

Case example (hypothetical scenario, based on several real cases)

A 26 year old man is run over by a truck and dies in emergency. His wife, also in her 20s, asks the doctors to extract her dead husband's sperm, saying that they have always wanted to have children and gives evidence of their treatment for infertility. The emergency consultant calls the clinical ethicist for advice. The legal situation is unclear. (The author's response to the hypothetical case example is on bmj.com)

reductions in time spent on ventilators and days in hospital, and that most doctors and nurses who have used the service find it helpful.^{9, 10} Furthermore, evidence shows that clinical ethicists score higher in moral reasoning tests than clinicians.¹¹

Clinical ethicists could also contribute to the continuing education of healthcare staff in medical ethics through lecturing and private consultations. From my own experience in Canada, doctors expressed a greater understanding of the ethical requirements of informed consent and do not resuscitate orders after attending lectures on these topics. Ethicists could teach ethics to students and doctors at the bedside, exploring the links between technical skill and ethical decision making. The hands-on involvement of clinical ethicists in teaching is likely to reduce the occurrence or recurrence of ethical violations by highlighting key ethical issues and drawing lessons from previous cases.

The idea of using clinical ethicists gives cause for some concern. Doctors may offload their ethical problems on clinical ethicists, abnegating their moral responsibilities too easily. This could be avoided through an awareness of this danger. Some sceptics may frown at the suggestion of creating yet another expert, but ethical cases, like medicine itself, are increasingly sophisticated. Questions also exist about the precise role, training, recruitment, and funding of these new professionals. Finally, the introduction of clinical ethicists should be in addition to the training in

medical ethics, clinical ethics committees, and the BMA's advice centre.

In light of the accepted importance and relevance of medical ethics to everyday practice, the demand for ethical support by doctors in the United Kingdom,^{6, 12} the impossibility of training medical students and doctors to sufficient levels of proficiency in ethics, and the success of clinical ethicists in North America, we now need to introduce clinical ethicists in hospitals in the United Kingdom. Doctors cannot possibly deal with all the ethical problems they encounter in their professional lives, nor can they be expected to analyse complex ethical issues, and to know how similar cases were handled elsewhere. Clinical ethics committees cannot alone cope with the demands of ethically troubled doctors at the coalface. The use of clinical ethicists would represent an important step forward.

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Children with psychiatric disorders and learning disabilities

Their needs extend beyond the provisions in national service framework

Global learning disabilities, or mental retardation as it is still referred to in the *International Classification of Diseases*, occur in at least 3% of the population. Classification systems vary in terminology, but most distinguish on the basis of the severity of the learning disability. In the United Kingdom, children with milder degrees of learning disabilities are likely to be educated in mainstream schools and are often physically well. Children with more severe learning disabilities may attend special schools and frequently have associated medical disorders and

sensory impairments, as either a cause or a correlate of the learning disabilities. Learning disabilities are life long and reduce life chances of employment and independent living.

Psychiatric disorders are two to four times as common in children with learning disabilities, with 30-50% having a mental disorder.¹ While all psychiatric disorders are over-represented in children with learning disabilities, autism and hyperkinetic disorder are particularly increased.² The relation between autism and low intelligence quotient has long been

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recognised, but the eightfold increase in hyperkinetic disorder has largely gone unnoticed. In general, psychiatric disorders are also less likely to be detected in children with learning disabilities than in the general population.

Diagnostic overshadowing, or the misattribution of psychiatric symptomatology to a manifestation of learning disabilities, is a well recognised phenomenon and can occur even with experienced mental health workers.³ Children are reliant on parents and other responsible adults for referral for possible psychiatric disorder; it may be more difficult for carers to detect symptoms in children who have reduced verbal communication. A similar challenge is posed for professionals where traditional psychiatric differential diagnosis relies on the patient's ability to report subjective thoughts and experiences. Considerable dispute exists about the use of behavioural equivalents as an alternative to direct access through language in applying diagnostic categories.⁴ Whether or not behavioural equivalents are incorporated in assessments, specialist skills are required to diagnose psychiatric disorder in people with more severe learning disabilities. The treatment of psychiatric disorders in children with learning disabilities may also be more successful when conducted by professionals with specialist skills.⁵

The psychiatry of learning disability has always been a neglected specialty, and the neglect is especially true in child psychiatry. An unspoken view exists that the psychiatric treatment of children with learning disabilities is less worth while because the effects of long term intellectual disability compromise recovery. However, we have no evidence that children with learning disabilities differ from children with average ability in the improvement in the quality of life they experience by alleviation of psychiatric disorder. The development of equal, although differentiated, mental health services for children with learning disabilities should be a priority for the NHS. This aim has been incorporated in the national service framework for children, where standard 9 embraces the mental health needs of children and young people with disability, along with other groups.⁶ In addition, standard 8 focuses on the need for high quality services for children with disability, and standard 1 highlights the importance of health promotion and early intervention.

The identification and successful treatment of psychiatric disorders in children with learning disabilities will require several developments not identified in the national service framework. Firstly, the awareness needs to increase of the possibility and manifestations of psychiatric disorder through education and training of the professionals whom carers consult regularly—general practitioners, teachers, and disability social workers. Secondly, the skills shortage in the United Kingdom in psychiatry and allied health professions in the assessment and treatment of child psychiatric disorders in children with learning disabilities must be addressed.⁷ Currently, many child and adolescent mental health services feel unable to evaluate or treat learning disabilities adequately and considerable variation exists in the services offered. The national service framework states that disabled children should be able

to access mainstream services. Such a view is praiseworthy, but these services need to include adequate specialisation to meet the needs of children with learning disabilities.

Service infrastructure needs to support the psychiatry of childhood learning disabilities. Integration of services between child health, community paediatrics, and child and adolescent mental health services is likely to be an effective way forward and is in line with the children's national service framework. Many children with moderate to severe learning disabilities will have come to the attention of child health services; this is the group most in need of specialist psychiatric services.

While the national service framework delivers a blueprint for what services should look like, and delineates the responsibilities of health, education and social services, little attention is given to the training, research, and development required to achieve the standards. Training requires expertise in generic child psychiatric skills and the presentation, assessment, and treatment of psychiatric disorder in children with learning disabilities. Well validated instruments exist to evaluate psychiatric disorder in children of average ability and in adults with learning disabilities,⁸ but currently we only have questionnaires for children with learning disabilities, which are insufficient for diagnostic purposes. Research into treatment of child psychiatric disorders is beginning to accumulate adequate evidence. With limited exceptions,⁹ few studies consider children with learning disabilities who are likely to differ in their response to psychological and pharmacological interventions. Meeting the needs of children with learning disabilities will require a comprehensive approach to increasing awareness, enhancing professional skills, developing service infrastructure, and investing in research.

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