

Can the courts be viewed as an appropriate vehicle to settle clinical unease?

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ABSTRACT

This paper is an exploration of the state of 'clinical unease' experienced by clinicians in contexts where professional judgement—grounded in clinical knowledge, critical reflection and a sound grasp of the law—indicates that there is more than one ethically defensible way to proceed. The question posed is whether the courts can be viewed as an appropriate vehicle to settle clinical unease by providing a ruling that clarifies the legal and ethical issues arising in the case, even in situations where there is no dispute between the patient (or her proxies) and the healthcare team. The concept of 'clinical unease' is framed with reference to the broader experience of clinical decision-making, and distinguished from other widely discussed phenomena in the healthcare literature like moral distress and conscientious objection. A number of reported cases are briefly examined where the courts were invited to rule in circumstances of apparent 'unease'. The respective responsibilities of clinicians and courts are discussed: in particular, their capability and readiness to respond to matters of ethical concern.

Four imagined clinical scenarios are outlined where a clinical team might welcome a court adjudication, under current rules. Consideration is given to the likelihood of such cases being heard, and to whether there may be better remedies than the courts. There are final reflections on what clinicians may actually wish for in seeking court involvement, and on whether a willingness to engage with the experience of clinical unease may lead to greater sensitivity towards the value perspectives of others.

INTRODUCTION

It is not unusual for healthcare professionals (HCPs)ⁱ to feel deeply challenged by the responsibilities they carry for decision-making in situations that are morally complex. In a recent report, Cass *et al*, surveying current challenges facing staff in paediatric services, describe 'an increase in the practical, ethical and moral dilemmas faced by clinicians and families, leading at times to conflict, and feelings of disempowerment and moral distress'.¹ HCPs are committed to a range of clinical, ethical and legal responsibilities, and the patients and their families with whom they interact have their own values, goals and commitments. In our value-pluralistic society, where perspectives on matters of ethical concern vary greatly, there is scope for uncertainty, hesitation and even inner conflict about the relevant

ⁱIt is now more realistic to speak, generically, of 'healthcare professionals' (HCPs) or clinicians rather than 'doctors' as decision-makers. Clinical teams are often multidisciplinary, with several disciplines providing vital input into treatment planning.

moral goods. Against this background, clinicians may experience a degree of moral misgiving about their treatment decisions, in a context where professional judgement—grounded in clinical knowledge, critical reflection, practical know-how and a sound grasp of the law—indicates that there is more than one ethically defensible way to proceed. This is the experience we call 'clinical unease'.

Our question is whether HCPs might reasonably turn to a court of law for support on the exceptional occasions when ethically complex treatment decisions must be made, and specifically in situations where there is no dispute between the patient (or her proxies) and the medical team. Courts only agree to hear treatment-decision cases where there is 'a serious justiciable issue'ⁱⁱⁱ to be addressed. Our argument is that some such cases are underpinned, for the HCP, by the experience of 'clinical unease'.

In what follows we briefly review some examples of case law in which a legal ruling was made with respect to a clinical predicament seemingly characterised by clinical unease. We then then set out four imagined scenarios of clinical unease, as we characterise it, where HCPs might hope that the courts could, under current arrangements, be approached to make a legal ruling. We consider the likelihood of each case being heard and contemplate whether there may be better remedies than the courts. We conclude with some reflections on what clinicians may actually wish for in seeking court involvement, and on whether a willingness to engage fully with the experience of clinical unease may lead to greater sensitivity towards the value perspectives of others.

CLINICAL DECISION-MAKING AT THE INTERSECTION OF MEDICAL, ETHICAL AND LEGAL FRAMEWORKS

Our notion of clinical unease is underpinned by a recognition that contemporary clinical work sits at the intersection of medical, ethical and legal considerations. The ethico-legal parameters of clinical decisions are set by established frameworks in statute and case law, and the contemporary clinician works with reference to a plethora of legal and professional guidelines. In cases concerning children and incapacitous adults, the HCP is guided by 'best interests'—that ubiquitous mix of medical/clinical and welfare issues² that is fundamental to clinical decision-making.

ⁱⁱⁱSee, for instance, *Re F (Adult Patient)* [2000] EWCA Civ 3029 per Dame Elizabeth Butler-Sloss.



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It is striking that everyday clinical decision-making, while inescapably engaging with ‘an existential and ethical agenda’,³ often proceeds quite swiftly and consistently.⁴ This is not to suggest that clinicians mechanically apply standard protocols. The experience of uncertainty is pervasive in clinical decision-making and managing it often has to be a ‘self-conscious and transparent endeavour’,⁵ requiring the particular mix of scientific understanding, legal awareness and ethical sensitivity that is the hallmark of good patient-centred clinical work. For Verkerk *et al*,⁶ it is the capacity of HCPs for deliberation that needs to be deployed in exceptional situations of high concern and moral complexity. The purpose of this skill is to reflect on difficult professional choices and on what would make a final decision defensible, especially when competing values and norms are not easily resolved. Coggon writes tellingly of ‘the fragility of the line between clinical and moral judgement...clinical indication is not the whole, and sometimes not even a part, of a medical decision’.⁷

CHARACTERISING CLINICAL UNEASE

‘Clinical unease’ occurs when a decision required to be made by an HCP seems, even after much hesitancy, exploration and consultation, to involve either an unresolvable choice between two potentially unsatisfactory responses—or a recognition that the preferred option involves seemingly irreconcilable moral commitments. In such situations, it may feel impossible to act on either of the plausible options, since each embodies a compelling, but conflicting, moral value. The clinician cannot evade her responsibility to choose, yet ‘whichever action one chooses, one violates the moral requirement to do the other action’.⁸

The particular professional expertise of the uneasy clinician is central to these predicaments—in how she assesses the patient, explores the problem, considers evidence, reviews options, consults etc—but her concern is also with what is ethically ‘right’ from the point of view of deeply important values originating in her professional role (some of which will also be held as personal commitments). In such situations, directly comparing the options is often not easy because each option may express values which are important in quite different ways. Some values express respect for the powerful claims to a patient’s self-determination; some involve protecting a child or incapacitous individual from making far-reaching and potentially damaging choices (or having such choices made for her by proxies); some values reflect a wish to esteem the perspective of an individual without conventional ‘voice’; some acknowledge the responsibility-based rights of parents to make decisions for their child.

Unsurprisingly, we see clinical unease especially provoked by new developments in biomedicine, associated with treatment interventions that are complex in their ethical significance—relating, for example, to the ‘quality’ of a medically prolonged life, organ donation, physical reassignment to the ‘other’ sex, the indeterminate confirmation of ‘death’.

To summarise, we define states of ‘clinical unease’ arising in situations of clinical decision-making where each treatment option (including ‘no intervention’) arguably has a rationale in evidence and clinical experience, can be justified legally and is grounded in a defensible moral position, and:

- ▶ Where the legal framework is not unclear—and yet there is room for doubt about what the law might permit in this case
- ▶ Where moral and social values are significantly engaged in a sensitive and contested area of practice
- ▶ Where either two conflicting interventions (A and B) recommend themselves to the clinician ethically, with each option

representing claims that cannot be fulfilled if the other option is chosen

- ▶ Or where an intervention, C, to which the clinician is committed in respect of certain of its features, has other features in respect of which she ought not to choose it
- ▶ Where between the patient (or her proxies) and the clinical team there is no active dispute about the best way to proceed (and hence no outstanding reason to seek judicial oversight of the treatment decision)
- ▶ Yet where the HCP may fear that she will be negatively judged for whichever option she decides on.

DISTINGUISHING CLINICAL UNEASE FROM MORAL DISTRESS, INSTITUTIONAL ANXIETY AND CONSCIENTIOUS OBJECTION

We distinguish ‘clinical unease’ from other widely discussed phenomena in the healthcare and wider ethical literature. ‘Moral distress’⁹ involves the HCP in a predicament where she identifies the ‘right’ thing to do, but institutional pressures or sociopolitical structures make it impossible for her to carry this out.¹⁰ In a state of clinical unease, by contrast, the clinician precisely struggles to identify what she believes *is*, overall, the right thing to do: her moral duties seem to conflict so that whichever action she takes threatens to involve her in either violating a responsibility or failing to uphold a responsibility.

Clinical unease is also significantly different from the kind of institutional anxiety and sense of powerlessness identified by Menzies-Lyeth¹¹ in healthcare organisations, when the HCP feels overwhelmed by the suffering of patients in their encounter with illness and death in a situation where she has little or no control. Here, the HCP finds a solution in a retreat from responsibility. In scenarios of clinical unease, by contrast, the clinician makes no attempt to refuse or deny her responsibility, but is deeply troubled by the seeming impossibility of making the morally ‘right’ choice.

‘Personalising’ these decisions by HCPs—implying that personal conscience is the main driver of uncertainty—also fails to capture the particular complexity of these ethical predicaments. There may be times when the sense of professional obligation clashes with personal values in ways that set up crises of personal conscience—as discussed from contrasting perspectives by Smith¹² and by Montgomery.¹³ But in situations of clinical unease, it is not that the HCP feels she should do one thing (as her conscience dictates) and not another (as the moral requirements that come with her professional role entail): the point in clinical unease is that she strongly feels the pull of the professional (and conceivably personal) ethical goods in *both* options. The HCP feels pulled towards honouring the moral values that each option independently represents.

‘MORAL REALISM’ AND THE REALITY OF REGRET

It is also important to add here a note about the kind of moral realism¹⁴ which invites the HCP to imagine an objectively ‘right’ moral decision as (almost) always within reach, were she just able to adequately appreciate what is at stake—morally, empirically and legally—in each option. Crucially, on this model, once she ‘rightly’ selects one option over another (both options having *prima facie* moral claims) and identifies the unique, action—guiding moral requirement, she will be released from any obligation to perform the action that was (correctly) not chosen. And it is true that identifying moral reasons for preferring one option over another may give an agent a sense of acting for the best, all things considered. But in thinking this way, as Williams argues,

she may fail to do justice to the facts of unease and regret.¹⁵ It is often the case that a clinician is unable to completely discard or repudiate the moral obligation she has felt towards the option that she eventually rejects (even once the decision has been made). The concept of the ‘moral remainder’¹⁵ helps explicate this kind of crisis where ‘the notion of ‘acting for the best’ may very well lose its content’.¹⁶

THE AUTHORISATION OF HEALTHCARE DECISIONS: EVOLVING RESPONSIBILITIES OF HCPS AND THE COURTS

Exploring the experience of clinical unease requires us to consider how healthcare decisions are currently authorised in England and Wales. Over the last four decades, the framework governing authorisation has evolved considerably, driven by key statutes (eg, Human Rights Act 1998; Mental Capacity Act 2005) and a host of rulings from the courts. Arguably, this judicial and legislative activity has been driven, at least in part, by an interrogation of the traditional deference of patients to doctors. Certainly, it has brought to an end a tradition that assumed the automatic right of HCPs to take key decisions.

In the burgeoning discipline of academic medical law, a central critique of medicine is that it historically monopolised decisions that fall beyond its professional remit.¹⁷ With concepts of health and ill health vastly expanding, Kennedy¹⁸ argued, influentially, that many decisions taken by doctors are ‘not within their unique and special competence...but rather involve questions of morality or philosophy or economics or politics’. This portrayal of HCPs as expanding their remit too widely—requiring the courts to limit their powers in the name of patients’ human rights—has been accompanied by a valorisation, by some academic commentators, of what the law can offer in place of medical authority in areas of decision-making which are as much about values as about technical knowledge. For Kennedy, ‘no social mechanism other than law is adequate to the task’,¹⁹ while Foster contrasts the decisions made by ‘detached’ judges compared with ‘harassed’ doctors.²⁰ And for Foster and Miola, ‘the more ‘ethical’ the issues in a case are, the more reason there is for the law to take control, because an ethical issue contains, by definition, elements other than issues turning on the appropriate exercise of technical medical skill’.²¹ Continuing developments in biomedicine seem to provide the very kinds of scenarios in which courts might arguably be involved, to develop, as Lee and Morgan²² write, ‘a social, even a moral vision with which to respond to the dilemmas created by the social and cultural revolutions of contemporary medicine’.

HOW DO THE COURTS HANDLE ETHICAL ISSUES?

But if the courts were to take a more proactive judicial stance in ethically challenging medical cases, does the law have in place, ‘as bioethics does not, structures and procedures for the detailed examination and adjudication of ethical questions’?²¹ This would require distinguishing between the ‘technical’ aspects of healthcare decisions—diagnosis, prognosis, determination of treatment options—and the ethical aspects—‘decisions about what ought to be done in light of certain values’.²³ Excising the ethical aspect of a treatment decision and handing it over to the law would marginalise the responsibility of HCPs for ethical reflection. But in their persuasive analysis of the ruling in *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam), Morgan *et al*²⁴ demonstrate that confirming Ms B as autonomously able to choose withdrawal of ventilation involved, for the healthcare team, a set of inter-related judgements—highlighting the

entwinement of medicine, ethics and law—in order to come to a decision.

Besides, what qualifies a court of law to be the highest body in society for resolving the most ethically challenging medical cases? Importantly, the judges themselves frequently acknowledge this question. In its most traditional guise, the law is viewed as qualified by being rigorous and disinterested, as engaging only in legal terms when faced with cases that are ethically, politically, morally and philosophically contested. And certainly, complex ethical questions are rarely, if ever, settled in court by means of learnt ethical analysis and debate. Indeed, judges often seek to exclude or obscure moral conflicts, relying instead on the traditional practices of statutory interpretation or reviewing legal precedent.²⁵ Striking in this regard was the approach taken by the Court of Appeal in *Bell v Tavistock* [2020] EWHC 3274 (Admin), where first instance court was strongly criticised for ruling on ethical, political and social issues well beyond its remit.

There is undoubtedly room to question—as Skowron²⁶ does—whether judges are, in fact, concealing their preference for one or other set of values under a ‘cloak’ of neutrality and clarity. But overall, we suggest that the courts have not been especially eager to slip into the space that medicine has been advised, by some academic commentators, to vacate.

One outcome of this is to allow a ‘regulatory vacuum’ to emerge²¹ with clinicians looking to courts for ethico-legal guidance and the courts returning responsibility to clinicians. In our value-pluralistic society, a consequence for individual HCPs may be that at times they feel unbearable unease in settling on a treatment decision.

WHEN FINELY BALANCED, ETHICALLY CONTROVERSIAL, BUT NON-DISPUTED, CLINICAL DECISIONS GO TO COURT

At this point, we ask how far it is a reasonable aspiration for clinicians to imagine requesting the courts to be more actively involved in ethically irresolvable but non-disputed healthcare decisions—that is, in cases of clinical unease. Certainly, courts concerned with the best interests of those whose decision-making capacity is impaired, or with the welfare of children, assert that their work is meant to be inquisitorial, not adversarial.

When the courts rule in non-disputed cases, the form of adjudication employed has traditionally been the declaratory judgment whose purpose is to resolve legal uncertainty by clarifying the rights, duties or obligations of one or more of the parties: ‘filling gaps in the common law’.²⁷ It has evolved from being a declaration which simply states whether a future activity will be lawful or not, into one which states it is lawful as long as it is in the person’s best interests. Glenys Williams²⁸ notes its ‘anticipatory, responsive and reflective role in shaping the common law to meet changing and technological demands [that] is within the courts’ authority’.

The declaratory jurisdiction of the higher courts has been maintained in relation to children. But the Court of Protection now has final jurisdiction to make declarations about whether clinical decisions in relation to patients over the age of 16 and lacking capacity are, or will be, lawful. Here, the preferred model of adjudication is now the making of a decision by the court on behalf of the person, whether or not to receive the treatment in question.²⁹ However, while the model of adjudication differs from the traditional declaratory approach, the principles are essentially the same. The 2020 Serious Medical Treatment

Practice Guidance,³⁰ⁱⁱⁱ issued by the then Vice-President of the Court of Protection, sets out the medical decision-making situations in which consideration should be given to bringing an application to court. Notably, for our argument here, situations are included where there are concerns that the way forward is ‘finely balanced’ (S8(a)) or where the case raises ‘a significant ethical question in an untested or controversial area of medicine’ (S11(e)). In other words, the concept of ‘serious justiciable issue’ appears to be deliberately and broadly cast in the medical treatment context even if, as we develop below, it may not in practice be as simple as that.

Since the 1970s, there have been a number of reported medical cases centring round the adjudication of reasons for intervening where the patient, her proxies and the medical team were not in dispute (and indeed, may have applied to the courts together). The legal questions in the cases we briefly review here focused on such issues as clarifying the requirement for court oversight in ethically challenging medical scenarios such as the sterilisation of incapacitous people (eg, *Re D (A Minor) (Wardship: Sterilisation)* [1976]; *Re: F (Mental Patient: Sterilisation)* [1990]). Another typical rationale involved the pressing need for elucidation of an unclear or a developing branch of the law, including human rights law (eg, *Re: SG (adult mental patient: abortion)* [1991]; *Re K, W and H (Minors) (Medical Treatment)* [1993]; *D v NHS Trust (Medical Treatment: Consent: Termination)* [2004]).

In other cases, judicial oversight was provided where ‘conflicting legal advice’ had been given for an ethically demanding clinical decision (eg, *AK (Medical Treatment: Consent)* [2001]). And there were a number of cases focused on the protection of incapacitous people who stood to suffer untoward consequences from novel, hazardous, uncertain or contentious interventions (eg, *Simms v Simms and another* [2003]; *Pennine Care NHS Foundation Trust v Mrs T & Mr T* [2022]). In addition, there were cases where an intervention did not medically benefit the incapacitous patient (eg, *Re Y (Mental incapacity: bone-marrow transplant)* [1996]). And the court’s help was also sought in cases which involved clarification of whether an intervention was, in fact, in a special category of interventions requiring court approval (eg, *AB & CD* [2021]).

Each of these cases can be characterised as involving a high-stakes ethical decision by the medical team, for which clear legal sanction was sought by families and medical trusts—often together. It is clear—and unsurprising—that the healthcare bodies framed the question as a legal one, rather than a clinical, social or moral one. However, it is claimed here that the necessarily legalistic language can mask the values-based doubt and indecision experienced by those holding clinical responsibility. In other words, clinical unease may well be eclipsed behind the legal framing.

Table 1 Four imagined scenarios of clinical unease

Scenario	Nature of clinical unease	What is hoped for from court intervention
1. A young man, S, with motor neurone disease makes a request of his GP, despite extremely limited communication, to have ventilation withdrawn. With ventilation, he may live for several months more. The GP is concerned that S is depressed and that this is driving his wish. A psychiatrist sees S briefly and takes the view that he is not depressed.	The GP knows S well and feels uneasy that his decision is only questionably autonomous. She wants to give time to exploring and questioning his wishes; she equally does not want to deny his rights as a competent adult to refuse.	External oversight of whether treatment withdrawal has been autonomously consented to by S.
2. T, 13-year-old girl has requested an early abortion. The GP thinks she may be ‘Gillick competent’ for this decision but is concerned that T has not disclosed the pregnancy to her parents. The GP is anxious not to break confidentiality but she is unsure whether the circumstances are such as to require her to contact parents (and perhaps raise a safeguarding concern).	The GP is unsure exactly how to evaluate for Gillick competency in this area of practice and fears doing too little to protect this vulnerable girl. She is especially uneasy as she is seeing increasing numbers of girls in their early teens requesting terminations.	Guidance from Court clarifying how Gillick ruling (and any other legislation deemed to be relevant to the doctor’s responsibilities) relates to this minor requesting an abortion.
3. N is a 4-month old premature neonate on life-sustaining treatment in intensive care for 3 months. His condition shows no signs of improvement and the clinical team considers no further advantage to intensively (and intrusively) supporting him to remain alive. They have worked hard to build a cooperative relationship with parents to make shared decisions but the parents want more time given to supporting N’s life.	The HCP team is anxious about the authority of parents to make treatment decisions for very ill babies. They note that the Trust is shifting towards acknowledging greater autonomy for parental authority, even when the child seems to be suffering. The team is desperately trying to avoid a dispute with the parents.	To have a decision about treatment made in principle by the court, to forestall conflict with baby’s parents.
4. At a specialist service for children with gender dysphoria, G, an 11 year old born female, and her mother wish for G to be assessed for puberty suspension medication (GnRH analogues). It is the task of the multi-disciplinary team to decide if this treatment can be offered in G’s best interests, in line with the NHS service specification.	The HCP team want to show respect to the child voicing an intense male identification and mother’s strong and loving support for her child. Their uncertainty as to whether this is safe and morally right intensifies with increased numbers of such children coming forward for PBs, at ever younger ages. They are unsure whether this intervention with non-competent minors has gained ethico-legal acceptability. Part of their unease concerns their eventual liability if they do proceed.	The team seeks authoritative external debate, according to sound principles of public decision-making, of this ethically controversial treatment, to establish whether PBs are in this child’s best interests and in the public interest, given increasing numbers of minors coming forward for treatment.

GP, general practitioner; NHS, National Health Service; PB, puberty blockers.

ⁱⁱⁱThis document provides interim practice guidance pending the review of the MCA (2005) *Code of Practice*. Under the current Code there is no requirement that conflict should exist between the parties before a declaration can be sought (s8.18).

FOUR IMAGINED SCENARIOS OF CLINICAL UNEASE

We present in [table 1](#) four imaginary scenarios of clinical unease. Our aim is to explore whether the courts could reasonably be applied to as a resource in such situations. We have drawn up

these scenarios following detailed conversations with professionals in National Health Service primary, secondary and tertiary (specialist) services and in hospices. For each scenario, we summarise the clinical concern, the nature of the clinician's unease and the hoped-for court intervention in relation to an outstanding legal issue that might also resolve or settle the ethical quandary. We have deliberately sought to identify scenarios where application to court is not mandatory.

We do recognise that the decision about whether to go to court is ultimately one that will incorporate advice from the relevant lawyers involved, and that there may be situations in which discussions with those lawyers may help resolve the unease. Here, we choose to sidestep this possibility because the purpose of these scenarios is, as much as anything else, to provoke discussions among and between HCPs and lawyers.

In these imagined situations of clinical unease, we suggest that the clinical decision-maker(s) may find it problematic to directly compare the alternatives, when each option expresses a value which is important in quite different ways. Some of the values present in the scenarios express respect for a degree of patient autonomy in healthcare decisions, even for children and people with questionable capacity; other values prioritise the protection of vulnerable individuals in perilous decision-making; some values honour the provision of controversial medical interventions for social/psychological reasons; and some reflect concern for a fair approach to resource allocation. It is easy to envisage how, in such scenarios, distress may ensue for the HCP team under pressure to make a decision, especially as the moral issues involved in contemplating the decision may be strongly felt as well as thought.

In devising the scenarios, we imagined that an HCP (perhaps together with family members) might hope for help from a court if they sense that the law is unclear, or still developing. They might hope that a confident weighing-up of the ethico-legal issues in court would assist them in selecting one option over another, perhaps by shifting the balance between the ethical claims of each treatment option. They might expect, additionally, that a court would find it appropriate to offer an appraisal of the public interest in a particularly contentious area of medical practice.

In addition, some HCPs may feel apprehensive that they will be censured for whichever option they decide on, and be seeking protection from public vilification or legal liability, now or in the future. Criticism of clinicians often follows the publicity around complex cases in the press.³¹ So the hope may be that the court will offer evidence of procedural legitimacy, in order to reassure patients, the team and the public regarding the way in which ethically contentious decisions are made³². A court judgement by an authoritative decision-making body—arguably, the most authoritative body—widely seen as independent, objective and impartial, could perhaps shield clinicians from criticism and even litigation. The desire for such authoritative sanction is likely to be especially strong just in those areas where the acceptance of certain social beliefs and practices—and concomitant medical interventions—is undergoing a process of change. And here it may be worth considering—but outside the scope of this paper—whether there could be more economical 'health tribunal courts' to offer decisional support in certain kinds of non-disputed cases.

³¹Montgomery suggests that a decision may be 'more palatable' if taken by the courts rather than 'being taken merely by doctors'. Montgomery J, Time for a Paradigm Shift? Medical Law in Transition. *Current Legal Problems*, 2000; 53(1):363–408.

The uneasy clinician—as portrayed in the four scenarios—may also want to involve a 'higher' decision-making authority out of the conviction that there are simply some medical decisions which society wants a judge to rule on. They may believe that that a court ruling would be in the public interest because a judge's decision is deemed more legitimate, literally. However, it is far from clear that this is the case, or whether the courts have simply asserted legitimacy in some arenas, such as end of life care (or have had such assertions made for them).

THE FOUR SCENARIOS: MIGHT THE COURTS BE AN APPROPRIATE VEHICLE TO SETTLE THESE INSTANCES OF CLINICAL UNEASE?

For each of the imagined scenarios, we gave ourselves the task of surmising whether the court would be an appropriate vehicle to settle the unease, even though any judgment would be unlikely to directly address the clinical dilemma. In other words, would the court be willing to accept that there was a serious justiciable issue to be determined?

In scenario 1, we hazard that it is possible, but unlikely, that the court would hear the case. Norms for withdrawing LST for patients with motor neurone disease are well established,³² so approaching the courts for guidance should not be necessary, unless the circumstances are exceptional.

In scenario 2, we suggest that the court might hear the case, in the light of *An NHS Trust v A, B, C and LA* [2014] EWHC 1445 where a court was willing to rule in relation to a similarly aged child who was judged to have sufficient understanding and intelligence to give her own consent. On the other hand, the appeal court judgment in *Bell v Tavistock* [2020] EWHC 3274 re-stated that the question of competency to consent is for medical professionals to settle, on a case-by-case basis, and not the courts.

With respect to scenario 3, it seems unlikely that a court would be willing to take the case and consider providing a ruling, unless the circumstances were exceptional. There is a hesitancy around making anticipatory declarations because the ruling must be derived from the facts of the case, while it is always possible that the facts may change in the interim between the declaration being made and the treatment being finally decided on.³³

Again, in scenario 4, it seems doubtful that a court would be willing to consider the case. In *AB & CD* [2021] EWHC 741 (Fam) it was ruled that authorising treatment with puberty blockers falls within the zone of parental consent, provided the child is not objecting, despite the relative novelty and deep contentiousness of the intervention. It is probable that court would insist that responsibility for the decision is held by clinicians, with commissioners and professional bodies providing essential up-to-date guidance around treatment criteria and good practice.

BETTER REMEDIES THAN RESORTING TO THE COURTS?

Applying to the court for ruling over a healthcare intervention is inevitably a time-consuming and expensive process and likely leads to significant delays in decision-making. Besides, in the kinds of scenarios we have considered, there may be a better remedy than recourse to the courts. And indeed, all plausible routes to resolution of the moral unease should be attempted before the assistance of the courts is sought.

At the very least, clinicians might better manage their unease in the face of ethico-legally complex decisions were they more

familiar with the relevant legal issues^v and if they could gain faster access to sound, clinically attuned legal advice. Besides, the clinician is typically not alone in her struggle with situations of clinical unease. Accordingly, it is her responsibility to make adequate opportunities for consultation with colleagues, seniors and appropriate experts, accessing all the necessary information and hearing all relevant views. Additionally, in a patient-centred healthcare system, decision-making is fundamentally to be shared with the patient and family. Clinical teams must work with these stakeholders to reach mutually acceptable decisions, perhaps with the help of mediators (although it is questionable whether shared decision-making actually ensures moral validity, at least in paediatric care).³⁴ HCPs need to develop good processes for reflecting on what they have garnered from all these resources, and to do all this in as timely a way as possible, with a degree of objectivity and impartiality.³⁵

A better remedy might often be to seek help from a Clinical Ethics Support Service (CESS), if one exists in the relevant healthcare Trust (perhaps employing an established model of reflective case review such as ‘moral case deliberation’³⁶) or from hospital or external mediation services, or from specialists able to offer an expert second opinion—all sites where complex legal and ethical matters can be evaluated by experienced people who are independent of the treating team. There is also a need for patients and the wider public to be helped to understand how the law works to authorise decisions in healthcare, and to understand more about the different consultative fora like a CESS, in order to grasp that clinicians do not work in isolation, unregulated and unsupported.

In addition, the practical ethical training of HCPs could be enhanced so that they feel better equipped to effectively reflect, and argue powerfully, on a clash of ethical goods in decision-making. In some treatment contexts, they might even be better advised to put their energy towards pursuing a more adequate professional, or even political, articulation of recurring issues around competing values, rather than expecting the courts to consider them in depth and definitively resolve them.

WHAT DOES THE UNEASY CLINICIAN REALLY SEEK?

We also want to push a little harder on the question about what expectations clinicians may have of resolution by the courts, and whether they are realistic. If a case does go to court, HCPs may naively hope that the judge would subject the pressing legal question to careful analysis, give sustained thought (rooted in reflections on the relevant value positions) to the complex ethico-legal predicament, and thereby frame the clinical predicament more manageably. But this paints an idealised picture of how the law might assist HCP decision-making. The likelihood of a skilled, learned and consistent ethical analysis (of direct assistance to clinicians) being obtained from the courts is vanishingly small: essentially, this is not their role.

A more plausible outcome, if a case is heard and a declaration made, is that the clinician does subsequently feel freer to think and act, with her final decision prospectively established within a transparent legal frame. Whatever decision is now made will have legal sanction, and the clinician or team will feel a degree of protection from adverse comment. Simply hearing the case argued in court and seeing it analysed, however summarily, in a judicial ruling may

make the whole predicament seem more tractable. If the ruling is available in a public document, this may help to authenticate the struggle to achieve a passably fair and impartial perspective. Just witnessing the court, whose job is procedural decision-making, step up to its responsibilities and not flinch from the difficulties of finding a way to attend to and interpret seemingly unreconcilable moral claims, may be reassuring and inspiring for the HCP. This is the court acting as a wayfinder.

Alternatively, it may appear to the HCP that the situation is more intractable than ever, even though the legal frame is now clear. The unwillingness of the court to take a proactive stance in rehearsing, deliberating and pronouncing on the ethical conflicts in the case may be disheartening if the HCP believes that such conflicts in healthcare delivered by a public institution should be open to impartial debate and argumentation in court. But, as we have suggested, the HCP may come to reflect on where that debate could best take place, if not in court, and she may go on to pursue opportunities for thoughtful, well-informed analysis and exchange in other professional and political fora.

If the more likely upshot is that the case is *not* heard in court, there may still be a positive result for the uneasy clinician in terms of understanding exactly why there is no legal question to be answered—usually, because the law is already clear on the relevant points. With such a re-statement of the law, some of the parameters of deliberate decision-making may be clearer too for the HCP. She may generally feel less at sea, less caught up in the moral torment of feeling a commitment to both of the ‘oughts’ represented in the conflicted case. She may reorient to other available and relevant frameworks, provided through her professional body, through specialist consultation, through additional review of the evidence base, or through a further discussion with an ethics forum.

Finally, the HCP may come to realise that what she was hoping for was unattainable. Accepting that some cases are inherently uncertain, with each outcome substantively ‘right’, she may see that she has been wishing for an idealised decision-making body—with greater expertise, credibility, wisdom, impartiality—to take the moral conflict she is experiencing and somehow remove the anticipated pain of the moral remainder. Instead, she may come to consider that residues and carry-overs are to be anticipated as the norm rather than the exception in the search for tolerable solutions to the moral binds of clinicians.³⁷

It is perfectly likely that the aware clinician will have already speculated in advance which way the judge would rule. So was the clinician posing a genuine question to which she did not already know the answer? Certainly, she was in the grip of a genuine moral clash, but it may not have been a fresh, imaginative, substantive judgment that was wanted, as much as a certified recognition of the painful fact of the conflict. In such a situation, we need to turn from explicating conscious, cogent reasons that clinicians might have for approaching the law to achieve a degree of reconciliation. We should look at a different kind of understanding of the HCP’s expectations of what the courts can provide.

Here, we draw on the language of the psychoanalyst Bion who developed the concept of ‘containment’ to describe how an infant experiences a range of intense emotions and only develops a capacity to tolerate these raw, distressing states by having a caretaker who can take them in as a communication, and ‘contain’ them by thinking about and finding meaning in them.³⁸ This is the beginning of a lifelong dynamic process where we seek ‘to find another (person, group, institution) which can be temporarily repository for experiences that threaten to overwhelm us’.³⁹

In the ‘containment’ process, we may look, as adults, for someone or some organisation that will tolerate our anxious, conflictual and

^vA recent study indicates that doctors have minimal legal training after their initial qualification: Machin LL, Latcham N, Lavelle C, *et al* Exploring the perceived medical ethics and law training needs of UK foundation doctors. *Med Teach* 2020; 42(1):92–100.

disturbing responses to a crisis, deliberate over them on our behalf, and then 'return the experience to their originator in a new form that the person finds digestible, meaningful and helpful'.⁴⁰ At best, containment can reanimate the individual or the group, providing emotional relief and allowing for the responsibilities to be reshouldered.⁴¹ As Baraitser and Salisbury write, 'the containment of various forms of mental distress is dependent on a person's belief that there is some entity or function, both internal and external, that can endure 'under fire' and enable us to understand our thoughts and feelings'.⁴² It is as if the institution of the law could serve as a third term, seeming to transcend the entangled relationship between the giver and receiver of care.

IS CLINICAL UNEASE A PROBLEM OR AN OPPORTUNITY?

We have argued that while the law, ethical values and professional knowledge provide frameworks for decision-making, in many of the ethico-legally complex scenarios considered in this paper—real and imagined—conflicting values may not be easily resolved and a deliberative decision made without moral remainder. HCPs often find themselves holding the tension between moral perspectives and 'tak(ing) responsibility for what is irreconcilable in the wider world'.⁴³

Indeed, in a 'tragic' dilemma⁴⁴ the decision-maker is said to face a personal moral confrontation when it is not clear that there is a 'better' thing to do, or that the virtuous agent's action, in such circumstances, can ever be right or good. This notion points us to the implacable irresolvability of some moral conflicts, in which no thoughtful work of comparison can override the claims of the action not chosen^{vi}. Such predicaments may be a reality for HCPs—although inaction is rarely an option. But even if the agent does make an all-things-considered decision—eventually resolving the conflict in an ethically accountable way—the process may still involve a considerable moral cost, because the rejection of one pathway has involved violating a moral requirement.

However, it may be a mistake to frame clinical unease as a problem. At worst, the experience risks the clinician giving in to passivity and paralysis. But the emotional and intellectual engagement that clinical unease engenders may also serve to improve the moral quality of decision making. The absence of dispute between clinicians, patient/family and other professionals can mean that there has been no articulation by different (adversarial) parties of the different moral perspectives on the pressing issues of the case. Experiencing clinical unease and anticipating moral remainders may make the HCP and her team deliberate more fully and thoroughly. Defending the 'Best Interests' construct in law-making, Coggon⁴⁵ observes that its value lies in the fact that 'it asks medical professionals to think. It makes proper contemplation a fundamental aspect of good practice.' We might say something similar about the experience of clinical unease.

Moral conflicts might be avoided by clinicians who aim to reduce moral clashes to a minimum by refusing 'proper contemplation' and by giving so little attention—imaginatively, empathetically—to the value-laden perspectives of patients, families and colleagues that they fail to see the situation as seriously involving other, conflicting, moral points of view. By setting store only by facts, protocols and a narrow conception of evidence, by sidestepping any interrogation of habitual beliefs

and preferences regarding what is good, right or just, such a clinician may evade the moral costs risked in treatment conflicts and thereby avoid a full engagement with her task. A morally insensitive style of practice might avoid both uncertainty and injury to her self-image as an effective and decisive clinician. But, as Williams writes, 'the notion of a moral claim is of something I may not ignore: hence it is not up to me to give myself a life free from conflict by withdrawing my interest from such claims'.¹⁵ We leave unexplored the question of whether judges themselves, when they make difficult all-things-considered decisions, suffer comparably from moral remainders.⁴⁶

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^{vi}It is to be imagined that, at least in the healthcare domain, some 'tragic' conflicts will be open to resolution in new ways as medical knowledge evolves.

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