NHS
East of England
Clinical Senate

The regional COVID-19 pandemic response and system learning.

Ethical considerations for the transfer of both critically ill emergency care pathway patients and patients needing urgent elective treatment, from one hospital or one region to another for treatment.

East of England Clinical Senate Council

December 2020

Executive Summary

Clinical Senate Council came together with a group of invited clinicians to consider ethical issues in relation to the transfer of both critically ill emergency care pathway patients and patients needing urgent elective treatment, from one hospital or one region to another for treatment. Whilst the question had been raised in the context of the COVID-19 pandemic, the principles discussed would generally apply.

Patients are transferred every day from one hospital to another, usually in order to ensure more specialist treatment. However, the COVID pandemic has placed unprecedented pressure on critical care beds with many critical care units operating well above their usual capacity.

In discussion, the panel considered how medical ethics principles, including the four pillars of medical ethics, and the NHS Constitution and values, could be applied to the transfer of a patient to another hospital either to make way for another patient or to provide treatment that had been delayed or suspended at the patient's local hospital.

The panel agreed there was a need for clear, transparent and fair processes to be put in place to make sure transfer decisions were not discriminatory and were just. Ideally these processes would be developed through coproduction with patients and members of the public.

The panel agreed that consideration should be given to the impact on the new location of the transfer and to the impact on staff, both at the current and new location.

The panel agreed that the overall balance of potential benefits must outweigh any potential for harm. In these situations, there will be the benefit to one or more patients who will receive higher quality care or earlier care or both. There will often be a potential disbenefit to one or more patients whose waiting time may be longer or who may need to travel to receive similar treatment.

It might therefore be the case that whilst it might not be in the patient's best interest to transfer to another location for treatment, provided it does not do them any significant harm and everything is done to minimise harm, if their transfer results in greater good then the decision to transfer should be ethically acceptable.

There was a unanimous view from the panel that it was both consistent with the NHS Constitution and ethically justified to move patients within the NHS for both emergency and elective care if this would either benefit the individual patient or overall it would deliver the greatest good for the greatest number.

Background and context:

The COVID pandemic has had a greater impact on both emergency and elective care for patients than any other event in decades. The impact has not been uniform, with some areas suffering more than others both in wave one and during the second surge. This differential impact has produced a greater geographical variation in access to healthcare both in the acute or emergency setting and the elective setting. In both cases, this has the potential to have profound impact on outcomes including mortality rates. This geographical variation has led to an increased focus on the possible benefits, either to the individual patient or the wider population, of transferring patients for both emergency and elective care.

Dr Sean O'Kelly, Regional Medical Director and Chief Clinical Information Officer, NHS East of England asked the East of England Clinical Senate Council to establish a panel that could provide ethical advice, focussed around issues related to the COVID pandemic including the possible need to transfer a greater range and number of patients. The request was to provide guidance and provide an ethical view regarding guidelines and protocols rather than offer advice about particular patients.

Lack of availability of critical care beds or critical care units that are operating well above their usual capacity can have a profound negative impact on outcomes. Many patients on elective care pathways are time critical and the COVID pandemic has caused delays at every step along patient pathways from initial assessment, referral, diagnostic tests to definitive treatment including surgery. For many cancers and other conditions requiring urgent treatment, such delays can lead to worse outcomes including an increased mortality rate. For all patients, such elective delays are likely to increase physical suffering whilst waiting and / or negatively impact on psychological health regardless of the final outcome.

Clinical Senate Council considered ethical issues in relation to the transfer of both critically ill emergency care pathway patients, and patients needing urgent elective treatment, from one hospital or one region to another for treatment and how that is consistent with the NHS constitution and values. Whilst the question had been raised in the context of the COVID pandemic, the panel agreed that the principles discussed would generally apply.

Six questions were posed to stimulate and focus the discussion, three relating to elective care and three relating to emergency care

Patients on elective care pathways:

- Is the transfer of patients from one hospital, or indeed one region, to another for urgent elective treatment ethical and consistent with the NHS constitution and values?
- If so, how should we prioritise those for transfer?
- How should we prioritise in comparison with patients from the local population?

Emergency Care situations – usually but not exclusively regarding patients with severe COVID-19 related illness

- Is it ethical to transfer critically ill patients from one hospital, or indeed one region, to another for treatment and is it consistent with the NHS Constitution and values?
- If so, is it appropriate to transfer patients before a service becomes critically saturated (consider benefit to individual)?
- How should patients be identified and prioritised?

Every day patients are transferred from one hospital to another usually in order to ensure more specialist treatment can be provided, for example patients requiring specialist critical or neonatal care or supra-specialist surgical or medical treatment. These transfers are supported by a clear framework and criteria and often managed through regional networks. Usually the patient, or their parent or guardian, will have given consent for the transfer. These transfers were not part of this discussion but were highlighted to demonstrate that inter and intra hospital transfers can, and already usually do, work well, although it was noted that where transfers and networks crossed boundaries this became more complex.

Ethical considerations and relevance of the NHS Constitution and values

In discussion, the panel experts referred to the well-recognised pillars of ethics to help analyse and consider each question. Beauchamp & Childress (1979) described four pillars of medical ethics – beneficence, non-maleficence, autonomy, and justice – that today still provide a clinical framework for decision-making. Senate Council discussed how those principles were applied to the transfer of a patient to another hospital either to make way for another patient or to provide treatment that had been delayed or suspended at the patient's local hospital and how that decision sat with the NHS Constitution and values.

Shröder-Back et al (2014) recommended using seven pillars in the public health context adding Health Maximisation, Efficiency and Proportionality to the initial four pillars described above.

Beneficence means to provide or produce benefit for individual patients or clients and has been recognised from the time of Hippocrates – physicians should heal or help their patients to the best of their abilities.

Non-maleficence, to do no harm (*primun nil nocere*) is also founded in the Hippocratic tradition and runs alongside this first pillar, as all interventions are based around a balance of risk and harm.

Autonomy provides a strong balance to the potentially paternalistic first two pillars in recognising the importance of individual freedom and choice. There is always the potential for a conflict between the pillars "the tension between individual rights and broader conceptions of public benefit is a profound one for public health as a field of practice" (Shröder-Back et al ibid).

Justice, sometimes also referred to as social justice, meaning we all have equal worth and the right to be treated fairly providing health equity.

Health maximisation – this takes the principle of beneficence and non-maleficence and applies it to a broader population rather than to an individual patient or health encounter. 'In the field of public health. The primary end sought is the health of the broader consistency of the public and improvements to this are the key outcome used to measure success' (Shröder-Back et al ibid). This could also be referred to or thought of as the greatest good for the greatest number.

Efficiency – throughout the world resources are constrained within organisations and health systems and therefore there is a moral duty to use resources as efficiently as possible. This is also reflected in the NHS Constitution in the sixth statement 'the NHS is committed to providing the best value for taxpayer's money'.

Proportionality – 'It demands that in weighing and balancing individual freedom against wider social goods, considerations will be made in a proportionate way' (Shröder-Back et al ibid). 'Is essential to show that the probable public health benefits outweigh the infringed general moral considerations'. – 'For instance, the policy may breach autonomy or privacy and have undesirable consequences. All positive features and benefits *must be balanced* against negative features and effects'.

We also considered the **NHS Constitution, values and rights** and how this potentially impacted on the questions posed.

The NHS Constitution was not specifically developed and written to cover pandemics but was intended to cover all situations. The panel felt it was applicable to our discussions.

The end of statement one demands that we pay particular attention to groups or sections of society where improvement in health or life expectancy are not keeping pace with the rest of the population – this would clearly include patients living in regions of the country where COVID-19 has either impacted more on emergency or elective care (see below).

<u>Statement 1 of the NHS Constitution states</u> 'The NHS provides a comprehensive service, available to all. It is available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and *to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population*.

<u>Statement 2</u> states that 'Access to NHS services is based on clinical need, not an individual's ability to pay' In our discussion, the second part of this statement is not relevant, but access based on clinical needs certainly is, again with markedly different access times across the country significantly exacerbated by the COVID pandemic.

<u>Statements 3</u> 'The NHS aspires to the highest standards of excellence and professionalism' is perhaps not as directly relevant, but professional ethical decision making is at the cornerstone of this report and the need for a clear, transparent and just process is discussed later.

<u>Statement 4</u> 'The patient will be at the heart of everything the NHS does' is clearly relevant, although in the panel discussion the need to balance individual needs against what is best for the greater good.

<u>Statement 5</u> however does clearly drive the expectation that the NHS should work across organisational boundaries in the interest of patients and populations. This is clearly highly relevant to the potential enhanced movement of patients for emergency and elective care (see below).

Statement 5: The NHS works across organisational boundaries. *It works in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values reflected in the Constitution.* The NHS is committed to working jointly with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.

When the values of the NHS Constitution are also considered, again several of these statements are very relevant to this topic:

'Working together for patients. Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. *We put the needs of patients and communities before organisational boundaries*. We speak up when things go wrong.'

This statement defining one of the NHS values states that we should be working across organisational boundaries for the benefit of patients which is directly relevant to the ethical decision making around transferring patients between organisations.

'Respect and dignity. We value every person – whether patient, their families or carers, or staff – as an individual, *respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do*.'

This statement reminds of the importance of transparency and honesty and also the needs to consider the individual needs of patients balancing them against the needs of the wider population.

'Compassion. We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.'

This statement is a clear reminder in this context of the need for compassion and care in all our decision making, communication and care in what are challenging and difficult circumstances.

'Everyone counts: We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources, we waste opportunities for others.'

The statement clearly states that we need to maximise resources for the whole community and this context we could consider to be either a whole (NHS) region or indeed the whole country.

Your rights. You have the right to

- receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.
- access NHS services. You will not be refused access on unreasonable grounds.
- receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.
- expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.
- in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available to you through your NHS commissioner.

The end of this statement regarding patients' and individual rights' emphasises the importance of the need and support required for patients to move significant distances for treatment where appropriate.

Discussion

Several members of the panel discussed the potential conflict between the different pillars of clinical ethics in the context of the questions posed. There was agreement that Health Maximisation or the utilitarian approach to provide the greatest good to the greatest number should be considered at the top of the hierarchy when there is a conflict between different pillars.

Closely following health maximisation, it was also agreed that Justice was an extremely important ethical pillar and a key element to the decision-making process. The panel agreed there was a need for clear, transparent and fair processes to be put in place to make sure transfer decisions were not discriminatory and were just. Ideally these processes would be developed in a coproduction manner with patients and members of the public.

The overall balance of potential benefits must outweigh any potential for harm. In these situations, there will be the expected benefit to one or more patients who will receive higher quality care or earlier care or both. There will often be a potential disbenefit to one or more patients whose waiting time may be longer or who may need to travel to receive similar treatment.

There are several possible scenarios. In one, the transfer is a disbenefit to both the individual and system – this in practice is never likely to be considered and would clearly be discounted as an option. In another scenario, there is a benefit to both – for example a Trust has an ICU that is at 100 percent capacity when another patient is admitted who requires critical care. Fortunately, they are stable enough for transfer and a nearby Trust has plenty of capacity – both the individual patient and the system benefits and decision making is straight forward.

There are other less straight forward scenarios where there are those who benefit and those that suffer a disbenefit. For example, a Trust with an ICU that is close to or at capacity but anticipates further admissions, so in in order to create capacity for future demand a decision is made to move a stable patient to another Trust. There is benefit to future expected patients, and there is a benefit to the staff in the department who can avoid exceeding their safe capacity. There is a disbenefit to the patient who is being transferred in that there is a risk due to the transfer and in addition they will most likely be further from their home, relatives and friends. The risk of transfer can however be minimised in a variety of ways including the use of specialist transfer teams. Many individuals, if given the choice, would choose to accept the transfer recognising this would be contributing to the ‘greater good’. This particular scenario includes the relatively challenging element that the transfer is for a probable, anticipated or expected patient rather than a definite and defined individual.

To consider this further.

Beneficence – to do what is in the best interests of the patient and may require a balancing of the benefits of treatment against the risks and **Non-maleficence** – to do no harm, avoid causing any harm.

Clinical Senate agreed that consideration of whether a patient should be transferred must include an assessment of the balance of risks resulting from the transfer:

- Would the transfer cause any harm or risk to the patient, for example would the patient's condition be likely to deteriorate during a transfer?
- Would the transfer be likely to impede their recovery and impact on recovery? The impact may be greater on those with mental health needs. The impact might also be greater the further the distance from relatives, loved ones and friends.
- Would the quality of outcomes (for the planned treatment) be at least the same at the new location as would be expected at the sending location?
- Would the treatment differ in any way at the new location; are treatment protocols, regimes, clinical opinion, staffing ratios at the new location in line with those at the base hospital?
- Does the new location have appropriate capacity, staff and facilities to safely accept the patient, are other patients (or potential patients) being placed at any risk by the location receiving this patient?

The panel however agreed that the consideration of beneficence and non-maleficence needed to be balanced alongside the two other pillars (out of the four described above) of medical ethics, autonomy (control by the individual) and justice or equity / fairness.

Autonomy is an extremely important ethical pillar and the panel agreed it should be a major consideration where possible. This should clearly be the case where someone who had capacity and was being offered elective care elsewhere – they would have the right, following informed consent, to decline to travel for treatment whilst accepting the consequences of a probable delay. It was agreed that individuals would not have the right to demand a treatment or indeed to demand a treatment on a given site.

The NHS Constitution lays out the right "to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences." However, this does not grant the right to demand a treatment or demand treatment in a given location and should not be confused with the NHS 'patient choice' agenda.

In the emergency care situation patients often would not be in a position to express their view if, for example, they were critically ill and potentially ventilated and unconscious. Even in situations where a patient were able to communicate, they may not have time to carefully consider the complexity of any potential choices.

It was agreed that patients and their relatives and friends would need to be communicated with and treated with care and compassion but ultimately could not be given the right to decide to remain and receive critical care treatment on a given site. Such situations can be challenging for patients, relatives and staff – it was noted that any tendency to make exceptions may widen health inequalities particularly when differences exist between patients or families in the ability to communicate their concerns. There was a recognition that there could occasionally be a tendency (in life in general) for preferential treatment to go to 'those who shout the loudest' and care needs to be taken to ensure that this is not allowed to result in unfair decision-making.

The 'Everyone counts' value states: the NHS will "maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources, we waste opportunities for others."

Whilst the principles applied equally to the potential transfer of both the critically unwell and the urgent elective patients, Clinical Senate recognised that there was likely to be a greater level of autonomy and the ability to engage in the discussion for transfer with urgent elective patients than there would be with a critically ill patient. This could present a risk of unintended inequality whereby a patient, their carer or relative, may well be able to put across a very convincing argument to remain and so place undue pressure on an individual clinician or team.

The autonomy of one person cannot override the autonomy of another and people should be given support to take their own decisions, using terms and language they can understand (Finlay 2019). The Mental Capacity Act (2005) provides a legal framework for decision making when people may lack capacity, including when capacity fluctuates or may be partially impaired, this can be time and decision specific. When an individual lacks capacity, a decision must be taken that is in their best interests, and accords with their own previously expressed wishes, feelings, values and beliefs.

Clinical Senate was also clear that the identification of patients for transfer should have a major focus on the principle of safety for the transfer, rather than purely on prioritisation of care. This would usually result on the most stable patient being transferred. The decision should not be based solely on a reading of the patient's medical records or a list of medical conditions, but on as broad an understanding of the individual and where possible the patient should contribute to the decision making.

Clinical Senate discussed this issue at length and agreed no one person had the right over another to refuse (to be transferred) and agreed that in addressing the question of autonomy, the clinician should take the focus away from the individual needs to those of the greater good. This principle of utilitarianism – whereby the most ethical choice is the one that would produce the greatest good for the greatest number – this is a choice faced daily across the NHS in the provision of care and making hard decisions about how best to maximise resources. Where it may feel difficult applying the principle of autonomy at a more subjective, individual level, the principle of utilitarianism should prevail.

It might therefore be the case that whilst it might not be in the patient's best interest to transfer to another location for treatment, provided it does not do them any harm and everything is done to minimise any harm, if their transfer results in a greater good then the decision to transfer should be acceptable.

Before the final decision to transfer a patient is agreed, and before the transfer is undertaken, other factors needed to be considered including does the new location have full access to the patient's medical records, the availability of a skilled transfer team to support the patient on their journey, infection control measures during and post transfer.

An additional factor to be considered in relation to the transfer of a patient is that of the impact on staff, both at the current and new location.

Staff currently involved in the care of the patients should be involved in the decision making wherever possible and the rationale for the decision should be transparent.

Consideration should be given to the impact on the new location of the transfer. A Trust that might be identified as having capacity to accept a patient transferred from another location may have only recently itself recovered from a surge or super surge and ideally requires time to support staff wellbeing for example. Transfers may place the new location at increased risk of a surge itself.

The East of England (COVID) Critical Care Cell has advised that generally, so far, Trusts / hospitals have been happy to help other Trusts requiring mutual aid, particularly if it had been supported itself in an earlier wave of the pandemic. The panel agreed that as the system faces increasing demand with acutely unwell patients, the ability to accept patients from other locations may become difficult and may be less accepted.

Clinical Senate agreed that there had always been a degree of disparity in relation to patients from different geographical locations and that the COVID pandemic had heightened that. The system needed to look carefully at the level of support for acute Trusts in order to ensure that there was an equitable approach to 'load levelling' and no disincentive to be efficient. This is particularly relevant to ensure that the backlog of elective care can start to be met and that health inequalities are not exacerbated in areas where the local acute Trust may have greater capacity to accept patients from other locations.

Key Findings

There was a unanimous view that it was both consistent with the NHS Constitution and ethically justified to move patients within the NHS for both emergency and elective care if this would either benefit the individual patient or if overall it would deliver the greatest good for the greatest number.

Clinical Senate agreed that 'transparency' in the decision making for transfer of patients and prioritisation of patients was fundamental. These decisions should be transparent to the patient and / or their relatives or carers if appropriate, to the staff transferring the patient out and those receiving the patient. The decision making should be relayed to and understood by the patient's GP. In an ideal world, the decision-making process should be developed in conjunction with patients and the public and understood by patients and the public.

Summary

The reasons for the transfer of a patient from one location to another must be transparent and understood by the patient (when appropriate), their relatives or carers, the patient's GP and the staff at both the outward and receiving locations. Patients, and staff, should be aware that patient treatment is provided through a care system and that whilst they may have a preferred (in-patient) location, patients do not have the right to demand treatment being provided from a chosen single provider or organisation.

The four principles of medical ethics apply equally to patients that are critically unwell and those requiring elective care, whether urgent or planned. No one person's choice or autonomy should override another person's and, when considering transfer of patients from one location to another, clinicians should consider the principle of the greater good for the greatest number to support their decision making.

Due consideration should be given to the impact on the patient and staff of any transfer and potential risks should be mitigated.

Clinical Senate Council agreed that it would be happy to continue to be used to support discussions on the principle of ethics and decision making (but not on individual cases). The additional members that had joined Senate Council to form this group for the discussion confirmed that they would be happy to remain involved in future discussions

Recommendations

1. It is ethically appropriate and consistent with the NHS Constitution and values to transfer patients from one hospital to another or one region to another in order to access timely urgent elective care provided the following are met:
    a. There is a clear and transparent process ideally developed collaboratively with, and understood by, patients, the population, relevant stakeholders and primary care.
    b. The process is equitable to patients at both sites and across the broader population meaning the access criteria, based on need are applied in a fair and just manner.
    c. Outcomes measures can provide assurance of high-quality care provision from the treating organisation.
    d. The transport related risk is minimised.
    e. Due consideration during the decision-making process is given to the potential impact on recovery for someone who may receive treatment some distance from their family and friends.
    f. A patient's autonomy is respected and a decision not to accept the offer for the transfer for treatment will be followed as long as they have received high-quality informed consent and they have capacity to make such a decision.
    g. If a patient does not have capacity to make the decision, then a best interests decision should be made following the offer of a possible transfer for treatment.
    h. Infection control factors have been taken into account and any infection controls risks have been mitigated.

2. It is appropriate to transfer patients to access timely emergency and critical care because local capacity has been exceeded and care for patients in need of such treatment cannot be provided safely without transfer and in such a situation care must be made to ensure the most appropriate patient is transferred. The following criteria must be met:
    a. Local capacity should be enhanced first as long as it is safe to do so, and this will not excessively negatively impact on other patients.
    b. There is a clear and transparent process ideally developed collaboratively with and understood by, patients, the population, relevant stakeholders and primary care.
    c. The process is equitable to patients at both sites and across the broader population, meaning the access criteria, based on need are applied in a fair and just manner.
    d. Outcome measures can provide assurance of high-quality care provision from the treating organisations.
    e. The transport related risk is minimised.

f. Due consideration during the decision-making process is given to the potential impact on recovery for someone who may receive treatment some distance from their family and friends.
g. Consideration should be given to minimise any infection control risks.
h. If a patient declines to be transferred following high-quality informed consent, knowing that they will receive less high-quality care by remaining at the first site this needs to be respected providing they have capacity to make such a decision and this decision does not negatively impact on others.
i. If more than one patient is equally suitable for transfer, patient wishes, and other patient related factors, should be considered before making the final decision.
j. A patient does not have the right to insist on local treatment if this expression of autonomy goes against the clear, transparent and fair decision-making process that has identified them as the most suitable patient for transfer.

3. When considering the transfer of patients, the system should aim to maximise the health benefit across a wide population providing the greatest good for the greatest number and should also aim to provide equity and fairness in access to both emergency and urgent elective care patients. Every attempt should be made to minimise the potential harm to individual patients who may either be required to transfer or be required to wait longer for treatment in order to accommodate a patient from another site.

Clinical Senate agreed that the ‘transparency’ in the decision making for transfer of patients and prioritisation of patients was fundamental. These decisions should be transparent to the patient and / or their relatives or carers if appropriate, to the staff transferring the patient out and those receiving the patient. The decision making should be relayed to and understood by the patient’s GP. In an ideal world, decision making processes should be developed in conjunction with patients and the public and understood by the patients and the public.

The final two recommendations are required to enable good patient outcomes to result from ethical decision making

4. The workforce needs to be considered in the ethical decision-making process. This includes the need for transparent decision making and also includes the need to consider workforce resilience. One hospital may have spare capacity on a given day, but the same hospital may have just recovered from a recent and significant surge in patients, resulting in staff fatigue and the potential impact on morale. Transferring a patient into such an environment may not lead to the optimal outcomes expected.

5. The safe transfer of patients requires appropriate systems and processes, including IT systems, to ensure that all relevant information is available to enable optimal patient care.

Recommendations related to Clinical Senate and next steps

Clinical Senate Council agreed it was appropriate for Senate Council and an extended group of experts to provide independent advice and recommendations to specific requests and issues related to ethical decision making in future and agreed that, with immediate effect, this would be a standing panel of the East of England Clinical Senate. This would be reflected in the formal Terms of Reference and Conduct of Business of the Clinical Senate.

The experts involved in this discussion (see details below) confirmed that they were happy to continue to join the Ethics panel of Clinical Senate and contribute their expertise to future discussions.

Clinical Senate Council agreed that it would be willing to develop some generic guidance / framework of principles that could support developing policy around some of these very challenging situations.

Clinical Senate confirmed that it was not the appropriate forum for the provision of advice or recommendations on the emergency individual patient level, nor research ethics, both of which were well covered within appropriate organisations.

Clinical Senate Council would like to thank the following who joined and supported the Council's discussion and have agreed to continue to support any future discussions.

Professor Lesley Bowker	Consultant in Older People's Medicine Norfolk & Norwich University Hospitals NHS FT
Dr Christiana Burt	Consultant Anaesthetist, Medical Examiner Royal Papworth Hospital NHS Foundation Trust
Dr Sarah Grove	Consultant in Palliative Medicine, Arthur Rank Hospice, Cambridge
Dr Julian Huppert	Deputy Chair and Lay Member, Cambridgeshire and Peterborough NHS CCG
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Dr Carina Tyrrell	Public Health Registrar and Academic Clinical Fellow, University of Cambridge

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