Final responsibility for treatment choice: the proper role of medical doctors?

Søren Holm BA, MA, MD, PhD, DrMedSci

Professor, Centre for Social Ethics and Policy, School of Law Manchester, University of Manchester, Manchester, UK

Correspondence

Søren Holm BA, MA, MD, PhD,
DrMedSci
Centre for Social Ethics and Policy
School of Law Manchester
University of Manchester
Manchester
M13 9PL
UK
E-mail: soren.holm@manchester.ac.uk

Accepted for publication

13 February 2011

Keywords: healthcare, multiprofessional, role of medical profession, role of patient, treatment choice

Abstract

Aims To analyse whether the traditional allocation of decision-making responsibility is still justifiable. And, if not to analyse the strength of claims made by other health care professions and by patients.

Background Traditionally doctors have been responsible for choices of treatment, both in terms of deciding and in terms of taking responsibility for the decisions. But modern health care work often takes place in teams involving health care professionals from different professions as well as the patient. In such teams it may not be obvious who should be responsible for treatment choice.

Methods Philosophical analysis of epistemic, ethical and organizational arguments, including analysis of the historical origins of these arguments.

Results The epistemic, ethical and organizational arguments for maintaining a primary decision making role for doctors are not sound. Other health care professionals can, in some circumstances make stronger and more justified claims. The arguments against allocation decision making authority to patients are also invalid or unsound in many circumstances.

Conclusion There are many situations in which final responsibility for treatment choice should rest with health care professionals who are not doctors and with patients.

Introduction

Team work is an integral part of modern health care. Not all health care involves team work, but much does. Team work has been a de facto reality in health care since the birth of the modern hospital in the second half of the 1800s and has been recognized as a reality since the 1970s. Team work occurs in many contexts and in teams with a wide range of configurations, but the kind of team work which will be the focus of the analysis in this paper is team work in a multidisciplinary team with a focus on the treatment and care of a par-

ticular patient or set of patients. Apart from being multidisciplinary, such teams will also often be multiprofessional as many professions work in modern health-care systems.

How should we conceptualize decision making in such teams and who should have the final say in cases of disagreement? What role should the patient have?*

*It is also interesting to explore the decision making role of the patient's family, but this is outside the scope of the present paper.

The traditional answer has been to conceptualize the team as a Weberian hierarchical bureaucracy with the Consultant (or in the US 'Attending') physician at the top of a decision-making pyramid. Information flows up the pyramid and decisions flow down. If any other team members have discretion to make some decisions on their own, this is only because they have been explicitly delegated the power to make those decisions from the consultant and any decision made at lower levels can be revised or overturned by someone higher up in the hierarchy. This model of decision making has often been embodied structurally in an organizational form where each consultant has his or her own 'firm' encompassing a number of junior doctors that work exclusively for this consultant (at least during normal working hours). Exclusive 'firms' are declining in the UK, but the model persists in other organizational hierarchies.

One metaphor used to describe this approach to team decision making is to describe the Consultant as the 'Captain of the ship', implying (i) that the rest of the team take various subordinate crew positions, (ii) that it is the Consultant who navigates the ship towards the safe harbour, and (iii) that the Consultant has the final responsibility, legal and/or moral for any decision that is made.

This approach originated at a time where it was uncontroversial that the consultant legitimately held both Aesculapic and Social power.¹ He was far more educated than any of the other members of the team and power based solely on hierarchical position was completely accepted.

In the USA, the 'Captain of the ship' idea also developed into a legal doctrine covering errors during surgery.² Hospitals traditionally had immunity from malpractice claims because of their charitable status, and this also covered the members of a surgical team who were directly employed by the hospital. The surgeon himself could however be sued for malpractice as he was not in the employ of the hospital but an independent professional. To be able to provide redress for patients who had been harmed during surgery, but where the harm had not been caused by any negligence or malpractice directly attrib-

utable to the surgeon in person a number of US states adopted the doctrine that the surgeon was responsible for everything that happened in the operating theatre, just as the captain of the ship was responsible for everything that happened on the ship. This legal doctrine has now been rejected in all the states where it had previously been operative, partly because hospitals have lost their charity immunity and it is possible to sue the organization or its employees directly. It is difficult to see that the medical profession could ever have had an interest in upholding this specific legal application of the 'Captain of the ship' idea of decision making.

The idea that doctors and only doctors can make decisions in health care has been criticized extensively since the 1970s where the other professions in health care started to assert their professional competence and independence. This discussion has been most prominent in the nursing literature and many elements of the analysis presented in this paper have already been put forward by others, for instance by Haddad in her seminal 1991 paper 'The nurse/physician relationship and ethical decision making'.³

Has this criticism, the changes in organizational structures in the intervening years and the increasing professionalization of nursing and other health-care professions led to the complete abandonment of the 'Captain of the ship' idea of decision making in health care? Not completely, and not at all in some circumstances. It is surely a noteworthy fact about the language we use that one of the terms in current use for other health-care professions than medicine are 'professions allied to medicine'. Why 'allied to medicine' and not for instance 'allied to patient treatment and care'?

It is also obvious that whereas the captain of the ship may be in retreat in the UK and similar health-care systems in first world countries, it is still the prevalent mode of conceptualizing health-care decision making in hospitals in many countries in the world (see for instance Ref. 4,5 in relation to South Africa, there is also a very large Chinese literature on this which I have only been able to access in abstracts). The idea of the doctor as the main decision maker is even to

some degree reflected in the second edition of the World Medical Association's 'Medical Ethics Manual' published in 2009:

Whereas relationships among physicians are governed by generally well-formulated and understood rules, relationships between physicians and other healthcare professionals are in a state of flux and there is considerable disagreement about what their respective roles should be. As noted above, many nurses, pharmacists, physiotherapists and other professionals consider themselves to be more competent in their areas of patient care than are physicians and see no reason why they should not be treated as equals to physicians. They favour a team approach to patient care in which the views of all caregivers are given equal consideration, and they consider themselves accountable to the patient, not to the physician. *Many physicians, on the other hand, feel that even if the team approach is adopted, there has to be one person in charge, and physicians are best suited for that role given their education and experience.*

Although some physicians may resist challenges to their traditional, almost absolute, authority, it seems certain that their role will change in response to claims by both patients and other healthcare providers for greater participation in medical decision making. Physicians will have to be able to justify their recommendations to others and persuade them to accept these recommendations. In addition to these communication skills, physicians will need to be able to resolve conflicts. (Ref. 6, p. 90, my emphasis)

So we have good reason to believe that the medical profession itself has not completely abandoned the idea, even in the UK and other similar countries. Let me provide two quite different illustrations of the truth of this claim.

In a recent article in the BMJ, a former GP describes her experiences of having hip replacements in 1997 and 2009. She writes:

I have nothing but praise for the surgeons and staff who cared for me on both occasions. However, the 12 years between the operations saw substantial improvements in surgical techniques and postoperative case management, making the second operation a much more pleasant experience. This was partly because the orthopaedic technique had been improved and refined and is now less invasive and so reduces damage to the surrounding muscles. After the first operation it was more than a week before I could raise the operated leg from the

bed, whereas in 2009 I could do so on the same day as the operation. For the second operation I had a spinal anaesthetic, which made the immediate pain control and recovery much better.

However, the most important difference was that in 2009 the preparation and recovery of hip replacement patients were in the hands of a multidisciplinary team of specialist orthopaedic nurses, physiotherapists, and occupational therapists, rather than only in the hands of the surgeon. *Specialist orthopaedic nurses had initiated the team approach, and the consultant surgeons had agreed to such delegation and compromised on a uniform policy of postoperative management.* The team members shared their different expertise to achieve a united aim of quality of care and rapid recovery for patients. (Ref. 7, my emphasis)

Here, the multidisciplinary team approach and its very significant advantages are clearly described, including that its introduction had in this specific case been initiated by nurses. But it is still conceptualized as an issue of delegation from the consultant surgeon and of compromise between different surgeons.

A perhaps even clearer example of the continuing pull of the idea that the medical profession should have a special privileged decision-making role in health care can be found in the debate about nurse prescribing.

Nurse prescribing has gradually been introduced in the health-care systems in a range of industrialized, english-speaking countries. In all of these countries, nurse prescribing has been controversial and has been strongly resisted by the medical profession.^{8,9} And in all of the countries a very similar set of arguments have been used in public pronouncements from the profession.⁸⁻¹¹ In relation to an extension of nurse prescribing in the UK in 2005, representatives for the British Medical Association were, for instance, quoted for the following 'insights':

But the British Medical Association said it was opposed to the move and demanded a meeting with the health secretary to discuss the plan.

Hamish Meldrum, chairman of the BMA's GPs committee, said: 'We believe only doctors have the necessary diagnostic and prescribing training that justifies access to the full range of medicine for all conditions'.

And Paul Miller, chairman of the BMA's consultants committee, added: 'This is an irresponsible and dangerous move. Patients will suffer'.

I would not have me or my family subject to anything other than the highest level of care and prescribing, which is that provided by a fully trained doctor.¹²

The BMA has since modified its official stance,¹³ but similar arguments are still being put forward in the media by individual doctors.^{14,15}

It thus seems that there is still significant resistance to anyone else than a medical doctor having the final say in treatment decisions, even if concepts such as multidisciplinary teams or care pathways are seemingly embraced.

This entails that there is still value in trying to answer the question whether there are any good reasons that decision making in the health-care team should continue to be conceptualized according to a strict Weberian hierarchy or whether there are there alternative and better models? The question is extremely relevant in many countries outside the UK and even in the UK its relevance has not yet disappeared.

Responsibility and decision making

Before trying to answer the question about decision making, it is necessary to briefly explore the different forms of decision making at play and their relation to responsibility for the eventual outcome. First, we need to differentiate between complete decision-making power and veto power. If an agent has complete decision-making power, he can decide what should happen and no one can override that decision. If an agent has veto power, he can decide that some course of action should not proceed, but not which course of action should.

Patients have traditionally been conceived as having veto power only. Among the treatment options offered, they can reject those they do not want, but they cannot force the team to offer them a specific treatment. Doctors on the other hand have traditionally been conceived of having complete decision-making power, only limited by the patient's veto. In recent years, the decision-making power of doctors have been

gradually circumscribed, not primarily by giving more power to patients or to other health-care professions, but by more or less prescriptive care pathways and guidelines that limit the available options.

With decision making follows responsibility and one justification of the 'captain of the ship' idea may be that we should *ex post facto* be able clearly to decide who made a particular decision and who is therefore responsible for it and for its consequences. If all team decisions can be attributed to one person and one person only, it simplifies the subsequent attribution of responsibility. This provides a reason for limiting decision-making authority to one person. But this ease of responsibility attribution only provides a very weak reason, as long as the alternative to 'the captain of the ship' is a system where we can, for purposes of responsibility attribution, decide which of the team members who made any particular decision.

The possibility to attribute legal responsibility is of specific importance, because it is only if legal responsibility can be established that a patient can obtain redress for any injury that has been sustained in jurisdictions relying on tort law and not on 'no fault' redress schemes. But even in the literature concerning legal implications of decision making in multidisciplinary teams there is a tendency to unnecessarily restrict the scope to a discussion of the responsibility of doctors. In one of the leading articles on this topic the authors, for instance, begin by describing the full multidisciplinary team in oncology including '... allied health practitioners...' (Ref. 16, p. 951); but then goes on to focus exclusively on doctors in a way that implies that only doctors can be legally responsible. But this is legally incorrect. All health-care professionals involved have a duty of care and can be sued by the patient.

What other reasons can justify limiting decision making to one person or one profession?

Effectiveness might provide a reason. We have good reason to ensure that decisions are made in a timely manner, even if there is disagreement within the team. Many health-care decisions are made under time constraints, and there need to be a way to resolve disagreement. This could be

performed by voting within the team, but given the different professional backgrounds and related areas of expertise within the team and given the often quite varying levels of practical experience and accompanying tacit knowledge, voting is not an attractive solution. And voting procedures are also often quite inefficient time-wise. So effectiveness does provide a reason for allocating final decision-making responsibility in advance, before decisions have to be made. One way of doing this is by identifying the most expert and experienced team member and let that person make the decision.

Part of the medical professions traditional claim to decision-making authority is exactly that doctors are, by virtue of their superior education, the most expert and that senior doctors are, also by virtue of their long and arduous training, the most experienced. The need for efficiency in decision making thus leads to two claims on behalf of the medical profession: (i) an epistemic claim to superior expertise; and (ii) a practical claim to superior decision-making ability through experience.

Let us look at the practical claim first. And let us for the sake of argument accept the premise that the more decisions you make the better you become at making decisions. Does it follow from this that senior doctors are necessarily more experienced than other members of the health-care team?

As far as I am aware there are no studies comparing the number of important decisions made by, for instance doctors and nurses during a working day. We can, however, fairly quickly estimate that the typical doctor had to make many more decisions than the typical nurse per working day, for it to be the case that a senior doctor necessarily was more experienced than a senior nurse. Nurses have a head start, given their shorter education and the senior nurse may well have worked more years in the NHS than the senior doctor. But maybe the argument can be reformulated not in terms of general experience, but in terms of diagnostic knowledge, experience and skill. In the New Zealand debate about nurse prescribing we can, for instance, find the following version of this argument:

Appropriate prescribing depends on accurate diagnosis. This is the fundamental purpose of a medical education. Nursing training, on the other hand, has been more about appropriate caring.¹⁰

This clearly misunderstands the nature of making a diagnosis. Patients make diagnoses and decide whether or not to seek medical attention based on their own diagnosis of their condition. Nurses make diagnoses to guide their caring, or to decide whether the change in the patient's condition warrants getting the junior doctor out of bed, or the consultant in from home. Physiotherapists routinely diagnose musculo-skeletal conditions etc., etc. Making a diagnosis is undoubtedly a skill, but it is not a skill that is unique to the medical profession.

However, even if we accept that senior doctors are not necessarily more experienced than other members of the health-care team, it could still be the case that they were more knowledgeable and therefore epistemically in a better position to make decisions. As the pseudonymous Dr Crippen explains in the UK newspaper the *Guardian* (perhaps channelling Dr Meldrum quoted above):

It takes 12 or more years of training to become a consultant paediatrician. Competition to get into medical school is intense. You need nine or 10 GCSEs, mostly A stars, and three A-grade A-levels. The minimum requirement for entry into a 3-year nursing course is five GCSEs, and two A-levels if you want to do the nursing degree. Who do you want to diagnose and treat your child?¹⁴

Let us first note that the comparison made is tendentious. What is being compared is the 12 years it takes to become a consultant paediatrician with the 3 years it takes to become a nurse straight out of university. But just as it takes many years to move up through the medical hierarchy to become a fully trained consultant, it takes many years and further study for postgraduate degrees to move up the nursing hierarchy to become a nurse practitioner with prescribing rights. Relatedly we need to note that even if we discounted the existence of nurse practitioners a claim of relevant epistemic superiority can only plausibly be made on behalf of *senior* medical doctors. The medical doctor

fresh out of medical school is undoubtedly very knowledgeable, but in most cases less knowledgeable about the specific patient group at a highly specialized department than the nurses who have worked there for some years.

But even with regard to senior medical doctors this claim to epistemic superiority is only true sometimes. There are many occasions where the team pharmacist knows more about drug interactions, the team physiotherapist more about the newest training regimes for the patient's condition, the team nurse practitioner more about the available support in the community, or the team dietician more about how to motivate the patient to change diet than the senior medical doctor does. And if the knowledge that is needed for a particular decision is of this kind, there is no reason for the decision not to be taken by the person who possesses that knowledge.

We can thus conclude that there are no good reasons to allocate decision-making power exclusively to one person or one professional group within the health-care team; or conversely that any member of the team can become the appropriate decision maker. Who should be the decision maker depends on the decision to be made (who is most expert and experienced in relation to this particular decision) and the context in which it is made (e.g. who is present at the time a decision has to be made).

What about the patient?

As already noted above, the competent patient usually has veto power over health-care decisions. The patient can decide that some diagnostic, therapeutic or palliative intervention should not happen and that decision cannot be overridden. This makes sense in a situation where we have an expert health-care team on one side outlining the available options and a non-expert patient on the other side choosing between them based on personal preferences.

But are there situation where patients can claim superior knowledge and expertise in relation to decisions about their health-care? The patient is almost always in a privileged position when it comes to personal knowledge about his

situation, and this is recognized in the emphasis on respect for autonomy in health-care ethics.

There are thus an increasing number of contexts in health care where a sharp distinction between the patient on one side and the health-care team on the other in terms of knowledge and decision making does not make sense. Let me just mention three: The management of chronic illness, the encounter with the internet adept patient-consumer and rehabilitation after major injury. This is not an exhaustive list, but just a list of examples that each raises slightly different issues. I will not provide a complete analysis of each but just draw out the features of each example that make the claims of health-care professionals to be final decision makers problematic.

In relation to the management of chronic illness, the 'expert patient' movement has convincingly argued that it is possible and desirable for many patients to become experts in the management of their own particular disease and illness.^{17–20} The patients can acquire the necessary knowledge and skills to make most decisions independently or in collaboration with health-care professionals. And the patient with chronic illness can also in many circumstances make a strong epistemic claim. The patient may not be a medical or health-care expert in general, or even the most expert concerning the condition from which he suffers, but he may well be the person with most relevant knowledge concerning his particular condition as it manifests itself in his body and his life.

The internet adept patient-consumer raises a different set of issues by coming armed with information and in some cases a desired treatment plan. The information may be wrong and the patient may be misguided, but this is not always the case. Not all health information on the net is invalid, and not all patients are unable to judge the quality and assimilate the information in a rational manner.^{21–27} There will thus be patients who know more about the small corner of health care that is currently relevant to them than the health-care professionals they are encountering. It will still be the case that the health-care team knows more about medicine

and health care than the patient in general terms, but this is often irrelevant to the concrete decision making. If the question is what to do in relation to condition X in context Y, the fact that I know more in total about what to do in relation to conditions A–Z in contexts A–Z does not make me the preferred decision maker on expertise grounds, if there is someone who knows more about the specific issue at hand. In such a case the patient does seem to have a strong *prima facie* claim to be the decision maker. Not only is the patient the most expert, but the he or she can also rely on the much more general claim that the decision is about their life and that this creates a presumption that they should be the decision maker.

Inpatient rehabilitation after major injury again raises a different set of issues, especially in those cases where it is likely that the patient will never reach their previous level of functioning. In such cases, the prognosis for the final outcome is often difficult to assess at the beginning of the rehabilitation process and the possible goals of the process are therefore liable to change over time. The professional members of the rehabilitation team will remain the experts concerning what goals are likely to be medically achievable, but it is the patient who will have to make the difficult decisions concerning what kind of life he wants to live in the future, given that he may not be able to continue to live his old life. What is medically achievable constrains what future life plans that can realistically be pursued, but within that set it is still the patient who will have to choose. This is relevant to our current discussion about decision-making power and adds to the previous examples because it is a very complex situation where the goals of treatment and the means to pursue those goals are inextricably intertwined and where both goals and means are under constant reconfiguration. Whereas it is true that it is the patient who will have to choose the goals in terms of a future life plan, it is also true that it would be cruel if the health-care professionals just provided information to the patient and then let him get on with the autonomous choosing. In this particular context, the patient is best conceptu-

alized as a member of the team continually contributing one kind of expertise to the combined expertise of the team and continually participating in collective decision making.

The counterarguments

There are a number of possible counterarguments to the arguments presented above, especially in relation to the patient as decision-maker. It might be claimed (i) that the patient's personal and emotional involvement makes them less suited as decision makers, (ii) that health-care professionals should take on the role of decision makers to shield patients from the responsibility and possible regret the patients might experience if they made decisions, or (iii) that patients cannot act as decision makers because they cannot take on the responsibility for resource allocation in the health-care system.

The first of these patient-related counterarguments is valid in some cases, but importantly only in some cases. If the patient is so emotionally distraught by his situation that he cannot make a sensible decision, or continually vacillates between decisions, then someone else may well have to make the decision. But this does not affect the vast majority of situations where the patient is not in such a state.

Similarly, the second counterargument is valid in some cases. There are undoubtedly cases where the context means that any decision made is likely to lead to later regret or distress. This may for instance be the case where there are no good options to choose from but only options that are bad in different ways. In such a context, whatever option is chosen it will lead to some bad consequences and the patient might well later think back and wonder what would have happened if another option had been chosen or even wish that another option had been chosen. But this is only a reason to remove the decision-making power from the patient, if the patient does not want to make the decision. There are many situations where I know that I may later regret the decision I make now, but where it would be monstrous to claim that that gives you a reason to make it for me.

The third patient-related counterargument may look plausible but it misconstrues the decision-making context. The reason it looks plausible is that we have good reason to think that if a patient is choosing between treatments the patient will not take cost into account, unless the patient has to bear some of that cost directly. The patient will look exclusively at the likely outcomes and the cost/benefit calculus that the patient will apply will only count 'health costs' (i.e. possible side-effects etc.) and not economic costs. But in a health-care system with resource constraints, all decision making must take economic costs into account. QED: patients cannot be decision makers.

Why is this third counterargument fallacious? The main problem is that it misconstrues what giving the patient decision-making power amounts to. In resource constrained health-care systems, the options available for any decision maker will be constrained by the system. There may be effective, but very costly treatments or interventions that the system does not offer, and there may be waiting lists for specific interventions. Such constraints will apply to all decision makers, whether they are doctors, nurses or patients. Allocating decision-making power to the patient is simply allowing the patient to choose between what is on offer from the system. A patient decision maker may, for instance want to have an MR scan, but will only be able to get one if it is on offer for the particular condition or symptoms, and will no more be able to jump any waiting list than anyone else who writes a valid referral for the scan. There are only very few situations in health care where decisions about individual patients involve, or ought to involve direct considerations of economic cost. For all other decisions, we can therefore safely allow patients to make them, even if they do not take cost into consideration.

Conclusion

Let us return to the captain of the ship metaphor and reflect on it in relation to the analysis above. Who should really captain the health-care ship? Well, maybe we should consider this from the

point of view of the person for whom the voyage is most important, i.e. the patient. The primary purpose of health care is not to create some abstract quantity of health, or some auditable adherence to a care pathway, but to help specific patients to obtain good health-care outcomes.

In so far as reaching this goal requires decisions to be made, these decisions should be made by those who are best placed to make them. No particular group of individuals occupy this position as a matter of course. Sometimes the patient is best placed to make decisions, sometimes a medical doctor and sometimes some other health-care professional. One of the most important decisions that the health-care team have to make together may therefore be who should be the captain on any particular part of the journey. In this decision, the views of the patient are of paramount importance.

Acknowledgements

I thank Professors Alan Cribb and Vikki Enthwhistle for prompting me to commit my thinking about these issues to paper, three anonymous referees for the journal who told me that the first version was muddled and confused, my wife, who is an Advanced Neonatal Nurse Practitioner, Pamela Holm, RN, RM, BSc, MSc, Supplementary and Independent Nurse Prescriber for discussing her clinical practice and encounters with other health-care professionals with me, and Dr. Øystein Ringstad for inspiring discussions in relation to his doctoral project on ethical issues in rehabilitation medicine.

Conflict of interest

The author is a medical doctor, currently non-practising but fully licensed. He thus has a clear interest in preserving the power and status of his profession.

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