Medentia Free Resource

Ethics Frameworks — The 4 Pillars, Made Simple

Made by Haroon | 98% offer rate across tutored students, 2026 cycle

Updated September 2026 for the 2027 entry interview season

Ethics questions come up in almost every medicine and dentistry interview, usually as a scenario station in an MMI or a "what would you do" question in a panel. A lot of applicants try to memorise the "correct" answer to each scenario. That's exactly the wrong approach.

Interviewers aren't looking for a right answer. They want to see that you can spot the competing values in a situation, reason through them calmly, and arrive at a considered position without pretending the dilemma is simpler than it is. This guide gives you the four principles, a step-by-step method for any scenario, and worked examples of the questions that come up most.

Part 1: The Four Pillars

1. Autonomy

A patient with capacity has the right to make their own decisions about their care, even ones you disagree with. This is why we need informed consent: the patient must understand the risks, benefits and alternatives, and must agree voluntarily. **In practice:** a competent adult can refuse a life-saving blood transfusion, and you must respect it.

2. Beneficence

Acting in the patient's best interests and doing good. **In practice:** recommending the treatment most likely to help, explaining it clearly, and following up.

3. Non-maleficence

"First, do no harm." Almost every treatment carries some risk, so this is really about making sure the benefits outweigh the harms. **In practice:** not prescribing antibiotics for a viral infection, because of side effects and antibiotic resistance.

4. Justice

Fairness, both to the individual patient and in how limited NHS resources are shared. **In practice:** deciding who gets a scarce organ or bed based on clinical need, not on who the patient is.

> **Which pillar is most important?**
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> This is a question in itself. There's no correct answer, but a strong one says that no single pillar always wins. In most scenarios autonomy carries a lot of weight in UK practice, but it depends on capacity, and it can be limited when a decision would seriously harm other people. Pick one, justify it, and acknowledge when it wouldn't win.

Part 2: The Supporting Concepts You Must Know

- **Capacity (Mental Capacity Act 2005).** Assume a person has capacity unless shown otherwise. Someone lacks capacity for a specific decision if they can't understand the information, retain it, weigh it up, or communicate their decision. Capacity is decision-specific and can change over time. An unwise decision does not mean someone lacks capacity.
- **Confidentiality.** The default is to keep patient information private. It can be broken when the patient consents, when the law requires it, or when there's a serious risk of harm to the patient or others (for example, safeguarding or a serious crime). Always tell the patient first where it's safe to do so.
- **Gillick competence.** A child under 16 can consent to treatment if they have enough understanding and maturity to fully understand what's involved.
- **Fraser guidelines.** The specific criteria for giving contraception to under-16s without parental involvement.
- **Best interests.** When a patient lacks capacity, decisions are made in their best interests, taking into account their past wishes, values and the views of those close to them.
- **GMC Good Medical Practice.** The professional standards every doctor in the UK must meet. Referencing it shows you understand what's expected of doctors.

Part 3: The Method for Any Scenario

1. **Clarify and gather information.** Don't jump to an answer. What don't you know yet? Why is the patient making this choice? Is anyone at risk?
2. **Identify the people involved** and what each of them wants: patient, family, colleagues, wider public.
3. **Name the principles in tension.** For example, autonomy vs beneficence, or confidentiality vs protecting others.
4. **Apply the relevant framework.** Capacity, consent, Gillick, confidentiality rules, GMC guidance.
5. **Weigh the options**, with the pros and cons of each.
6. **Reach a clear, balanced conclusion**, and say when you'd escalate to a senior.

Throughout, stay patient-centred and empathetic. The interviewer wants to see how you'd make the patient feel, not just what rule you'd follow.

Part 4: Worked Examples

"A Jehovah's Witness needs a life-saving blood transfusion but refuses it. What do you do?"

How to structure it

1. **Check capacity** and make sure the refusal is informed. Do they understand that without it they could die?
2. **Explore the reasons** with empathy, and check the decision is theirs and not the result of pressure from others. Offer to speak to them privately.
3. **Discuss alternatives** that may be acceptable, such as cell salvage or medicines that reduce blood loss.
4. **If they have capacity and still refuse, respect it.** Autonomy wins here, even though it's painful for the team. Document everything and involve seniors.

The twist to be ready for

If the patient is a child, it changes. When parents refuse a life-saving transfusion for their child, doctors can seek a court order to treat in the child's best interests. In an emergency, doctors can give treatment needed to save the child's life.

> **Common mistake to avoid**
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> Trying to persuade or pressure the patient until they agree. Respecting a decision you disagree with is the whole point of autonomy.

"Should the UK legalise assisted dying?"

Where it stands in 2026: the Terminally Ill Adults (End of Life) Bill passed the House of Commons in June 2025 but ran out of time in the House of Lords in April 2026. It was reintroduced in the new parliamentary session, and on 11 September 2026 MPs voted it down at second reading, 286 to 270. Assisted dying remains illegal in England and Wales. Scotland has considered its own separate legislation.

Arguments for

- Autonomy: a competent, terminally ill adult should have control over the manner and timing of their death.
- It could reduce suffering where palliative care can't fully relieve symptoms.
- Some people currently travel abroad, for example to Switzerland, which is expensive and means dying away from home.

Arguments against

- Protecting vulnerable people: some may feel pressure, even subtle, not to be a "burden" on their family or the NHS.
- Concerns that eligibility could widen over time, as some critics argue has happened in other countries.
- Uneven access to good palliative care means some people might choose to die because their care isn't good enough.
- Some doctors feel it conflicts with their role, which is why conscientious objection matters.

What the interviewer is looking for

- That you can lay out both sides fairly and accurately.
- Up-to-date knowledge: the Commons vote in September 2026 is a big change from 2025.
- A personal view you can defend calmly, or an honest explanation of why you find it genuinely difficult.

> **Common mistake to avoid**
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> Saying the bill "passed" or that assisted dying is now legal. That was true of the Commons vote in 2025, but the bill fell in 2026. Outdated facts undermine an otherwise good answer.

"You notice your consultant smells of alcohol on a Monday morning. What do you do?"

1. **Patient safety comes first.** If they're about to see patients or operate, act now.
2. **Don't accuse, and don't ignore it.** If appropriate, speak to them privately and with concern: there may be another explanation.
3. **Escalate** to another senior (for example the clinical lead or another consultant) if there's any risk to patients.
4. **Remember they're a person too.** Alcohol problems may be a sign they're struggling and need support.

> **Common mistake to avoid**
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> Either ignoring it because they're senior, or confronting them publicly in front of patients and staff.

"Is it ethical for doctors to strike?"

Where it stands in 2026: resident doctors in England held repeated strikes in 2025 and 2026 over pay and a shortage of specialty training jobs. In June 2026 BMA members accepted a government offer on pay and jobs (52.9% voted yes), which included around 4,500 extra specialty training places over three years, and the strikes ended.

- **For:** doctors have the legal right to strike; poor pay and conditions push doctors abroad, which harms patients in the long run; emergency care was covered during strikes.
- **Against:** thousands of appointments and operations were postponed, harming patients now; it can damage public trust.
- **Balanced view:** think about non-maleficence in the short term against justice and long-term patient safety.

"You have one kidney and two patients who need it. How do you decide?"

- This is a justice question. Decisions should be based on clinical factors: medical need, likelihood of success, tissue match and time on the waiting list.
- Not on social worth, wealth or who "deserves" it more.
- In reality these decisions are made by transplant teams using national criteria, not by one doctor. Saying so shows maturity.

Before your interview

Don't memorise answers. Memorise the four pillars and the six-step method, then practise applying them out loud to scenarios you haven't seen before. That's what the station is actually testing.

If you want to practise ethics stations with realistic follow-up questions and feedback, book a 1-1 or group interview session at **medentia.co.uk**.