

## **A practical guide to medical ethics for intensivists**

Richard Innes<sup>1</sup> , Hugh Montgomery<sup>2</sup> , Jim Bolton<sup>3</sup> , Matthew Rowland<sup>4</sup> , Andrew Hannam<sup>5</sup> , Simon Lindsay<sup>6</sup> and Paul Sankey<sup>5</sup>

You are the consultant on call. It's midnight and the phone rings. An 89-year-old woman has been admitted via the Emergency Department with severe breathlessness and is now on a general ward. She is cachectic, with extensive abdominal surgical scars, and is severely demented (with a 4x/day carer package). A medical note relating to 'referral to a palliative care team' is found on the electronic system, but there are no details. Her daughter says that she has no further information to offer, but that she has power of attorney. The daughter has earlier refused to accept that a DNAR order be put in place. An hour ago, the patient vomited and aspirated and suffered a cardiac arrest. Five cycles of CPR later, the daughter is insistent that her mother goes to ICU. Your registrar wants to know what to do. It hasn't been a good day. Earlier, you were greeted by a senior nurse. She anxiously shows you a Facebook page, frequently updated by family members, which logs the clinical timeline and course of a relative who is unconscious on ICU. The page has attracted comments from many well-wishers. Photographs have been uploaded which identify staff, and some have negative comments attached. Adjacent patients are also visible in photographs. The relatives of one have complained. So has one of the defamed staff. Your 'legal department' has been outsourced, and no-one is familiar with issues relating to social media. For those working in critical care (at every level of seniority and across all disciplines) such problems have become ever more prevalent. Further, the law always seems to be changing and rarely seems to offer 'black and white' clarity on what has to be done. This leads to feelings of insecurity and uncertainty: dealing with such issues can be far more frightening than is the management of multi-organ failure. In the spring of 2017, the ICS organised a one day seminar to explore just these sort of issues. We brought together experts from Psychiatry, Social Care and the Legal world, those who mainly practiced in 'defense', but also those more regularly involved in litigation. All who talked were senior and experienced, giving their time pro bono. There was generous discussion time, and feedback was extraordinary. Many spontaneously made contact, calling the day, 'the best education seminar they'd ever attended'. In an effort to distil some of what we all learned, representative members of the speakers, organisers and delegates have put together a series of short articles. They cover Informed Consent (and the significance of the 'Montgomery Ruling'), Capacity, assessment of 'Best Interests', the role of (and access to) the Court of Protection, and even how (and when) to access a Judge at 2 a.m. Exemplar fictitious (but 'representative of real life') cases, such as those above, will be offered. The articles are presented in two parts which will be published in successive issues of this Journal. We hope that you find them easy to read, and that they offer some practical advice and comfort when navigating the legal minefield into which we increasingly feel that we have been parachuted without warning.

Richard Innes and Hugh Montgomery