South West Regional Health & Care Ethics Reference Group (SWERG): Frequently Asked Questions (FAQ) about Ethics, Law and Professional Guidance in relation to the SARS-COV-2 /COVID-19 (CV19) PANDEMIC

November 2020

Authors:

Professor Raanan Gillon:

Emeritus Professor of Medical Ethics Imperial College London; past President British Medical Association; Honorary President Institute of Medical Ethics

Professor Richard Huxtable:

Professor of Medical Ethics and Law, and director of the Centre for Ethics in Medicine, Medical School, University of Bristol

Dr Elizabeth Mearns:

Medical Director (System Improvement) NHS England & Improvement South West Region

Contents

Key Messages 3
Frequently Asked Questions 3
Ethical considerations & ethical principles 3
Professional guidance & obligations 3
Law & legal obligations 3
Ethical considerations and ethical principles 4
Professional guidance & professional obligations 11
General professional ethical guidance 11
Local Sources of advice & guidance 13
Law & legal obligations 14
Acknowledgments 16

Key Messages

FAQ: What are the key ethical, professional and legal considerations in the pandemic?

As a very brief general guide, we advise that you:

- Be aware of, and heed, any instructions as to what you **must** (or must not) do. You may be required, for example, to heed the instructions of your employer, the law, or your professional regulator.
- Be prepared to make your own decision about what you **should** (or should not) do. Some obligations – arising from law, your regulator or your employer – might be non-negotiable. However, in many circumstances, what is required of you might not be clear and you may need to make your own **judgment**.
- When making a judgment as to what you should (or should not) do, be prepared to **balance** potentially competing ethical, legal and professional obligations. Essentially, the law, professional guidance and ethical considerations all point to the need to balance benefits and harms, respect individuals' autonomy, and make just decisions, having regard for yourself, those with and for whom you work or who work for you, those close to you (such as family members), and the wider society.
- Be prepared to **explain and justify** how you have balanced the different considerations and the basis for your decision.
- Be sure to **consult** appropriately and **document** any significant decisions made.

Frequently Asked Questions

Our advice is set out as a series of FAQs in three groups. Each group will be addressed in turn. The FAQs are listed here for ease of reference.

Ethical considerations & ethical principles

- FAQ: Which ethical considerations inform SWERG's work?
- FAQ: Why does SWERG use the "four principles" approach?
- FAQ: How are these general ethical principles relevant to the pandemic?
- FAQ: How do these general ethical principles relate to the various additional principles found in professional guidelines?

Professional guidance & obligations

- FAQ: What additional ethical considerations are proposed in professional guidance?

Law & legal obligations

- FAQ: Why should I follow the law?
- FAQ: Where can I obtain legal information, advice and support?
- FAQ: Which key messages emerge from the law?

Ethical considerations and ethical principles

FAQ: Which ethical considerations inform SWERG's work?

The SWERG was founded in order to "support and advise on ethical decision-making" in relation to the CV19 pandemic. This section sketches the approach to ethics taken by the SWERG.

Ethics is about right and wrong, good and bad, what ought and ought not to be done. It is also about being a good person, leading a flourishing life of which one can be proud.

There are many overarching theories of ethics of which the currently most mainstream can be grouped as:

- **Deontological theories** that focus on duties, and increasingly on rights (which always of course have corresponding duties – though the reverse is not necessarily the case)
- **Consequentialist theories** of which **utilitarianism** in its various forms is the most important

These two groups focus on right and wrong **actions**. Deontology is primarily concerned with carrying out one's moral duties – including one's moral duties to those who have rights – on the basis of moral rules (some of which may be consequentialist in nature). Consequentialist theories are *entirely* based on the good or bad consequences or outcomes of one's actions.

The third overarching group of ethical theories falls under the banner of:

- **Virtue ethics**. This is characterised by a focus on leading a good (virtuous) and flourishing life and on having the character dispositions (virtues) that result in a good and flourishing life, and on avoiding those character dispositions (vices) that undermine such flourishing, and on awareness of the need in many circumstances to find a "mean" or balance between vices. To use Aristotle's original example, the virtue of courage is the mean between the vices of foolhardiness and cowardice.

Other overarching theories of ethics include religious theories, humanist theories, political theories, feminist theories, care-focused theories, environment–focused theories, relationship-focused theories, narrative-focused theories, interpretation-focused theories ("hermeneutical ethics") and the related experience-focused theories ("phenomenological ethics") – and doubtless many others.

Our approach to CV19 ethical issues will not be much concerned with these overarching theories other than to seek compatibility with the justified universalizable conclusions claimed by any of them.

To do this we adopt the **four principles** (or the “four pillars”) approach to ethics, familiar to many health care professionals and now usually called ‘principlism’.[1] This was designed by Beauchamp and Childress in the 1970s precisely to help doctors and other health care workers to deal with the ethical issues they regularly faced, usually in contexts where neither the health care workers themselves nor their patients or clients shared a common “overarching” ethical theory, whether religious, secular, political or philosophical.

Principlism claims that four prima facie principles **– beneficence, non-maleficence, respect for autonomy and justice** – provide a set of basic moral commitments, which (often in combination) are, arguably, compatible with the justified universalisable claims of all the overarching theories. Although principlism has been attacked for being over-simple (and for many other deficiencies), it is rare to find explicit rejection of any one of these general prima facie moral commitments and the SWERG has explicitly accepted that these four principles provide a helpful framework for thinking about ethics, being compatible “upwards” with the justified universalisable claims of the overarching moral theories, and compatible “downwards” with many of the more specific claims found in the various CV19 ethics guidelines which we discuss in a separate section (Professional Guidance and Professional Obligations). Some of the latter principles are clearly statements or variants of the four principles, some are combinations of those principles, some are specifications of the use of the principles in particular situations or types of situation, some are accounts of relevant character dispositions (virtues) that facilitate the attainment of agreed moral objectives, and some are instrumental and procedural principles that again facilitate the attainment of agreed moral objectives.

Simply summarised, the four principles in no order of precedence are:

- **Beneficence**: the prima facie moral obligation to benefit (at least some) others. It is important to note that this principle requires assessment and achievement of beneficial consequences – it is a consequentialist principle – but it does not of itself require a utilitarian obligation to *maximise* beneficial consequences. Sometimes, for example, such maximisation may conflict with and be trumped by one or other of the other remaining three principles, but even if it does not, moral agents may decide for themselves how much to limit their commitment to benefit others. However, although maximisation is not a necessary component of beneficence – we can morally reputably commit ourselves to a universalizable moral commitment to provide *some* benefit to *some* others – we may nonetheless regard people who commit themselves to maximising benefit to others as being morally admirable, morally virtuous or perhaps as moral idealists, while being clear that such maximising commitment is not a moral *obligation*, not even a prima facie moral obligation.

- **Non-maleficence**: the prima facie moral obligation to avoid harming others. Again, this principle is consequentialist – but again it does not necessarily require a utilitarian minimisation of harmful consequences. Some harmful consequences may be morally acceptable in the interests of reducing

[1] Beauchamp T, Childress J. Principles of Biomedical Ethics (2019 - 8th ed). New York, Oxford: Oxford University Press

unacceptable interference with people's autonomy, or in the interests of justice.

- **Respect for autonomy**: the prima facie moral obligation to respect people's autonomy, roughly defined as people's deliberated choices for themselves. Note that this principle requires – though is rarely given when presented in summaries such as this one – the qualification "insofar as this is compatible with respect for the autonomy of all potentially affected". Note too that it is people's self-rule (autonomy literally means self-rule), not their rule of others, that is to be respected, no matter how autonomous is their desire to rule others!

- **Justice/fairness**: the prima facie moral obligation to treat people as equals unless there is good reason to treat them as unequal, in which case they should be treated differently in proportion to the morally relevant inequality. Note that this may involve treating them better or worse than others depending on the morally relevant inequality. This summary of justice/fairness is in effect a restatement of Aristotle's formal theory of justice according to which equals should be treated equally while unequals should be treated unequally in proportion to the relevant inequalities. The most obviously relevant inequalities in the context of health and social care concern people's needs, but other morally relevant concerns can conflict with trying to meet peoples' needs.

FAQ: Why does SWERG use the "four principles" approach?

Principlism carries some "health warnings":

- These are very high level and general principles; very often in practice they need, singly or more usually in combination, to be made more specific for application to particular circumstances or types of circumstance.

- The four principles approach does not incorporate a method for dealing with conflicts between the principles or their specifications. All such methods require the mysterious and undefinable capacity of moral judgment.

- The four principles approach does not incorporate a method for addressing the scope of these principles (to whom or to what do they apply and to what extent?).

So why, it may be asked, does SWERG choose to use the four principles approach?

First because it provides a set of four universalizable high level prima facie **moral commitments** to which all (or almost all?) moral agents – whatever their overarching moral theory – can commit themselves. It thus removes the *necessity* for health and social care staff to engage in high level moral discourse debate and disagreement about their overarching moral theories. Moral decision making in health care is a real-time activity and acceptance of these four commitments facilitates this. We invite all who consult us to ask themselves if they can personally accept these four prima

facie moral commitments (and to feed back to us rejection of any one of them and the rationale for such rejection).

Given acceptance of these four prima facie moral commitments, they provide a mutually agreed basic moral language and a basic moral framework for addressing analysing and sometimes helping to resolve real life moral issues, including those arising as a result of the CV19 pandemic.

Finally, in the context of the CV19 pandemic, these principles, understood as moral objectives, help us make sense of the various specific CV19 ethics guidelines. We have scrutinised many of these (see section on Professional Guidance and Professional Obligations) and the very many different specific requirements contained in them. We suggest below that those specific requirements, when they are not essentially restatements of those broad ethical commitments, are adjuncts towards achieving them, whether by combining them, specifying them, providing useful methodologies and procedures for achieving them, or by providing advice about appropriate personal attributes (virtues) necessary or preferable for achieving the agreed moral objectives.

FAQ: How are these general ethical principles relevant to the pandemic?

Benefiting, not harming, and the aim of achieving net benefit

Although the four principles are not presented in any hierarchy or order of precedence, in our current context producing health benefit and minimising health harm are clearly desirable moral objectives and in the context of health and social care interventions, since most interventions intended to produce benefit also involve actual or potential harm, the obvious moral objective must be to try to produce net benefit over harm. This has been a moral objective in medical practice since Hippocratic times, but it is a morally desirable combination for anybody who tries to benefit others. It requires us to think about and try to minimise or at least reduce to an acceptable level any harmful consequences both intended (the surgeon's cut is an intended harm – but intended only as a necessary means to obtain a net benefit) and unintended (the potential wound infection is an unintended harm). And since the unintended harms may affect other people, non-maleficence requires us to consider their interests too, even if we do not have any specific moral obligation to benefit them! For example, breaking a lockdown rule may benefit the breaker's family but may also result in harm to others.

The scope of beneficence is a long-contested aspect of moral philosophy. In therapeutic medical practice, the emphasis has always been to prioritise benefit to the individual patient: as the General Medical Council puts it, "make the care of your patient your first concern".[2] However, there are other patients too, and in public health practice the concern is to benefit populations whether or not they are "patients" – and in medical research the moral concern is usually to try to benefit future people including patients and/or populations. As we state in the background paper to our terms of reference, in the context of the COVID pandemic we favour a

2 https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice

shift in that *balance* between concerns for the individual and concerns for the population, "towards the utilitarian objective of equitable concern for all – while maintaining respect for all as 'ends in themselves'" – a reference of course to "the categorical imperative" of treating every person as intrinsically of moral concern – an end and not merely a means – as argued for by the deontological philosopher Immanuel Kant. And that need for ethical *balance*, here between concern for the individual and concern for populations, may be seen as recognising one of the central concerns of virtue ethics, the need for balance, for the "mean" between excess and deficiency.

Beneficence can encounter conflict not only with non-maleficence (as above) but also with the other two principles, respect for autonomy and justice. Indeed, as far as the former goes, the combined principle of aiming for net benefit with minimal harm may be seen to itself require respect for autonomy whenever we are trying to benefit people who are able to make their own decisions (adequately autonomous people) about what for them counts as benefit, harm and net benefit. However, respect for autonomy (understood as free will in many religious contexts) is in any case widely understood to be an independent moral obligation, whether or not there is a co-existing obligation of beneficence.

Respect for autonomy

Autonomy is the ability to think and make decisions for oneself (note the etymology – self-rule, not rule of others), and to implement those decisions for oneself. The capacities to exercise the first and second components of this trio of capacities are necessary conditions for being a moral agent – if you can't think for yourself and if you can't make decisions for yourself, then you can't be a moral agent (though you can certainly be a moral *patient* – a subject of the moral concern of moral agents). The third capacity is not of course a necessary condition for being a moral agent because the capacity to implement one's thought-out decisions for oneself may be impaired by a huge variety of intrinsic and extrinsic conditions.

Respect for autonomy is the respect of moral agents for each other – hence the qualification mentioned above – we need to respect other people's choices for themselves in so far as such respect is compatible with equal respect for the autonomy of all the other moral agents potentially affected by such respect; So my decision not to allow others to operate on me or administer medications is an autonomous decision that does not interfere with the *autonomy* of anyone else (though it may well interfere with what they wish to happen) and so it should be respected. On the other hand, my request for a particular sort of treatment does impinge on the autonomy of someone else (the doctor, and maybe others) and so requires a *request* for assistance of the other (as distinct from an instruction to desist), which may or may not be met depending on his or her autonomous response.

Respect for autonomy underpins a range of normal moral norms, attitudes and dispositions, such as honesty and non-deceit, seeking (adequately) informed consent to proposed interventions, respect for privacy and confidentiality (though this is also underpinned in some contexts, including professional relationships, by

beneficial outcomes) and promise-keeping (incidentally, appointments are mutual promises!).

Justice or fairness

As outlined above, justice involves treating people as equals (what some health economists sometimes call “horizontal equity”) unless there are morally relevant reasons for not doing so, in which case they should be treated unequally in proportion to the morally relevant inequalities (“vertical equity”).

Philosophers, politicians, theologians and many others have been arguing about morally relevant equalities and inequalities at least since Aristotle wrote about them and may well continue to do so for another two and a half thousand years. One obvious and relevant inequality in our context of health and social *care* is the ***need*** for such care; with the underlying assumption that justice/fairness requires health and social services resources to be provided in proportion to the need for them – the underlying premise of the National Health Service. However, other moral concerns may compete with need: thus, in the realm of distributive justice, the utilitarian concern for maximising welfare on the (Benthamite) basis of seeking to produce the greatest good for the greatest number may conflict with providing resources to those in greatest need. Respect for autonomy may conflict with meeting need – the autonomy of those in the greatest need themselves (who may reject the offered interventions – some shielded patients are rejecting the protection they are considered to need and returning to work for example); but it may also conflict with the autonomy of those who, on behalf of us all, are providing the resources that are needed – i.e. government or its agents (or insurance companies in other contexts). And the utilitarian objective of creating as much benefit as possible (“the most bang for one’s buck”) out of one’s limited resources may also compete with meeting need. And then in the zone of rights-based justice, people may, on the one hand, exercise the right *not* to be treated according to their need as in the example above; conversely they may exercise their right not to be exposed to danger in their work, even though others may need their professional assistance.

As can be seen, justice/fairness is probably the most difficult and complex of the four principles to summarise – but the underlying Aristotelian notion that justice requires us to treat people as equals unless there are morally relevant reasons for not doing so is widely accepted, even though we shall inevitably continue to argue about what those “morally relevant inequalities” are in different contexts.

FAQ How do these four general principles relate to the various additional principles found in professional guidelines?

This question brings us to all those additional principles described in the various professional guidelines, designed to aid our moral decision making during this CV19 pandemic. Perhaps the most important of these is **good judgment** when the agreed moral objectives are in conflict.

As suggested above, if we see the four principles as high level prima facie moral objectives, we can see the many *additional* principles found in the large number of

government and professional and other CV19 ethics guidelines as adjuncts to achieving those high-level moral objectives. So apart from what are essentially restatements or versions of the high level four prima facie moral commitments/principles themselves, the extra principles in the various CV19 guidelines can be seen as:

1) *Combinations* of some or all of those four basic commitments/ principles. For example, the Government's pandemic ethics framework combines, under the heading of "Equal concern and respect", not only concerns for justice/fairness but also for "*minimising the harm that a pandemic might cause*".[3] There is of course nothing wrong with such combinations – but it may help to discern the different high-level moral objectives when they are combined within an apparently unitary moral principle especially if the components may conflict.

2) *Specifications* of one or more of those principles, specifying how they can be applied in particular circumstances or types of circumstances; the BMA's CV19 guidelines' statement that in circumstances of overwhelming demand and inadequate supply of intensive care facilities "it will be necessary to adopt a threshold for admission to intensive care" is an example of a specification of the general commitment to produce as much benefit for as many as possible.[4] The Government's principle of reciprocity can be seen as another example of specification: those who take greater risks or face increased burdens during the pandemic should be supported in doing so, their risks minimised as far as possible. This may be seen as a specification of the principle of justice/fairness – those in greatest need should be given priority. It may also be seen as incorporating the virtue of gratitude as an adjunct to achieving such fairness. There are of course potentially huge numbers of possible specifications of the four high-level principles.

3) *Processes and methodologies* that help to achieve those high-level moral commitments and their specifications; collaborative working, flexibility, proportionality, processes for handling ethical challenges, open and transparent decision making, are among the examples.

4) Personal *characteristics (virtues)* that are recommended as necessary or at least advantageous for achieving those high-level moral commitments and or their specifications. The seven principles of public life, adherence to which is required for membership of the CV19 app ethics advisory board, are examples of *required* virtues for appointment to that group (selflessness, integrity, objectivity, accountability, openness, honesty, leadership).[5] Reasonableness and flexibility in the CV19 framework for adult social care[6] (and in other guidelines) are further examples.

5) Approaches that help with that mysterious capacity of *judgment* (the capacity that Kant claimed could have no rules!). The principle of good decision

[3] https://www.gov.uk/guidance/pandemic-flu#ethical-framework
[4] https://www.bma.org.uk/media/2360/bma-CV19-ethics-guidance-april-2020.pdf
[5] https://cspl.blog.gov.uk/2019/10/24/standards-in-public-life-need-constant-attention/#:~:text=It%20was%20in%20this%20report,those%20who%20serve%20the%20public.
[6] https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care

making in the government's pandemic guidance seems a good example.[7] The requirement of the virtue of reasonableness in several guidance documents may also nurture the mysterious process of good judgment.

Professional guidance & professional obligations

FAQ: What additional ethical obligations are proposed in professional guidance?

Much professional guidance concerning the pandemic has been prepared and issued by professional organisations, including regulators. As well as the four general ethical principles discussed above this guidance contains a range of more specific ethical requirements and proposals.

General professional ethical guidance

In line with its terms of reference, SWERG's advice is based on an ethical framework first articulated in relation to pandemic flu, which contains several key principles.[8]

The framework and its principles have authoritative support, as they have been adopted by the Moral and Ethical Advisory Group,[9] which provides independent advice to Government.

[7] https://www.gov.uk/guidance/pandemic-flu#ethical-framework
[8] https://www.gov.uk/guidance/pandemic-flu#ethical-framework
[9] https://www.gov.uk/government/groups/moral-and-ethical-advisory-group

The Pandemic Flu Framework (summarised)

The document states: "*Equal concern and respect is the fundamental principle that underpins the ethical framework. This means that:*
- *everyone matters;*
- *everyone matters equally – but this does not mean that everyone is treated the same;*
- *the interests of each person are the concern of all of us, and of society; and*
- *the harm that might be suffered by every person matters, and so minimising the harm that a pandemic might cause is a central concern.*"

The specific principles are:
- Respect;
- Minimising the harm a pandemic could cause;
- Fairness;
- Working together;
- Reciprocity;
- Keeping things in proportion;
- Flexibility; and
- Good decision-making.

The specific principle of good decision-making notes that good decisions are:
- Rational;
- Based on evidence;
- The result of a process, taking into account how quickly a decision has to be made and the circumstances in which it is made; and
- Practical – what is decided should have a reasonable chance of working.

It also requires that records be kept of decisions made.

In another governmental COVID19 ethics guidance document,[10] Sir Jonathan Montgomery, co-Chair of the MEAG and also Chair of the Ethics Advisory Board (EAG) of the CV19 contact tracing app, specifies six principles (**Value**, **Impact**, **Security and privacy, Accountability, Transparency and Control**). In Appendix 3 of that letter, Sir Jonathan also specifies that members of the EAG should "abide by the highest standards of behaviour as set out in the Seven Principles of Public Life" which are (the virtues of) **selflessness, integrity, objectivity, accountability, openness, honesty and leadership**.[11]

BMA pandemic ethics guidance clearly states:

> "*doctors should be reassured that they are extremely unlikely to be criticised for the care they provide during the pandemic where decisions are:*
> - *reasonable in the circumstances*
> - *based on the best evidence available at the time*

---

[10] J Montgomery's letter of 21/4/20 to the Secretary of State for Health and Social Security on key principles for an ethical and effective CV19 contact tracing app https://nhsbsa-socialtracking.powerappsportals.com/EAB%20Letter%20to%20NHSx.pdf

[11] https://cspl.blog.gov.uk/2019/10/24/standards-in-public-life-need-constant-attention/#:~:text=It%20was%20in%20this%20report,those%20who%20serve%20the%20public.

- *made in accordance with government, NHS or employer guidance*
- *made as collaboratively as possible*
- *designed to promote safe and effective patient care as far as possible in the circumstances*".[12]

A joint statement from professional regulators adds:

> "*We recognise that the individuals on our registers may feel anxious about how context is taken into account when concerns are raised about their decisions and actions in very challenging circumstances. Where a concern is raised about a registered professional, it will always be considered on the specific facts of the case, taking into account the factors relevant to the environment in which the professional is working. We would also take account of any relevant information about resource, guidelines or protocols in place at the time*".[13]

In the UK Government CV19 Ethical Framework for adult social care, eight principles are stated: Respect, Reasonableness, Minimising harm, Inclusiveness, Accountability, Flexibility, Proportionality and Community.[14]

Local Sources of advice & guidance

Local systems and organisations usually have their own ethics advisory committees which publish ethical frameworks and guidance. These are often examples of specifications of high-level principles or descriptions of processes or systems to support the ethical provision of services. Combinations of these many additional specific principles, beneficial personal characteristics and working procedures are to be found in a wide range of advisory documents, links to many of which are provided by the NHS Confederation[15] and also in regional ethics advisory documents good examples of which include those of the Devon Ethics Reference Group[16,17].

Such local guidance may have been signed into policy by statutory organisations, have involved Local Authority governance in its development and publication and have been devised with the benefit of local public engagement, legal advice and attention to prevailing local circumstances and ethical dilemmas. Readers should therefore be aware of their local guidance and either comply with it; or seek advice from the issuing body if you are concerned it may be inadequate or inappropriate.

---

[12] https://www.bma.org.uk/media/2360/bma-CV19-ethics-guidance-april-2020.pdf
[13] https://www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus
[14] https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care
[15] https://www.nhsconfed.org/supporting-members/covid19/information-and-guidance/where-to-find-information
[16] https://www.togetherfordevon.uk/download/appendix-a-devon-ethical-framework/
[17] https://www.togetherfordevon.uk/download/appendix-b-devon-guidance-allocation-and-withdrawal/

Law & legal obligations

FAQ: Why should I follow the law?

In a democratic society, there may be an ethical obligation to follow the law. There are also sound prudential reasons for doing so: laws are usually backed by sanctions or penalties, so failure to follow the law might jeopardise your liberty, livelihood, or finances. In short, law indicates what you **must** (or must not) do, on pain of sanction.

You are advised to:
1) Find out and follow the law(s) that apply to your practice(s).
2) Assume that existing laws continue to apply during the pandemic – unless you learn from a reputable and authoritative source that the law has changed. Such sources are likely to include Government departments and bodies, your regulator, and/or your defence union.

FAQ: Where can I obtain legal information, advice and support?

Although practice in some contexts might require detailed knowledge of the law, health and social care professionals will not generally be required to consult primary legal sources (such as Acts of Parliament or court rulings). You should, however, know where you can access legal information, advice, or support.

You are advised to:

1) Consult and follow any authoritative professional guidance that is issued by (for example) your regulator or employer. Following this sort of guidance should offer some legal reassurance. Although it is not a formal source of law, such guidance will typically be based on, and take due account of, the law. In the event of a legal action, your compliance with authoritative guidance might also help to establish that your practice was responsible or reasonable.
2) If the need arises, seek and heed legal advice or support. You should familiarise yourself with sources of legal support, such as your regulator, defence union, trade union, or employer's legal team.

FAQ: Which key messages emerge from the law?

Law covers many aspects of human behaviour and has many branches, which makes it difficult to convey legal obligations in the abstract. Instead, legal obligations tend to be easiest to identify in the context of a specific scenario (or "case"). Despite this, some very general legal pointers can be offered in the form of **four principles of (healthcare) law**.

You are advised to:

1) **Talk** i.e. communicate appropriately. Many legal complaints originate in poor communication between a professional and a patient, service user, or someone close to them, so careful communication may help to avoid a later claim for legal redress. In various ways and places, the law emphasises the importance of communicating appropriately with colleagues, patients, service users, relatives, and others: for example, there are legal rules around maintaining confidences, protecting patient data, obtaining consent, and being open and honest.
2) Strive to serve the **best interests** of your patient or service user. There are explicit legal obligations to serve the best interests (or welfare) of adults and children who lack mental capacity (or competence). A patient or service user's best interests encompass not only their medical interests, but also their wider social and psychological welfare, and their personal views, values, and wishes (in line with their autonomy rights). The law also generally expects professionals to seek to benefit – and avoid harming – those in their care: for example, human rights law includes an obligation to avoid inflicting inhuman or degrading treatment.
3) Ensure your practice is **reasonable**. The concept of "reasonableness" runs throughout the law and is particularly dominant in the law of negligence. The reasonable professional will (for example): take due account of the needs and wishes of the patient or service user; base their decision on the best up-to-date evidence; heed responsible opinion regarding best practice; act in good faith; and will not recklessly or intentionally expose those in their care to harm.
4) Follow the applicable **processes** and complete the necessary paperwork. Good record-keeping is an important aspect of providing professional care, which is further supported by the existence of robust processes for sharing information and making decisions. There may also be legal benefits to completing the requisite paperwork and following the relevant processes. The law sometimes sets down specific processes to follow, and the associated documents to complete, in particular contexts (such as when terminating a

pregnancy). More generally, the legal process invites careful notetaking by the professional, as this will provide some of the evidence that might be required in a future legal claim. Without careful notes, not only might patient care be compromised, but the professional might later find it harder to evidence and defend what they did and why.

These "principles" can be succinctly conveyed in one or two words as, respectively, talk (T), best interests (B), reasonableness (R), and process (P). For ease of recall, these words can be combined into the following mnemonic: **To Be Responsible Professionals** (where "responsible" should be understood as "lawful").

Acknowledgments

RH thanks Louise Austin and Oliver Quick, for their helpful feedback during drafting. He also thanks his colleagues on the "COVID-19 and Clinical Ethics Support" (CCES) project, particularly Helen Smith, for directing the drafters to relevant professional ethical guidance. CCES is kindly funded by the Elizabeth Blackwell Institute, University of Bristol.

RG thanks colleagues- too numerous to name individually- both in the British Medical Association and especially in its Medical Ethics and Human Rights Department and Committee, and in the Institute of Medical Ethics.

EM thanks the NHS England & Improvement SW Regional Director team for their support in setting up SWERG

All three drafting authors thank the members of the SWERG for insightful discussion of earlier drafts and proposals.