a clinical ethics committee or clinical ethics advisory group (hereafter collectively referred to as CECs) during the COVID-19 pandemic. More detailed guidance from UKCEN can be found [here](#).

2. AIMS AND FUNCTIONS OF CECS

CECs are multidisciplinary groups, which can **advise** clinical teams on the ethical aspects of patient care. Whilst clinical ethics committees cannot make the final clinical decision, they can offer helpful advice to clinical teams. CECs can help teams to identify and articulate ethical questions, clarify ethical arguments, weigh up possible alternative courses of action, offer an external perspective on complex issues and, on occasion, challenge the clinical team on what might be felt to be potentially controversial courses of action. They can also support healthcare professionals dealing with the moral distress that they can experience when making ethical decisions.

When incorporated into the governance structure of the host organisation, formal clinical ethics support provides a valuable mechanism for the organisation to transparently and systematically address ethical challenges arising from clinical practice. The existence of a CEC within an organisation can promote positive patient perceptions of the organisational approach to the provision of clinical care.

CECs typically have three functions, the first two of which are likely to take priority during the pandemic:

1. **Policy Input:** Providing ethics input into policy and guidelines around patient care in your institution
2. **Case Consultation:** Providing ethics advice to clinicians on individual cases
3. **Education:** Facilitating ethics education for health professionals within your institution

3. COMPOSITION/MEMBERSHIP

CECs can provide an **independent, rich, multi-perspective view**, which can challenge, elucidate and inform the choices available to health professionals. In order to provide this, it is worth considering the range of disciplines, experience and backgrounds needed for your CEC.

Many UK CECs tend to have 10-20 members. We appreciate, during the pandemic, that membership might vary, but examples of typical membership include:

- Chair (see below):



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- Vice-Chair (see below)
- Doctors, from different specialties
- Nurses, from different specialties
- Other healthcare professionals e.g. Allied Health professionals, dieticians, pharmacists, psychologists
- A lawyer
- A medical ethicist or philosopher
- A chaplain or other faith leader/representative
- A patient or other user of the service
- Lay members i.e. someone who is not a practicing healthcare professional
- Administrative support (circulating case referrals, preparing minutes, booking meetings etc.)

The CEC should ensure it has a Chair and a Vice Chair. The Chair should be appointed (or, if elected by the CEC, approved) through local governance approval mechanisms. The Vice Chair may act as Chair in their absence and/or may lead a particular aspect of the CEC's work. The Chair and Vice Chair are often – but do not necessarily need to be – clinicians.

4. TERMS OF REFERENCE

At a minimum, terms of reference should outline:

- The **relationship** of the CEC to the host organisation and the scope of functions of the CEC within the organisation. This should be appropriately agreed with the host organisation. (Provision of adequate resources for the CEC to function within the host organisation should also be agreed including, as a minimum, rooms for meetings, IT support and administrative support.)
- The **purpose** of the CEC i.e. aims and objectives of the CEC
- The main **responsibilities and remit** of the CEC i.e. its functions and the scope of the support the CEC provides (including any topics/areas beyond the CEC's remit)
- The **process** for managing CEC activities e.g. the referral process for case consultation, including the process for handling urgent referrals (especially during COVID-19)
- Statements covering **accountability and governance** e.g. where (and how) the CEC reports
- Indicative **membership** and terms of service, including how members and the Chair are to be appointed, duration of membership, and roles and powers of any officers of the CEC including the Chair

Please see [Appendix 1](#) for an example template of Terms of Reference.



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5. INDEMNIFICATION

It is possible that the advice issued by a CEC will be acted upon by the referring clinicians and, in hopefully rare circumstances, this might lead to later **legal action** from a patient or family member. Institutions should ensure that CECs are legally protected e.g. the CEC and all of its members should be indemnified. Each institution should arrange this, ensuring (in particular) that external members are covered.

UKCEN would recommend that:

- CEC members who are not employed by the host institution are covered e.g. via honorary appointments at the institution
- A CEC should not seek to provide advice outside its host organisation without the explicit agreement of that host organisation and this should include assurance that such advice is indemnifiable. In general, such arrangements are possible between many NHS organisations.

6. ETHICAL FRAMEWORK(S)

An ethical framework can provide a **clear and consistent process** to enable the committee to analyse ethical issues. The framework can be deployed to work through ethical issues in specific clinical cases or to scrutinise the ethical aspects of policy documents.

There are a number of ethical frameworks that have been developed to assist with the provision of clinical ethics support, and you may choose from a number of these frameworks, depending on which approach the committee members find most useful. Examples of these approaches include the '4 quadrant approach', the '4C model' and the ETHOX framework. References outlining what these different frameworks involve are listed at the end of this document in [Appendix 4](#).

Colleagues in Melbourne have developed an [ethical decision-making tool](#), to help with planning for and managing COVID-19. More generally, new committees may find the **ABC Toolbox** to be a straightforward and efficient framework. This is a short, structured approach to thinking through ethical questions in care settings. Using the ABC Toolbox requires no formal training in ethics. Brief details of this approach are outlined in [Appendix 2](#) at the end of this document.

However, we appreciate that not all CECs choose to use an explicit ethical framework. The important thing to remember is that ethical problems are complex. A framework is not there to simplify but to draw out the complexity of the problem to ensure it is thoroughly considered from a wide range of perspectives.

7. CORE SKILLS AND COMPETENCIES

As discussed in this [article](#), all members of the CEC should have or gain relevant core skills and competencies. These include:

Personal characteristics/values of CEC members:

All members should be committed to such values as:

- Tolerance, patience and compassion (enabling different views to be held in difficult situations)
- Honesty, fair mindedness, self-knowledge, transparency and reflection (enabling recognition of personal limitations and development of trusting and respectful relationships)
- Courage and the willingness to advocate (enabling the voices of the weaker or more vulnerable to be heard, and dissenting views to be put to those in authority)
- Prudence and humility (allowing recognition of one’s personal limitations or biases)
- Integrity (enabling the pursuit of ethical aims, even when it might be more convenient to do otherwise)

Core skills and competencies for CEC members:

		All members/CEC as a whole	Select members (additional)
SKILLS	Ethical assessment skills	<ul style="list-style-type: none"> • Ability to recognise and discuss moral conflicts within the clinical situation • Ability to understand the moral perspective of all parties 	<p><i>Chairs and Vice Chairs:</i></p> <ul style="list-style-type: none"> • Ability to explain the ethical dimension of a case to those involved and to others • Ability to formulate and justify morally acceptable solutions • Ability to review established practices that have generated moral concerns or conflicts, to determine whether change is necessary • Ability to clearly articulate the propositions and arguments in play and synthesise a written document as minutes for the meeting, summarising these along with any conclusions reached

	Operational skills	<ul style="list-style-type: none"> Ability to facilitate meetings, record cases etc. 	<i>Chairs and Vice Chairs:</i> <ul style="list-style-type: none"> Skills in facilitation, of both case consultation discussions and CEC meetings Sensitivity for and ability to support and assist in cases of moral distress
	Interpersonal skills	<ul style="list-style-type: none"> Active listening 	<i>Chairs and Vice Chairs:</i> <ul style="list-style-type: none"> Communication skills Advocacy skills to enable articulation of the views of those who find it difficult to express themselves
KNOWLEDGE		<ul style="list-style-type: none"> Introduction to ethical theory and moral reasoning Awareness of the CEC's position in the hospital framework and links to clinical governance Relevant knowledge of clinical terms and disease processes Beliefs and perspectives of patients and staff population and community staff. Relevant professional standards e.g. GMC, NMC Relevant health care law. Local and national government policy, e.g. resource allocation. 	<p>Some members may bring additional expert knowledge e.g.</p> <ul style="list-style-type: none"> <i>Medical ethicist:</i> 'Advanced' knowledge of ethical theory and moral reasoning <i>Clinicians/professionals:</i> Specialist knowledge related to practice in their area(s) <i>Lawyer:</i> Specialist knowledge of relevant healthcare law <i>Multi-faith representative:</i> Knowledge of faith/community perspectives

8. DEVELOPING A PROCESS FOR CASE CONSULTATION

The CEC should have a clear process for receiving, considering and responding to referrals of cases and ethical issues by healthcare professionals and managers within the organisation.

Things to consider include:



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Item	Questions and Considerations
Who makes a case referral	<ul style="list-style-type: none"> • Who can refer a case? E.g. only the responsible/lead clinician? • What is the role of the patient in any referral? • Can a patient initiate a referral? Most CECs will not accept referrals that are or likely to become part of the complaints process. CECs can choose to only accept referrals from and advise clinical teams
How to make a case referral	<ul style="list-style-type: none"> • How can clinicians (etc.) make case referrals? • Are these to be written and/or verbal? • What is the method of logging/assessing referrals? • What is the time-frame for dealing with a referral?
How to make urgent case referrals	<ul style="list-style-type: none"> • Is there a process for urgent referrals?
Referral documentation	<ul style="list-style-type: none"> • Where is the discussion/advice documented? A structured pro-forma referral document setting out the base facts and the question that the clinical team or other referrer wish to address is recommended. The CEC's advice can also be added to this document. See Appendix 3 for an example template
Ethical framework	<ul style="list-style-type: none"> • Will the CEC use an ethical framework when addressing a case? Not every CEC does so, but see Appendix 2 for an example of a framework
Participants/roles in case discussions	<ul style="list-style-type: none"> • Who attends a case consultation/meeting? • Who facilitates the discussion? • Who writes up the discussion?
Communicating the CEC's advice	<ul style="list-style-type: none"> • How is the advice communicated to the referrer? • How is the advice and any conclusion communicated to the patient? • Is the written advice to become part of the medical record?
Managing CEC data (e.g. advice on cases)	<ul style="list-style-type: none"> • Can the advice be shared outside the context of the referral e.g. for research purposes? If so, consent or other justification for such advice to be shared should be built into the consultation process • Where are referrals/case discussions stored? • What safeguards are in place for data protection?
Feedback and evaluation	<ul style="list-style-type: none"> • How is feedback (on the CEC advice and process) sought from referrers?

Please see [Appendix 3](#) for an example template of a case referral form.



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APPENDIX 1: Example of Terms of Reference

An example of terms of reference follows:

[NAME OF ORGANISATION] CLINICAL ETHICS COMMITTEE (CEC) TERMS OF REFERENCE	
Committee Name:	
Purpose:	<p>The purpose of the CEC is to promote the delivery of consistently high standards of ethical clinical practice throughout the Trust. The CEC's role will be supportive and advisory. Clinical decisions will continue to be made by individual employees, teams and existing decision-making structures, in partnership with patients.</p>
Membership:	<p>The CEC will not attempt to achieve comprehensive representation of every profession or interest group associated with the Trust but will seek to ensure that its membership reflects a broad range of clinical and non-clinical expertise. Members should be clear that they are present for their individual contribution and not as representatives of any body, group, profession or organisation.</p> <p>Membership of the CEC is not restricted to employees of the Trust. Total membership will be in the region of fifteen members and will include lay and professional members. Members of the CEC who are not employees of the Trust are required to sign a confidentiality agreement.</p> <p>The CEC will undertake an annual audit of the skills and experience of its members, and continually. Members must be willing to undertake education and training in order to meet the requirements of CEC membership.</p> <p><i>Recruitment</i></p> <ul style="list-style-type: none">• The suitability of new applicants will be assessed according to their enthusiasm for clinical ethics and an assessment of the knowledge and experience they can contribute to the work of the committee, in light of the requirements of the committee at the time of application.• Potential applicants may contact any member of the CEC in the first instance to enquire about the work of the committee and the application process.



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- An invitation for applications will be circulated within the Trust annually.
- Applicants will submit a CEC membership application form and a short curriculum vitae that will be considered at the next regular meeting of the committee.
- Suitable applicants will be invited to attend an interview with the Chair or Vice-chair (or their delegated representative CEC member) plus at least one other member of the CEC.
- The CEC may co-opt additional members at the discretion of the Chair or Vice-chair in order to facilitate a broader discussion of a topic than might be possible with the current membership. (This may be particularly relevant during the COVID-19 epidemic where specific clinical expertise may be helpful.)
- Co-opted members, who may include persons referring issues for consideration, will play a full part in the discussions of the committee for the duration of the co-option, but they will not have voting rights and their attendance will not contribute to quorum.

Appointment of Chair and Vice-chair

- The Chair and Vice-chairs are to be elected by a simple majority by the CEC from the membership of the CEC, subject to ratification by the relevant Trust Committee.
- Members can either nominate themselves for election or be invited to stand for election by another member of the committee.
- All members of the CEC are required to vote.

Term of office of members

- A period of five years, renewable by mutual agreement of the individual member and the CEC, when the particular expertise of the individual is thought to be essential to the work of the committee and cannot be replaced.
- Care will be taken to ensure that terms of office are staggered to ensure retention of a consistent level of expertise in the committee membership.
- The CEC membership of a member of Trust staff will ordinarily end when the staff member leaves the Trust's employment. A departing member of staff may be invited to continue membership of the CEC for a fixed term if their expertise is considered to be essential to the work of the CEC.



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	<ul style="list-style-type: none">• A fixed-term membership, not exceeding two years, may be allocated to a junior doctor, subject to the usual application procedure. <p><i>Term of office of Chair and Vice-chairs</i></p> <ul style="list-style-type: none">• The Chair and Vice-chairs of the CEC are appointed for a period of three years, renewable for a second term of three years, on each occasion by election by the CEC members and subject to ratification through local governance approval mechanisms.
Attendance:	<p>In order to ensure continuity and the accumulation of a body of expertise, it is expected that members will commit themselves to not less than 75% of regular meetings of the full CEC.</p> <p>Members will also be expected to participate in CEC Rapid Response Teams convened between regular meetings of the CEC to consider referrals requesting a rapid response.</p> <p>Monitoring of members' attendance will take place. When members fail to attend the required percentage of meetings, a review of their membership will take place.</p> <p>If a member is consistently unable to attend or is otherwise believed not to be meeting the expectations of the CEC then, following discussion with the member and subject to a quorate vote of the committee, the Chair may ask him or her to relinquish membership.</p> <p><i>During the COVID-19 epidemic, full committee meetings may be suspended as face-to-face meetings and arrangements made for secure video/audio conferencing. Minimum expectation of attendance will be waived at this time to recognise the potential impact of coronavirus on members.</i></p>
Quorum:	<p>A quorum will be one third of the membership. When quorate, the Chair or Vice-chair retains discretion to decide whether or not there is sufficient relevant expertise available to provide advice on a particular topic or referral.</p>
Frequency:	<p>Monthly</p>
Duties:	<p>The remit of the CEC will be to provide a mechanism within the Trust for multi-disciplinary discussion of ethical issues arising from clinical practice. The group may, on a case-by-case basis with the</p>



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	<p>agreement of the Chair or Vice-chair, receive referrals from beyond the Trust.</p> <p>The CEC will not consider any issue not primarily of a clinical ethical nature. It will not for example:</p> <ul style="list-style-type: none">• Provide advice on research ethics• Provide legal opinion, although its advice will necessarily be given within a legal context• Undertake risk management <p>The CEC's key responsibilities will be to:</p> <ul style="list-style-type: none">• Deliberate on clinical ethical issues about which the view of the CEC has been requested, providing a written response;• Identify needs for clinical ethics education and, where appropriate, assist in the education and training of Trust staff;• Develop in-house guidance on clinical ethical issues according to local need;• Provide advice and guidance on clinical ethical issues arising in development of policies and standards, and developing policies itself as required;• Undertake audit of the impact in the Trust of the CEC's activities;• Raise general awareness in the Trust of the ethical issues that arise from clinical practice;• Promote good clinical ethical decision-making practice throughout the Trust.
Referral process	<p>Referrals will be made to the Chair/Vice-chair/Acting chair and by completion of a referral form (available on the Trust intranet).</p> <p>Wherever possible, the clinician responsible for referring the case to be discussed should be present to give an overview of the case. Where they are unable to attend, a nominated representative familiar with the case should be present. If this is not possible, the Chair/ Vice Chair or Acting Chair should endeavour to meet or discuss with the clinical team prior to the meeting so that the committee's deliberation can be as informed as possible. The clinical team will receive a written summary of the meeting.</p> <p>The CEC will provide a written response to the referrer</p> <p><i>Rapid response service</i> For referrals related to individual clinical cases that require a rapid response, a sub-group of the Committee will convene to include</p>



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	<p>at least three members including chair/vice chair, one clinical member and one lay member.</p> <p>A written report will be presented to the referrer/referring team</p> <p>The written report of a sub-group discussion will be presented to the next CEC meeting and any further comments on the case fed back to the referring team.</p>
Reporting Arrangements:	<p>The CEC will submit minutes of the CEC meetings to the relevant Trust committee (<i>e.g. patient safety committee, clinical and cost effectiveness committee depending on where the CEC sits in the Trust reporting structure</i>) and escalate issues to the relevant Trust committee as required.</p> <p>The CEC will present for approval by the relevant Trust Committee an annual report and forward plan.</p>
Date Ratified by relevant Trust committee:	

APPENDIX 2: The ABC Toolbox

The ABC Toolbox has been developed by Dr Michael Dunn (ETHOX, University of Oxford) to support clinical ethics decision-making at the frontline in time-limited settings. Originally developed in Singapore, it offers a straightforward, and easy to digest, approach to reasoning through ethical issues in clinical cases or policy review.

Ethically challenging situations in clinical practice often feature disagreement about the right thing to do. Resolving the conflict requires that someone recommend an ethical course of action, and that others reach agreement on whether to adopt this course of action, or whether to propose something different. After deliberating, a CEC will sometimes advise on a single course of action; occasionally, however, the CEC 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 individual ethical uncertainty – what should I do when I am faced with this situation? – even if there is no disagreement between the people involved.

Here is a step-by-step approach for a CEC to adopt to analyse an ethical question and develop an ethical argument to support a recommended course of action:

Step 1: Confirming whether your question is an ethical question

Ethical questions are the types of questions that CECs are configured to advise on. Such questions are 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.)

‘What should I do?’ is an 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 depend on clarity about relevant facts and sensitivity to the political and legal context of decision-making.

Step 2: Making an ethical argument

The **ABC Toolbox** (Centre for Biomedical Ethics, 2017) is a short, structured approach to developing an ethical argument that addresses a specific ethical question.



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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 US by Beauchamp and Childress, is known as the **Four Principles** approach. These modified principles are:

- **Respect patients as persons (respecting a person's autonomy or self-determination)**. This principle 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 her decision, what their preferences and values would likely point towards in this clinical scenario.
- **Do no harm to patients (non-maleficence) and Do good for patients (beneficence)**. These two principles capture the duty 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.
- **Act fairly (justice)**. 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). During the pandemic, questions of distributive justice are also likely to 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. This principle is of particular importance in the context of clinical and ethical questions relating to COVID-19, such as those relating to ICU triage and the allocation of limited ventilation.

Notwithstanding these principles, we all have **gut reactions** about what we believe we ought to do in a situation. This is true of CEC members just as it is true of healthcare professionals themselves. These moral intuitions reflect the norms of our



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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.

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 a given 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**. 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 make ethical decisions, 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?

The ABC Toolbox in practice

A short, worked example outlining how to apply the ABC Toolbox in practice is available. This video concerns an ethical issue arising in a community setting, but the points are generally applicable to other clinical settings.

<p>Balancing risks and choices in the care of Mrs Kwok: http://www.bioethicscasebook.sg/guide/</p>



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APPENDIX 3: Example of Case Referral Forms

An example of a case consultation form follows:



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<p>[NAME OF ORGANISATION] Clinical Ethics Committee (CEC)</p> <p>CEC Referral and Response Form</p>	<p><i>Note that, while it may be necessary to disclose identifiable details during the course of the CEC consultation, patient details must be anonymised on this referral form.</i></p>
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Please note that a request for a CEC consultation should result from discussion with the referrer's multi-disciplinary team. Clinical teams are not obliged to seek the involvement of the CEC, and while the opinion of the CEC, once sought, should be taken into consideration, the responsibility for making the clinical decision remains with the clinical team in partnership with the patient and those close to the patient. Involvement of the CEC should augment, but not replace, the MDT's own thorough discussion and analysis of ethical issues.

REFERRAL

CEC ref no:	Referral date:	Response date:
<i>Please provide details of a member of the referring team nominated to be the contact for the CEC:</i>		
Name:		Job title:
Tel ext:		Mobile:
email:		Bleep:
<i>Names and job titles of staff most closely involved in the case:</i>		
Name:		Job title:
Name:		Job title:
Name:		Job title:
Name:		Job title:
Name:		Job title:
Name:		Job title:

Is this referral to the CEC being made with the approval of the Lead Clinician?			
<i>Please place an 'X' in the relevant box below:</i>			
Yes		No	
<i>If 'no', please state why:</i>			



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Please identify the key ethical concerns of relevant MDT members, patients and others.

Are there differences of opinion inhibiting achievement of an agreed course of action (e.g. disagreement between members of the MDT, between the MDT and a patient, between a patient and his / her family?)

Are there firmly held views about what course of action should be taken?

Please provide details of any IMCA or other patient advocate involved.

CEC RESPONSE



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CEC members involved in consideration of the referral (if RRT, identify co-ordinator in space provided)		
	Name	Job title
RRT Co-ordinator:		
Declarations of interest:		



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Opinion of the Clinical Ethics Committee or Rapid Response Team:

A large, empty rectangular box with a thin black border, intended for the input of an opinion or response.



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Does the CEC or RRT wish to follow up this referral? <i>Please place an 'X' in the relevant box below:</i>			
Yes		No	
If 'yes' provide details of how follow-up will take place:			



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APPENDIX 4: Further Resources

Further Detail on Creating and Running a CEC

For further information on setting-up and running a CEC, please see:

- UKCEN, [A practical guide for clinical ethics support](#) (ETHOX, 2004)

Ethical Guidance on COVID-19

Ethical guidance is emerging; please consult the UKCEN website for updates:

- <http://www.ukcen.net/covid-19/>

Ethical Frameworks for CECs

There are various different ethical frameworks, which CECs might use in their work, particularly in case consultation. More details about the ABC Toolbox that is summarised in Appendix 2 is available here:

- Centre for Biomedical Ethics (2017) *Caring for Older People in an Ageing Society and Making Difficult Decisions with Patients and Families*. <http://www.bioethicscasebook.sg>. Singapore: National University of Singapore.

Beyond this ethical framework, you may also wish to consult:

- UKCEN, [A practical guide for clinical ethics support](#) (ETHOX, 2004)
- UKCEN, [Ethical Frameworks](#) (including the ETHOX framework)
- DK Sokol, 'The "four quadrants" approach to clinical ethics case analysis: An application and review' *Journal of Medical Ethics* 2008; 34; 513-516
- JBL Knox, 'The 4C model: A reflective tool for the analysis of ethical cases at the neonatal intensive-care unit' (2014) 9(4) *Clinical Ethics* 120



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UKCEN, 31 March 2020

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Giles Birchley
Rami El-Shirbiny
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Sara Mason
Adrian Robertson
Elizabeth Thomas

Richard Huxtable, Vice Chair
John Bridson
Kiran Jani
Anne MacNiven
Rex Poulson
Andrew Stanners
Anne-Marie Slowther

Contributor:

Michael Dunn

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