Medical Ethics

CKT

Core ethical principles

The 4 main ethical principles

Beneficence

Nonmaleficence

Autonomy

Justice

Autonomy

Respect patients as individuals (e.g., respecting their privacy by maintaining confidentiality and being truthful about their medical care).

Provide the information and opportunity for patients to make their own decisions regarding their care (e.g., informed consent).

Honor and respect patients' decisions regarding their choice to accept or decline care.

In addition to having the right to refuse a diagnostic or therapeutic intervention, patients also have the right to refuse to receive information.

Beneficence

Act in the best interest of the patient and advocate for the patient.

May conflict with autonomy

Nonmaleficence

Avoid causing injury or suffering to patients

May conflict with beneficence

Justice

Treat patients fairly and equitably.

Equity is not the same as equality.

Obligation to treat

- A physician is obligated to treat patients in a medical emergency in which failing to provide treatment would immediately endanger the patient's life.

- Physicians are not obliged to treat a patient longitudinally and may end a doctor-patient relationship if they wish, **as long as:**
  - The patient or their surrogate decision maker is notified and
  - Has the ability (e.g., time, money) to establish care with another physician.

- The physician is also obligated to facilitate the transfer of care.

Decision-making capacity

- **Definition:** the psychological and/or legal capability to process information, make decisions, and understand the consequences of the same with regard to health care
- Typically determined by the attending physician
- In order to have capacity, a patient must have:
  - **Understanding:** the patient's ability to understand the meaning of information provided by the physician
  - **Appreciation:** the patient's ability to determine how facts are relevant to their situation
  - **Reasoning:** the patient's ability to use the information provided by the physician to make decisions regarding their care
  - **The ability to express a choice:** the patient should have the ability to clearly communicate their choice of treatment

Legal competence

Definition: legal assessment of a patient's ability to make decisions

Assessed by a court of law (physicians do not have the legal power to pronounce patients legally incompetent)

Questions of legal competence arise in the presence of reduced mental capacity (e.g., severe mental illness, intoxication, impulsive/constantly changing decisions, or decisions that are inconsistent with the patient's values)

Shared decision-making

A model in which patients and physicians decide on the best treatment option together

Empowers patient, as it is based on the patient's personal values, cultural beliefs, and preferences

Results in better health outcomes and increases patient satisfaction

Surrogate decision-making

When a patient lacks decision-making capacity or competence, another person must make treatment decisions for them.

The surrogate decision-maker may be appointed by patients (e.g., medical power of attorney), legally appointed (e.g., court-ordered guardian), or next of kin (if no advance directive exists).

Hierarchy of decision-making

It generally follows the following order:

1- A mentally competent patient capable of expressing his/her own decision

2- Advance healthcare directive

- Durable medical power of attorney: a document through which an individual designates a surrogate health care decision-maker in the event that he/she lacks decision-making capacity or competence
- Living will
  - ✓Should the durable medical POA and the living will be in conflict, the POA can override the living will only if such a decision is in line with the patient's most recently expressed wishes.

Hierarchy of decision-making

3- Next of kin

- Spouse
- Adult child
- Parent
- Adult sibling
- In about half of states: “close friend”

Hierarchy of decision-making

4- Ethics committee or legal consult

- When no surrogate is available or there is ongoing dispute (i.e., between equal priority surrogates) regarding who takes precedence as surrogate.

- Legal action may be necessary to appoint a legal guardian if there is no surrogate available or there is ongoing dispute between equal priority surrogates.

  - ❑ When there is ongoing disagreement (i.e., between equal priority surrogates) about treatment decisions that cannot be resolved

  - ❑ When a physician determines that a surrogate's decision may go against the patient's best interests or preferred decision

  - ❑ When a physician determines that a surrogate's decision is made to benefit a third party, rather than in the patient's best interests

Pay Attention!!

Regardless of who the surrogate is, it is paramount that decisions be made based on what patients themselves would have wanted.

The decision-maker should not let their own preferences influence decision-making.

A patient may have expressed their wishes via:

- **Oral advance directive:** an incapacitated patient's prior oral statements regarding their preferences
- **Living will (written advance directive):** a legal document in which patients describe their wishes regarding their healthcare (e.g., to maintain, withhold, or withdraw life-sustaining care)

Pay Attention!!

- **If the patient's wish cannot be determined and there is a disagreement regarding the course of action:**
  - It is prudent to convene a meeting between the disagreeing parties in order to facilitate a conversation about what the patient would have desired.
  - If the patient's most recent wish still cannot be determined, the wishes of the appropriate surrogate decision maker should ultimately be followed.

Informed consent

Definition

- The process of briefing a patient (or a surrogate decision-maker) about their medical condition and treatment options, then obtaining consent to pursue a selected course of treatment.

- Patients (or their surrogate) must demonstrate decision-making capacity and competence before they can consent to, or refuse surgery
  - ✓(e.g., if patients make decisions contrary to sound medical reasoning such as refusing blood transfusions out of religious conviction).

Informed consent

Language

- Discuss health care decisions with patients in terms they can relate to
- Communicate in a language that the patient understands

Timepoint of patient briefing

- The patient must be informed in time (with a sufficient interval) prior to an elective medical procedure

Informed consent

Extent of patient briefing

A patient should be educated about their diagnosis, treatment options, and the risks and benefits of those options before treatment.

- Diagnosis and natural course of the disease without any treatment
- Nature of the proposed medical or surgical treatment
  - ✓Benefits
  - ✓Known complications, estimated risks of death and morbidity
- Types and risks of anesthesia, if necessary
- Alternative treatments
- Informing the patient about the possibility of intraoperative findings that may require more intervention than originally planned.
- **Medical safety advisory:** The physician is obliged to brief the patient about the measures necessary for assuring treatment success (e.g., physical rest after surgery).

Informed consent

Expressing a decision

- After patients reviews the standardized information sheet, they are briefed by the physician over the course of the planned intervention and all relevant risks and complications.
- Once patients (or their surrogate decision-maker) have been briefed, they must be provided with adequate time to digest that information.
- The patient (or their surrogate decision-maker) must then clearly communicate their decision

Exceptions to standard informed consent

The following measures are generally performed without (or against) the patient's consent, although a thorough attempt to persuade the patient to comply voluntarily is preferred:

- Life-threatening emergencies (e.g., an unconscious trauma patient without a surrogate decision-maker present)
  - The physician can be individually accountable for unequivocally necessary measures in an acute emergency.
  - If the patient is unconscious, the patient's presumed will is determined, with a particular gravity assigned to the advance directive.

- A patient lacking decision-making capacity, but whose surrogate decision-maker has authorized intervention

- A patient lacking decision-making capacity, for whom no surrogate decision-maker is available, and treatment is in the best interest of the patient

- Examination, treatment, or quarantine to prevent epidemics

Exceptions to standard informed consent

- If the patient's decision to refuse treatment poses a safety risk to their own well-being and/or the welfare of others (e.g., in the event of severe psychosis, patient with active TB)
  - A legal form must be completed by a physician that allows temporary commitment (usually for a few days at most)
  - Informed consent of the patient or surrogate is required if hospitalization is required beyond the stabilization period

Informed consent in minors

A minor is any person < 18 years old.

Parental consent is required before a minor receives medical care, with a few exceptions:

- The hospitalization or treatment is emergent and life-saving (e.g., trauma, suicidal ideation)
- The minor is legally emancipated
- The minor is seeking care regarding sex (contraception, pregnancy care, or STIs) or addiction care

If the parents of the patient are themselves minors, the grandparents may give consent for their grandchildren.

- Even in these situations, the minor should be encouraged to discuss their issues with their parents.

Informed consent in minors

If parents refuse consent to treatment of a child for a non-emergent but fatal medical condition (e.g., bacterial meningitis, malignancy), the physician should first discuss this decision with the parents, then seek a court order mandating treatment if parents continue to refuse.

A parent cannot refuse an emergently life-saving intervention for a minor (e.g., blood transfusion for hemorrhage), not even for religious reasons

Informed consent during pregnancy

A pregnant woman has the right to refuse health care even if her decision poses a risk to the unborn fetus.

Disclosure

Full disclosure

- Patients have the right to full medical disclosure
- A family does not have the right to ask a physician to withhold information from a patient with decision-making capacity and competence without good reason

Exceptions:

- If the patient requests that the physician withholds information
- **Therapeutic privilege:** a physician determines that full disclosure would cause severe psychological harm (e.g., following an unfavorable prognosis)

Medical errors

Regardless of the outcome of a treatment, a physician must inform the patient immediately if an error has occurred and disclose the nature of that error

- There are several elements of an optimal error disclosure
- Clearly admit an error has occurred
- State the course of events leading to and during the error, avoiding jargon
- Explain the consequences of the error, both immediate and long term (if necessary)
- Describe corrective steps and future preventative steps
- Express personal regret and apology
- Allow ample time for questions and continued dialogue

Medical errors

- If a physician believes that a colleague has committed an error in a patient's care, the physician should urge their colleague to report this error to the patient.
- If the colleague refuses, the physician should report this error via their hospital's or clinic's standard protocol.
- If the cause of an error is not immediately known, the physician should inform the patient and maintain contact while investigations are being carried out.

Research disclosure

Patients must receive full disclosure prior to enrollment in a clinical trial

- All aspects of the experimental protocol (i.e., the purpose of the study, the study design)
- Any potential conflicts of interest
- Any foreseeable hazards to the patient
- The likelihood of direct benefit to the patient
- All alternative treatment options
- Medical strategy, treatment, or device is safe

Research disclosure

The differences between physician responsibility in the role of researcher and in that of attending physician

- A physician-researcher is primarily concerned with clinical data and medical innovation
- A treating physician is primarily concerned with the treatment and best interests of the patient

An informed consent form, approved by the responsible research institutional review board, must be completed by the patient prior to initiation of treatment

Patients participating in clinical research have the right to withdraw from a clinical trial at any time, for any reason (as with any form of informed consent)

Confidentiality

A physician is ethically and legally obliged to keep a patient's medical information (including information disclosed by the patient to the doctor) confidential, with the following exceptions:

- The patient directly requests the physician to share information with another party (e.g., a family member or for insurance purposes)
- The Health Insurance Portability and Accountability Act requires verbal or written consent before releasing medical information

Individual hospitals or physician practices may have additional policies to verify the identity of the receiver (e.g., via phone call) before sharing information

The patient has a notifiable disease

- In this case, a physician is legally permitted to notify only a public health official.
- Depending on the disease, the patient should be encouraged to inform any third parties that may have been infected (e.g., sexual partners).
- The physician does not, however, have the right to inform third parties without the patient's consent.

Confidentiality

The patient poses a danger to others (e.g., impaired driver, homicidal)

- Physicians should protect the intended victim of homicide by any reasonable means (e.g., notify the police)

The patient poses a threat to himself or herself

Elder abuse and child maltreatment

The patient has suffered penetrating trauma from assault (e.g., a gunshot wound, stab wound)

The patient is a minor and care does not involve sexual or addiction medicine

Confidentiality

Confidential information should only be shared with other health care workers if they are immediately involved in the patient's care.

Any other requests by health care workers to share information should be denied

Avoid discussing patient information in public areas.

End-of-life issues

End-of-life care

- There is several ethical dilemmas may arise in context of end-of-life care.

- The physician's role in ethical dilemmas is to facilitate communication (e.g., family meetings) and to reiterate the importance of focusing on what patients themselves would have preferred.

Physician-aided death

Physician-assisted suicide

- When a physician supplies a patient with the means to end their own life (e.g., a physician provides a patient with a lethal dose of morphine that the patient then self-injects)
- Illegal in most states

Euthanasia

- The active termination of a terminally ill patient's life by a physician to end suffering. (e.g., a physician injects a lethal dose of morphine).
- Euthanasia is illegal in the United States.

Terminal sedation

It is legal to adjust medical therapy accordingly to provide relief from pain and suffering in a patient with terminal illness, despite hastening the patient's dying process (e.g., increasing doses of morphine in a patient with metastatic cancer)

Legal and distinct from euthanasia in so far as the intent must be to relieve pain rather than bring about death, even though it may hasten the dying process.

Principle of double effect: An ethical principle that legitimizes an act of good intent despite causing serious harm (e.g., terminal sedation).

End-of-life issues

Do not resuscitate orders (DNR orders)

Only refers to withholding cardiopulmonary resuscitation

Withdrawal of care

Patients with capacity (or their surrogate decision-makers) have the right to refuse any form of treatment at any time, even if that would result in that patient's death.

Physicians should make an effort to understand the reasons behind the patient's decision for refusing treatment.

Futile treatment

A physician is not ethically obligated to provide treatment if it is considered futile (inappropriate treatment), even if requested by the patient or surrogate.

Treatment can be considered futile if:

- There is no evidence for the effectiveness of treatment
- If the intervention has previously failed
- If last-line therapy is failing
- If treatment will not fulfill the goals of care

Organ and tissue donation

Deceased donors

- Patients may declare themselves organ and tissue donors prior to death
- Hospitals must discuss organ donation with the family of the deceased Patients (e.g., in a living will) or their families may specify which organs may be donated after death
- Hospitals must decline organs that are considered unsuitable:
  - Sepsis
  - HIV
  - Poor organ function (e.g., patient died of acute renal failure, so kidneys would be refused)
  - Hypothermia
  - Patient > 80 years old
  - Prolonged organ ischemia (e.g., patient found deceased at home)

Living donors

Nonvital organs and tissues can be acquired from living donors (e.g., liver or bone marrow)

Prior to donation, donors must give full informed consent

Donors have the right to withdraw from donation at any time

Donors may select the recipient of their donation

Donors may not be paid for their donation, but can be reimbursed for associated costs (travel, food, lost wages, etc.)

A donor may engage in an “organ swap”

Death

Criteria: Death can be diagnosed if a patient meets criteria for brain death or cardiopulmonary death.

Only one of these conditions is required, although they may coexist.

Brain death

- Irreversible, complete loss of function of the entire brain (including the brainstem), even if cardiopulmonary functions can be upheld by artificial life support
- Cardiopulmonary death: the absence of a spontaneous heartbeat in an asystolic patient.

Notification of diseases

The diagnosis of several infectious diseases must be reported to public health officials (e.g., CDC).

Reportable diseases vary from state-to-state, but some notifiable diseases include:

- HIV
- Sexually transmitted infections (e.g., gonorrhea , chlamydia)
- Hepatitis
- Tuberculosis
- Rabies
- Meningococcal meningitis
- Some forms of food poisoning (e.g., salmonellosis)

Patients must be informed that their disease is reportable, and they should be encouraged to inform any recent contacts at risk of infection.

The public health department is responsible for notifying third parties if the patient refuses to inform them

Elder abuse/neglect

Any form of physical, psychological, or financial mistreatment of an elderly person.

- **Signs of this include:**
  - Uncommon fractures
  - Malnutrition
  - Dehydration
  - Anogenital injury
  - Unexplained cuts, bruises, pressure ulcers, burns
  - Depression/suicidality
  - Unusual loss of property/money

Always perpetrated by someone with a longitudinal relationship and responsibility for the patient (e.g., a caregiver or relative)

Physicians are legally (and ethically) obliged to report suspected elder abuse

Child maltreatment

The precise legal definition of child abuse and neglect broadly can be defined as any act (or failure to act) that produces an imminent risk of serious harm to an individual < 18 years old

Physicians are legally (and ethically) obliged to report suspected child abuse

Domestic violence

Refers to any form of actual or threatened physical or emotional harm within a household, frequently used to by one person to maintain power over another.

Usually occurs between partners in a relationship, in which case it is more accurately called intimate partner violence.

When a physician suspects domestic violence, they should privately speak with the affected patient, inquire further, and offer assistance.

Physicians are not legally permitted to report domestic violence without patient consent (unless the patient is incompetent e.g., mentally disabled, elderly, or a minor).

In cases where the patient refuses aid, a physician should reiterate their support of the patient and the availability of aid at any time.

Driving restriction

Physicians are sometimes required to report patients who are considered unsafe to drive (e.g., uncontrolled epilepsy is one of the most common reasons) to the licensing authority.

A physician should always suggest another means of transportation.

Generally, only patients at a high risk of having a seizure while driving should be restricted.

Frequent, poorly-controlled seizures.

Recent history of seizures.

Prisoner execution

- It is not ethical for physicians to participate in any executions, regardless of state laws that enforce the death penalty.

Physician-patient romantic relationships

Romantic relationships with current patients are always unethical and inappropriate

A romantic relationship compromises the objectivity of the physician's decisions regarding the care of that patient

Such relationships make patients more vulnerable to exploitation

Physician-patient romantic relationships

Romantic relationships with former patients are also inappropriate if:

The physician has a position of influence from his/her previous professional experience with the former patient (e.g., details of emotions expressed in previous interactions with the patient)

Less than one year has passed since the end of the patient-physician relationship

A physician feel that their actions may be perceived as sexual and/or lead to a romantic relationship with a current patient, the physician should take active measures to avoid unnecessary contact with the patient

- Use direct, close-ended questions
- Interview with a chaperone present

Torture

- **A physician should act in the best interest of their patient, and provide all possible support to aid the patient and facilitate removal from harm, including:**
  - Refusing to participate in torture
  - Ensuring the patient's safety

Abortion and stillbirth laws

Stillbirth: an autopsy of the fetus and placenta should be performed (with permission from the parents if the parent is a minor) after a confirmed and unexplained stillbirth

Abortion

- Most states only permit a licensed physician to perform abortions:
  - If the mother's life or health is at risk because of the pregnancy
  - Up to a certain gestational age
- Most states allow physicians to refuse performing abortions under the condition that patients are referred to another physician who is skilled and willing to perform abortions
- Patient counseling prior to abortion procedures is mandatory in some states
- Most states require that parents of minors undergoing an abortion procedure are notified and/or informed to provide consent

Malpractice

A civil suit because of negligence is due to substandard care by a physician

Medical negligence leads to patient harm

Conflicts of interest

- A conflict of interest occurs when a physician's objectivity regarding their primary interest (e.g., patient welfare) is potentially affected by a secondary interest (e.g., personal financial gain).

- Patients may offer gifts to a physician for a variety of reasons.
  - Not accept gifts of inappropriately high value

Examples of ethically challenging situations

Autonomy

An adult patient refuses treatment based on religious belief:

- Explain the treatment option and other available alternatives
- Make sure that the patient understands the consequences
- Respect patient's choice

Patient wants to try alternative medicine

- Identify the underlying reason behind the decision
- Do not negate or devalue patient's idea (will affect patient-physician relationship)
- Evaluate for drug interaction, adverse effect, safety; allow treatment integration if it is safe

Abuse

Patient discloses abuse by close partner

- Evaluate safety and the presence of emergency plan
- Show empathy and willingness to provide continuous support
- Counsel and evaluate for comorbid psychological issues
- Perform thorough documentation as the victim might want to take legal measures
- Do not force the patient to leave the partner

Abuse

A pediatric patient has injury inconsistent with caregiver's report

- Physicians are obliged by law to report cases of child abuse
- Inform authorities and keep the child in a safe place

Confidentiality

Family members request information about patient's health condition:

- Do not discuss issues with relatives without the consent of the patient

Family members request the physician to withhold information about the diagnosis of the patient (e.g., patient is diagnosed with lung cancer)

- Understand why the family members want to withhold this information (helps to build an empathetic relationship, addresses fear and anxiety)
- Evaluate the extent of information the patient wants to receive
- Deliver information based on the patient's preference

Confidentiality

Patient with HIV refuses to inform his/her partner

- Counsel the patient to disclose the information to individuals at risk
- If the patient refuses, inform the health department for tracing at risk individuals
- At risk individuals can be informed by the physician or the health department
- There is no legal consequence for breaching confidentiality

Competence and decision making

Parents refuse life saving treatment for their child

- Emergency treatment: go ahead and treat
- Non-emergency essential treatment: get court order

A 16-year-old pregnant teenager wants to have an abortion

- Many states require parental consent for an abortion in minors

Competence and decision making

A 15-year-old teenager wants to keep her baby against her parent's will

- The patient has the right to decide about her baby's fate (adoption or keeping the baby)
- Provide practical information about all options
- Support the patient irrespective of her decision

A 14-year-old girl request for contraceptive

- Advise on safe sex practices and prescribe contraceptive
- No need to notify parents to get a consent

Competence and decision making

Patient is suicidal or homicidal

- Considered to have impaired judgement
- Assess the threat (organized plan, access to weapons)
- Admit patient voluntarily, admit involuntarily if patient refuses
- In homicide threats: inform authorities and threatened individual

Malpractice

Patient receives wrong treatment/ test

- Inform the patient even if no harm has been inflicted and apologize.

Miscellaneous cases

Angry Patient

- Angry patient (e.g., waiting at the office for a long time): apologize, acknowledge anger, refrain from justifying or explaining the delay.

Unnecessary intervention

Patient desires an unnecessary intervention (e.g., diagnostic or therapeutic procedure, unnecessary medication)

- Find out why the patient wants the intervention and address any underlying concerns.
- Avoid performing unnecessary medical or surgical interventions.
- Do not refuse to see the patient or refer the patient to another physician.

Poor Adherence

Patient has poor adherence or difficulty of taking medications

- Identify the underlying causes of non-adherence.
- Take a non-judgmental stance and use motivational interviewing if possible.
- Evaluate willingness to change.
- Describe treatment plan in easily understandable language, give written instructions, use teach-back method, and involve other relatives with the permission of the patient.
- Do not refer the patient to another physician.

Physician is impaired in work environment (e.g., due to substance use)

- As the physician is a threat to the safety of his patients, he should be reported to a supervisory entity.
- The supervisory entity handling impaired physician and monitors their license is the Physician Health Program (PHP).
- If PHP measures fail, the state licensing board needs to be informed.

Patient asks a medical student to disclose treatment, diagnostic, or prognostic information

- Act in the best interests of the patient at all times.
- Disclosure should take place in an appropriate environment and at a suitable time to ensure that patient's privacy and emotional needs are met.
- **Medical students usually lack the experience and knowledge to disclose complex diagnostic, treatment, or prognostic information. Hence, they should ensure the following:**
  - Maintain honesty (if the information is available, explain why disclosure has been postponed).
  - Inform patients that complex treatment plans or diagnostic information will be disclosed by senior members of the team

Parents who refuse to vaccinate their child

Respect	Respect the parents' decision, and address their concerns regarding vaccination
Provide	Provide parents with reliable information • Regarding the risks and benefits of vaccination, and attempt to address/adjust misconceptions to ensure an informed decision can be made.
Revisit	Revisit the topic in the subsequent visits.

Parents who refuse to vaccinate their child

In exceptional cases: adopt coercive measures

- E.g., reporting the refusal to the public health agency, involve state agencies to override parents' decision on the basis of medical neglect.

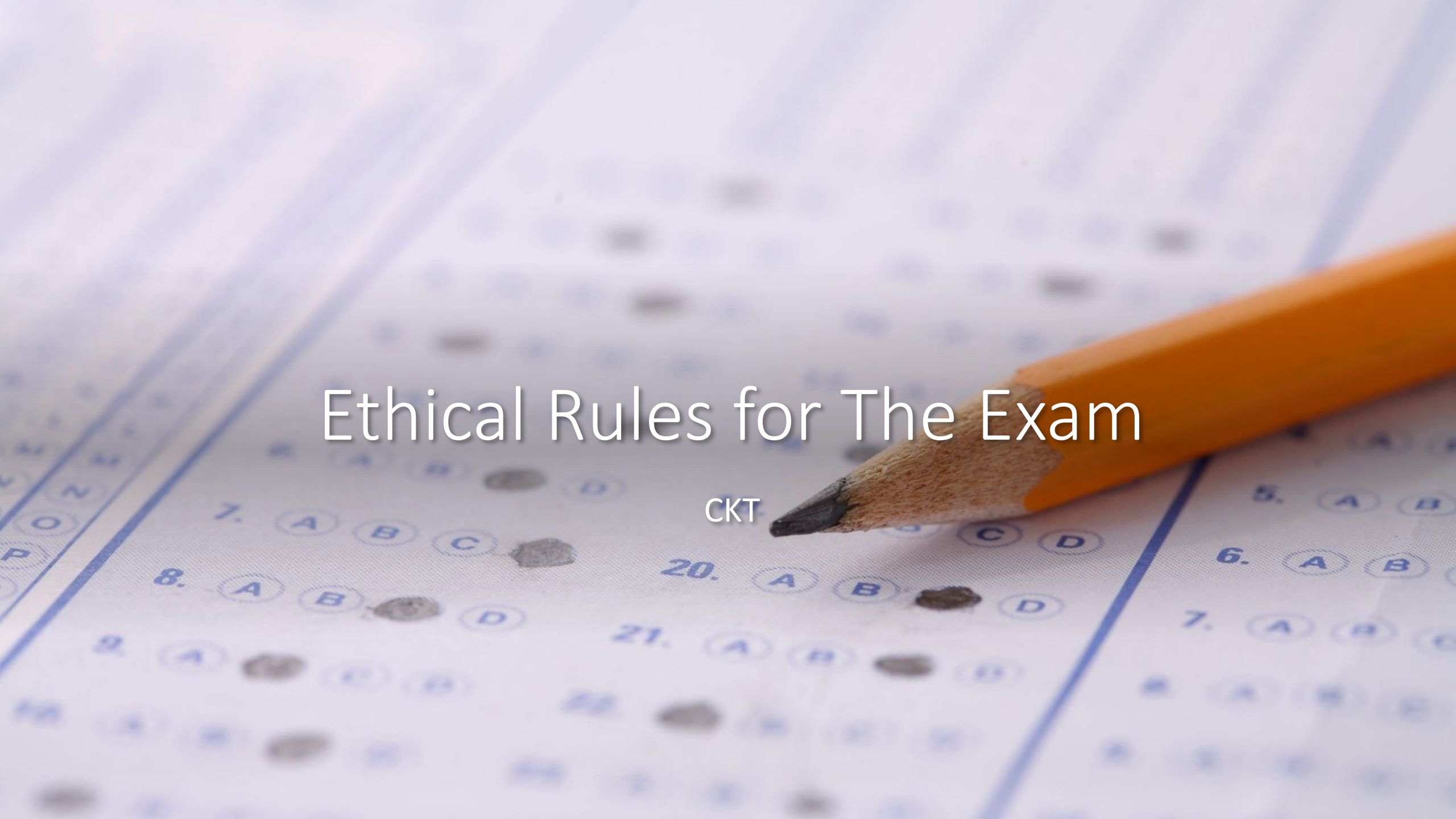
Inform child protective services when there is a significant risk of serious harm for the child and/or for others

- E.g., diseases with very high morbidity and mortality, in case of an epidemic , when vaccination is vital to reducing the spread and protecting individuals at risk.

A family member or close friend requests a drug prescription or treatment

Generally, do not perform any treatment or make prescriptions for close family/friends.

In emergency situations, treatment should be given regardless of the relationship to the patient.



Ethical Rules for The Exam

CKT

Rule #1: Competent patients have the right to refuse medical treatment.

Incompetent patients have the same rights, but these rights must be exercised differently (via a surrogate).

Patients have an almost absolute right to refuse. Patients have almost absolute control over their own bodies. The sicker the patient, the lesser the chance of recovery; thus, the greater the right to refuse treatment.

Rule #2: Feeding tube is a medical treatment and can be withdrawn at the patient's request.

- Very controversial. See Cruzan case, 1990.
- A competent person can refuse even lifesaving hydration and nutrition.

Rule #3: Assume that the patient is competent unless clear behavioral evidence indicates otherwise.

- Competence is a legal, not a medical issue.
- A diagnosis, by itself, tells you little about a patient's competence.
- Clear behavioral evidence would be:
  - Patient is grossly psychotic and dysfunctional.
  - Patient's physical or mental state prevents simple communication.

If you are unsure, assume the patient is competent. The patient does not have to prove to you that he is competent. You have to have clear evidence to assume that he is not.

Rule #4: Special rules apply with children.

- Children younger than age 18 years are minors and are legally incompetent.
- Exceptions are emancipated minors.
  - If older than 13 years and taking care self, i.e., living alone, treat as an adult.
  - Marriage makes a child emancipated, as does serving in the military.
  - Pregnancy or having a child, in most cases, does not.
- Partial emancipation
  - Many states have special ages of consent; generally, age 14 and older.
  - For certain issues only: *1*) substance drug treatment, *2*) prenatal care, *3*) sexually transmitted disease treatment, and *4*) birth control.

Rule #5: Parents cannot withhold life- or limb-saving treatment from their children.

- If parents refuse permission to treat child:
  - If immediate emergency, go ahead and treat.
  - If not immediate, but still critical (e.g., juvenile diabetes), generally the child is declared a ward of the court and the court grants permission.
  - If not life- or limb-threatening (e.g., child needs minor stitches), listen to the parents.
- Note: The child cannot give permission. A child's refusal of treatment is irrelevant.

Rule #6: Avoid going to court. Decision-making should occur in clinical setting if possible, without going to court.

- Consider going to court only if (often resolved without court action)
  - There is intractable disagreement about a patient's competence, who should be the surrogate, or make the decision on life support.
  - You perceive a serious conflict of interest between surrogate and patient's interests.
- Court approval of decision to terminate life support is, therefore, rarely required.

Rule #7: When surrogates make decisions for a patient, they should use the following criteria and in this order:

1. Subjective standard
    - Actual intent, advance directive
    - What did the patient say in the past?

2. Substituted judgment
    - Who best represents the patient?
    - What would patient say if he or she could?

3. Best interests standard
    - Burdens versus benefits
    - Interests of patient, not preferences of the decision-maker

Rule #8: If patient is incompetent, physician may rely on advance directives.

- Advance directives can be oral.
- Living will: written document expressing wishes
  - Care facilities must provide information at time of admission.
  - It is the responsibility of the institution, not the physician.
- Health power of attorney: designating the surrogate decision-maker
  - "Speaks with the patient's voice"
  - Beats all other decision rules

Rule #9: Do nothing to actively assist the patient to die sooner.

- Active euthanasia and assisted suicide are on difficult ground.
  - Passive, i.e., allowing to die → acceptable
  - Active, i.e., killing → unacceptable
- On the other hand, do all you can to reduce the patient's suffering (e.g., giving pain medication).

Rule #10: Patients decide when treatment stops, but physicians declare death.

- What if there are no more treatment options (the patient is cortically dead), and the family insists on treatment? If there are no options, there is nothing the physician can do; treatment must stop.
- What if the physician thinks continued treatment is futile (the patient has shown no improvement), but the surrogate insists on continued treatment? Of course, the treatment should continue. See the Wangley case, 1989.

Rule #11: Never abandon a patient.

- Lack of financial resources or lack of results are never reasons to stop treatment of a patient.
- An annoying or difficult patient is still your patient.

Rule #12: Always obtain informed consent.

- Full informed consent requires that the patient has received and understood five pieces of information:
  - Nature of procedure
  - Purpose or rationale
  - Benefits
  - Risks
  - Availability of alternatives

- Four exceptions to informed consent:
  - Emergency
  - Waiver by patient
  - Patient is incompetent
  - Therapeutic privilege (unconscious, confused, physician deprives patient of autonomy in interest of health)
- Gag clauses that prohibit a physician from discussing treatment options that are not approved violate informed consent and are illegal.
- Consent can be oral.
- A signed paper the patient has not read or does not understand does *not* constitute informed consent.
- Written consent can be revoked, orally, at any time.

Rule #14: Good Samaritan Laws limit liability when physicians help in nonmedical settings.

- Not required to stop to help.
- If help offered, shielded from liability provided:
  - Actions are within physician's competence.
  - Only accepted procedures are performed.
  - Physician remains at scene after starting therapy until relieved by competent personnel.
  - No compensation changes hands.

Rule #15: Confidentiality is absolute.

- Physicians cannot tell anyone anything about their patient without the patient's permission.
- Getting a consultation is permitted because the consultant is bound by confidentiality, too. However, watch the location of the consultation. Be careful not to be overheard (e.g., in elevator or cafeteria).
- If you receive a court subpoena, show up in court, but do not divulge information about your patient.
- If patient is a threat to self or other, the physician *must* break confidentiality.
  - Duty to warn and duty to protect (Tarasoff case)
  - Suicide, homicide, and abuse are obvious threats.
  - Infectious disease should generally be treated as a threat, but be careful. Here, the issue is usually getting the patient to work with you to tell the person who is at risk.
  - In the case of an STD, the issue is not really whether to inform a sexual partner, but how they should be told. Best advice: Have patient and partner come to your office.

Rule #16: Patients should be given the chance to state DNR (Do Not Resuscitate) orders, and physicians should follow them.

- DNR refers only to cardiopulmonary resuscitation.
- Continue with ongoing treatments.
- Most physicians are unaware of DNR orders.
- DNR decisions are made by the patient or surrogate.
- DNR discussions should occur early in treatment.

Rule #17: Committed mentally ill patients retain their rights.

- Committed mentally ill adults legally are entitled to the following:
  - They must have treatment available.
  - They can refuse treatment.
  - They can command a jury trial to determine "sanity."
- They lose only the civil liberty to come and go.
- They retain their competence for conducting business transactions, marriage, divorce, voting, and driving.
- The words "sanity" and "competence" are legal, not psychiatric, terms. They refer to prediction of dangerousness, and medicopsychologic studies show that health care professionals cannot reliably and validly predict such dangerousness.

Rule #18: Detain patients to protect themselves or others.

- Emergency detention can be effected by a physician and/or a law enforcement person for 48 hours, pending a hearing.
- A physician can detain; only a judge can commit.
- With children, special rules exist. Children can be committed only if:
  - They are in imminent danger to self and/or others
  - They are unable to care for their own daily needs
  - The parents have absolutely no control over the child, and the child is in danger (e.g., fire setter), but not because the parents are unwilling to discipline a child.

Rule #19: Remove from the patient contact health care professionals who pose risk to patients.

- Types of risks
  - Infectious disease (e.g., TB)
  - Substance abuse
  - Depression (or other psychologic issues)
  - Incompetence
- Actions
  - Insist that they take time off.
  - Contact their supervisors if necessary.
  - Get them to treatment.
  - The patient, not professional solidarity, comes first.

Rule #20: Focus on what is the best ethical conduct, not simply the letter of the law.

The best answers are those that are both legal and ethical. Increasingly, right answers are determined by selecting the right process, not merely the right goals. The exam questions are testing your capacity to select the proper *means*, not just recognize the proper *ends*.

Physician – Patient Relationship Rules For The EXAM

CKT

Rule #1: Patient is number one: always place the interests of the patient first.

- Choose the patient's comfort and safety over anyone else's.
- The goal is to serve the patient, not to worry about legal protection for the physician.

Rule #2: Always respond to the patient.

- Answer any question that is asked.
- Respond to the emotional, as well as the factual, content of questions.

Rule #3: Tell the patient everything, even if he or she does not ask.

- Do not force a patient to hear bad news if the patient does not want it at that moment, but do try to discuss it with him or her as soon as possible.
- Information should flow through the patient to the family, not the reverse.
- If you have only partial information, say that it is partial, and tell what you know.

Rule #4: Work on developing a rapport on an ongoing basis. Always seek a good, long-term relationship with the patient.

- Make eye contact.
- Defined touch: Tell him or her what you are doing.
- Talk to patient, not colleagues: Patient is always the focus.
- Arrange seating for comfortable, close communication.
- Shy away from large desks and tables.
- If at all possible, both patient and physician should both be sitting.

Rule #5: Listen, reflect, encourage.

- Getting the patient to talk is generally better than having the physician talk.
- Take time to listen to the patient before you, even if other patients or colleagues are waiting.

Rule #6: Negotiate rather than order.

- Treatment choices are the result of agreement, not commands by the physician.
- Remember, the patient makes medical decisions from the choices provided by the physician.

Rule #7: Notice and respond to new information.

- Change plans and goals as events change. New information should cause you to stop and reassess.
- Don't get carried away by inertia. *How* you reach your goal may shift with new information, even if the goal itself stays the same.
- When new people enter the picture, you must adjust and deal with them.

Rule #8: Admit to the patient when you make a mistake.

- Take responsibility. Don't blame it on the nursing staff or on a medical student.
- Admit the mistake even if it was corrected and the patient is fine.

Rule #9: Never "pass off" your patient to someone else.

- Refer to psychiatrist or other specialist when beyond your expertise (but usually not the case).
- Refer only for ophthalmology or related subspecialties.
- Provide instruction in aspects of care, e.g., nutrition, use of medications.

Rule #10: Express empathy, then give control: "I'm sorry, what would you like to do?"

- Important when faced with a patient who is grieving or is angry
- Important when faced with angry or upset family members

Rule #11: Agree on problem before moving to solution.

- Tell the patient your perceptions and conclusions about the condition before moving to treatment recommendations.
- Informed consent requires the patient to fully understand what is wrong.
- Offering a correct treatment before the patient understands his or her condition is wrong.

Rule # 12: Be sure you understand what the patient is talking about before intervening.

- Seek information before acting.
- When presented with a problem, get some details before offering a solution.
- Begin with open-ended questions, them move to closed-ended questions.

Rule # 13: Patients do not get to select inappropriate treatments.

- Patients select treatments, but only from presented, appropriate choices.
- If a patient asks for an inappropriate medication that he/she heard advertised, explain why it is not indicated and suggest an alternative.

Rule#14: Be sure who your patient is.

- Is it the injured child or the mother who brings him in? (The child)
- Is it your long-term patient, who is now in a coma, or her husband? (The patient)

Rule # 15: Never lie.

- Not to patients, their families, or insurance companies
- Do not deceive to protect a colleague.

Rule#16: Accept the health beliefs of patients.

- Be accepting of benign folk medicine practices. Expect them. Diagnoses need to be explained in the way patients can understand, even if not technically precise.
- Be careful about having young family members translate for elderly patients.

Rule #17: Accept patients' religious beliefs and participate if possible.

- Your goal is to make the patient comfortable. Religion is a source of comfort to many.
- A growing body of research suggests that patients who pray and are prayed for have better outcomes.
- Ask about a patient's religions beliefs if you are not sure (but not as a prelude to passing off to the chaplain!).

Rule #18: Anything that increases communication is good.

- Take the time to talk with patients, even if others are waiting.
- Ask "why?"
- Seek information about the patient beyond the disease.

Rule #19: Be an advocate for the patient.

- Work to get the patient what he or she needs.
- Never refuse to treat a patient because he or she cannot pay.

Rule #20: The key is not so much what you do, but how you do it.

- The right choices are those that are humane and sensitive and put the interests of the patient first.
- Treat family members with courtesy and tact, but the wishes and interests of the patient come first.
- Theme: The key is not what physicians *actually* do, but what the most ideal physician *should* do.

Review Questions

CKT

Ethical Legal Rules for Exam Questions

1. Should physicians answer questions from insurance companies or employers?
2. Should physicians answer questions from the patient's family without the patient's explicit permission?
3. What information can the physician withhold from the patient?
4. What if the family requests that certain information be kept from the patient?
5. Who owns the medical record?

1. Not without a release from the patient
2. No
3. Nothing, if patient may react negatively; figure out how to tell patient to mitigate negative outcome
4. Tell the patient, but first find out why they don't want the patient told
5. Health care provider, but patient must be given access or copy on request

What should the physician do in each of these situations?

6. Patient refuses life-saving treatment on religious grounds.
7. Wife refuses to consent to emergency life-saving treatment for unconscious husband citing religious grounds.
8. Wife produces card stating unconscious husband's wish to not be treated on religious grounds.
9. Mother refuses to consent to emergency life-saving treatment for her daughter on religious grounds.
10. What if the child's life is at risk, but the risk is not immediate?
11. From whom do you get permission to treat a girl who is 17 years old?

6. Don't treat
7. Treat; no time to assess substituted judgment
8. Don't treat
9. Treat
10. Court takes guardianship
11. Her guardian

From whom does the physician obtain consent in each of the following cases?

12. A 17-year-old girl's parents are out of the country and the girl is staying with a baby-sitter.
13. A 17-year-old girl who has been living on her own and taking care of herself.
14. A 17-year-old girl who is married.
15. A 17-year-old girl who is pregnant.
16. A 16-year-old daughter refuses medication, but her mother consents. Do you write the prescription?
17. The 16-year-old daughter consents, but the mother refuses.
18. The mother of a minor consents, but the father refuses.
19. When should the physician provide informed consent?
20. Must informed consent be written?
21. Can written consent be revoked orally?
22. Can you get informed consent from a schizophrenic man?
23. Must you get informed consent from a prisoner if the police bring in the prisoner for examination?

12. If a threat to health, the physician can treat under doctrine of in locum parentis
13. The girl herself
14. The girl herself
15. Her guardian
16. Yes
17. No
18. Yes, only one permission needed
19. Always
20. No
21. Yes
22. Yes, unless clear behavioral evidence that he is incompetent
23. Yes

Physician–Patient Relationships

24. A 17-year-old boy is brought to an outpatient clinic and requires sutures to close a laceration on his left calf sustained during football practice at his prep school, a military academy where he lives full-time on campus. His parents live in another state, approximately 800 miles from the school; the doctor is unable to reach either parent by telephone. From whom does the doctor receive permission to treat the boy?

    A. The boy himself; he is an emancipated minor
    B. The Dean of Students at the prep school
    C. The boy's football coach
    D. The boy's 18-year-old teammate who accompanied him to the clinic
    E. The boy's family physician in his hometown

25. A 14-year-old girl, sitting in the passenger seat, is severely injured in a broadside collision. She has profuse internal bleeding and loses consciousness immediately. The mother, who is driving, sustains a forearm fracture but remains alert. Transported by emergency helicopter to the regional trauma center, the emergency medicine physician immediately recognizes that rapid-infusion transfusion is essential to save the girl's life. Nevertheless, the girl's mother objects on religious grounds. The physician will

A. abide by the mother's directive and not transfuse the girl
B. administer the transfusion immediately to save the girl's life
C. discuss the options and alternatives with the mother to make sure that she clearly understands the consequences of declining blood transfusion
D. ask the mother's permission to transfuse blood plasma rather than whole blood
E. ask the mother's permission to obtain and transfuse "blood substitute" from the regional blood bank

26. A physician is favorably impressed with the effectiveness of a new aerosol medication for treatment of asthma and wishes to prescribe it for a 13-year-old girl with recurrent asthma attacks. She is eager to try the new medication. However, her mother, who accompanies her to the clinic, asks that she not receive the medication. The physician's most appropriate action would be to

A. politely but firmly prescribe the medication in the health interests of the girl despite the protest of the mother
B. not dispense the medication because is adherence is jeopardized by the mother's lack of support
C. not dispense the medication because the mother has not consented to this treatment
D. inform the mother that the child will need to be declared a ward of the state if she, the mother, does not provide consent
E. provide a free sample inhaler and ask the girl and her mother to try it out before deciding to decline the prescription

27. A white man, estimated to be 50 years of age, was brought to the ER by the police who found him wandering in a local park on a cold December night with no clothes on and without identification. The patient is able to speak but only utters curses directed first at the police and then at the medical staff. Beyond this, the patient is calm and nonaggressive. However, he refuses all attempts to question him, refuses all medications offered, and continues to refuse to wear clothes. What action should the physician take?

A. Commit the patient to a locked psychiatric ward for observation and treatment
B. Declare the patient incompetent based on his manifest behavior and administer the appropriate psychiatric medications
C. Seek the permission of the police to administer the appropriate psychiatric medications
D. Detain the patient for observation pending a status hearing in the next few days
E. Contact the Public Guardian to secure consent for the man's treatment

28. A young Hispanic man in the Navy visits the physician's office during regular office hours to request treatment for recently acquired gonorrhea. During the taking of standard patient history, the man reveals that he is only 16 years old that he got into the Navy just this past year by lying about his age. The young man asks the physician to treat him and asks that the doctor keep his secret. Before treating this man, the physician should

A. obtain permission from the patient's senior officer

B. obtain permission from the chief medical officer connected to the patient's unit

C. obtain permission from the patient's parents because he is underage

D. treat him only under the condition that he allow the entry of his correct age on the medical record

E. obtain his consent then treat him as he requests

29. A 56-year-old man has been nonadherent with his hypertensive medication. When questioned in the course of his regular office visit, he reports that he feels fine and just gets so busy that he forgets to take his pills. "I know this is a serious condition," he says, "but it really doesn't look like it is a threat to me." According to the Health Belief model, what course of action by the physician is most likely to increase his adherence in the future?

A. Have him attend a hypertension support group

B. Ensure that he has access to a pharmacy to get his prescription filled

C. Modify his prescription from a once a day to a three times a day dosage

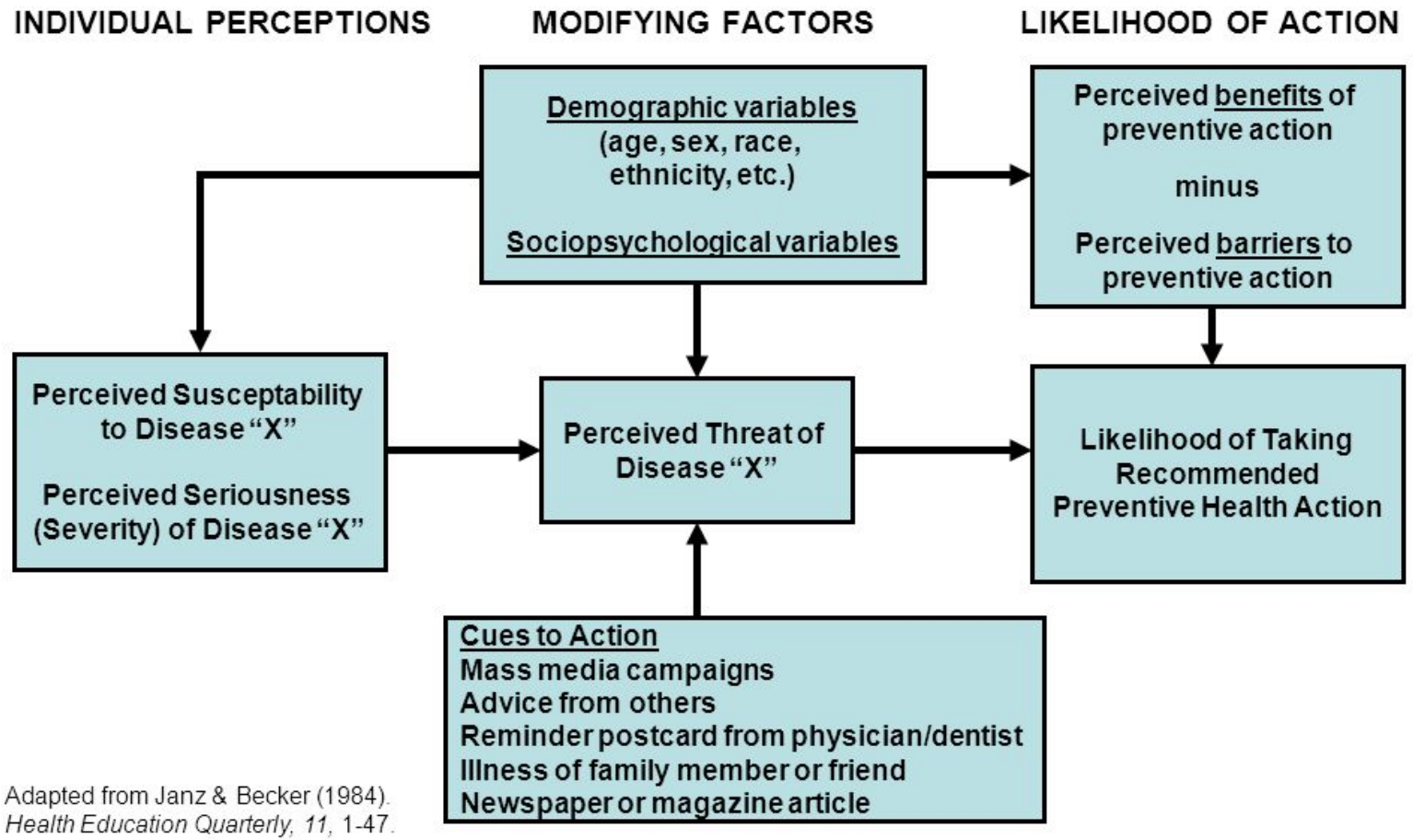
D. Tell him a story about another patient who, like him, was asymptomatic with hypertension but who has recently died

E. Give him a pamphlet on the dangers of hypertension and ask him to talk to you after he reads it

24. Answer: B
25. Answer: B
26. Answer: C
27. Answer: D
28. Answer: E
29. Answer: D

Health Belief Model

(Becker, 1974, 1988; Janz & Becker, 1984)



Adapted from Janz & Becker (1984). *Health Education Quarterly, 11,* 1-47.